



**Contract Year Ending 2025
External Quality Review Annual
Technical Report**

April 2026



Contents

1. Executive Summary.....	1-1
Background	1-1
Contractors Reviewed	1-2
AHCCCS Complete Care (ACC) Program.....	1-2
ACC-Regional Behavioral Health Agreement (ACC-RBHA) Serious Mental Illness (SMI)- Designated Program.....	1-2
Arizona Department of Child Safety Comprehensive Health Plan (DCS CHP) Program	1-3
Arizona Long Term Care System Elderly and Physically Disabled (ALTCS-EPD) Program	1-3
ALTCS Developmental Disabilities (ALTCS-DD) Program.....	1-4
Program-Level Summary of Findings and Assessment	1-4
ACC Program.....	1-5
ACC-RBHA SMI-Designated Program.....	1-11
DCS CHP Program	1-15
ALTCS-EPD Program	1-19
ALTCS-DD Program.....	1-23
2. Introduction to the EQR Technical Report	2-1
ACC Program	2-1
ACC-RBHA SMI-Designated Program	2-2
DCS CHP Program.....	2-2
ALTCS-EPD Program.....	2-3
ALTCS-DD Program	2-3
Assessing Quality, Timeliness, and Access	2-3
Quality	2-4
Timeliness	2-4
Access.....	2-4
Overview of the Report Sections.....	2-5
3. Overview of AHCCCS.....	3-1
AHCCCS Medicaid Managed Care Program History.....	3-1
AHCCCS Waivers and Legislative Updates	3-4
1115 Waiver Update	3-4
Legislative Update	3-13
AHCCCS' Strategic Plan	3-14
Key Initiatives and Accomplishments for AHCCCS	3-16
Accessing Behavioral Health Services in Schools.....	3-16
Arizona Olmstead Plan	3-17
Building an Integrated Health Care System and Improving Care Coordination	3-17
Electronic Visit Verification.....	3-19
AHCCCS Housing Programs	3-20
AHCCCS Payment Modernization	3-20
Medicaid Enterprise System (MES) Modernization Program.....	3-20
Targeted Investments Program.....	3-21

Telehealth Services	3-21
Using Technology to Improve Patient Care	3-21
Whole Person Care Initiative	3-22
2025 AHCCCS Year in Review	3-22
AHCCCS' Medicaid and CHIP Quality Strategy	3-24
Quality Strategy Goals and Objectives	3-25
Recommendations	3-28
4. ACC Program-Level Comparative Results.....	4-1
Validation of Performance Measures	4-1
Results for Information Systems Standards Review	4-1
ACC Program-Level Results	4-2
ACC Program-Level Strengths, Opportunities for Improvement, and Recommendations	
Related to Performance Measure Validation	4-13
Validation of Performance Improvement Projects	4-18
Back to Basics PIP	4-18
ACC Program-Level Validation Results	4-18
ACC Program-Level Measure Results	4-19
ACC Program-Level Interventions	4-20
ACC Program-Level Strengths, Opportunities for Improvement, and Recommendations	
Related to Validation of Performance Improvement Projects	4-21
Prenatal and Postpartum Care PIP	4-21
ACC Program-Level Validation Results	4-22
ACC Program-Level Measure Results	4-23
ACC Program-Level Interventions	4-24
ACC Program-Level Strengths, Opportunities for Improvement, and Recommendations	
Related to Validation of Performance Improvement Projects	4-25
Compliance Reviews	4-26
ACC Program-Level Results	4-26
ACC Program-Level Strengths, Opportunities for Improvement, and Recommendations	
Related to Compliance Review	4-27
Network Adequacy Validation	4-28
ACC Program-Level Results	4-28
ACC Program Conclusions, Opportunities for Improvement, and Recommendations Related	
to Network Adequacy Validation	4-30
Consumer Assessment of Healthcare Providers and Systems Results	4-31
ACC Program Adult Medicaid Results	4-31
ACC Program Strengths, Opportunities for Improvement, and Recommendations Related to	
the Adult Medicaid Consumer Assessment of Healthcare Providers and Systems Results	4-32
ACC Program Child Medicaid Results	4-33
ACC Program Strengths, Opportunities for Improvement, and Recommendations Related to	
the Child Medicaid Consumer Assessment of Healthcare Providers and Systems Results	4-35
KidsCare Results	4-36

KidsCare Strengths, Opportunities for Improvement, and Recommendations Related to Consumer Assessment of Healthcare Providers and Systems Results.....	4-38

5. ACC Program Contractor-Specific Results	5-1
AzCH-CCP ACC-RBHA	5-1
Validation of Performance Measures	5-1
Validation of Performance Improvement Projects.....	5-12
Compliance Reviews	5-19
Network Adequacy Validation	5-19
Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)	5-22
BUFC ACC	5-26
Validation of Performance Measures	5-26
Validation of Performance Improvement Projects.....	5-36
Compliance Reviews	5-43
Network Adequacy Validation	5-45
Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)	5-48
Care1st ACC-RBHA	5-51
Validation of Performance Measures	5-51
Validation of Performance Improvement Projects.....	5-58
Network Adequacy Validation	5-65
HCA ACC	5-68
Validation of Performance Measures	5-68
Validation of Performance Improvement Projects.....	5-75
Compliance Reviews	5-82
Network Adequacy Validation	5-84
Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)	5-87
Mercy Care ACC-RBHA	5-90
Validation of Performance Measures	5-90
Validation of Performance Improvement Projects.....	5-97
Compliance Reviews	5-103
Network Adequacy Validation	5-105
Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)	5-107
Molina ACC	5-110
Validation of Performance Measures	5-110
Validation of Performance Improvement Projects.....	5-118
Compliance Reviews	5-128
Network Adequacy Validation	5-130
Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)	5-132
UHCCP ACC	5-136
Validation of Performance Measures	5-136
Validation of Performance Improvement Projects.....	5-142
Compliance Reviews	5-148
Network Adequacy Validation	5-150
Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)	5-154

6. ACC-RBHA SMI-Designated Program-Level Comparative Results	6-1
Validation of Performance Measures	6-1
Results for Information Systems Standards Review	6-1
Results for Performance Measures	6-2
Strengths and Opportunities for Improvement	6-10
Validation of Performance Improvement Projects	6-14
Preventive Screening PIP	6-14
Prenatal and Postpartum Care PIP	6-18
Compliance Reviews	6-21
ACC-RBHA Program-Level Results	6-21
ACC-RBHA Program-Level Strengths, Opportunities for Improvement, and Recommendations Related to Compliance Review	6-21
Network Adequacy Validation	6-22
ACC-RBHA Program-Level Results	6-22
ACC-RBHA Program Conclusions, Opportunities for Improvement, and Recommendations Related to Network Adequacy Validation	6-24
Consumer Assessment of Healthcare Providers and Systems Results	6-25
ACC-RBHA SMI-Designated Program Results	6-25
ACC-RBHA SMI-Designated Program Strengths, Opportunities for Improvement, and Recommendations Related to Consumer Assessment of Healthcare Providers and Systems Results	6-26
7. ACC-RBHA SMI-Designated Program Contractor-Specific Results	7-1
AzCH-CCP ACC-RBHA	7-1
Validation of Performance Measures	7-1
Validation of Performance Improvement Projects	7-8
Compliance Reviews	7-15
Network Adequacy Validation	7-16
Consumer Assessment of Healthcare Providers and Systems Results	7-18
Care1st ACC-RBHA	7-19
Validation of Performance Measures	7-19
Network Adequacy Validation	7-25
Mercy Care ACC-RBHA	7-27
Validation of Performance Measures	7-27
Validation of Performance Improvement Projects	7-33
Compliance Reviews	7-39
Network Adequacy Validation	7-41
Consumer Assessment of Healthcare Providers and Systems Results	7-42
8. DCS CHP Program Results	8-1
DCS CHP Program	8-1
Validation of Performance Measures	8-1
Validation of Performance Improvement Projects	8-9
Compliance Reviews	8-13
Network Adequacy Validation	8-14

Consumer Assessment of Healthcare Providers and Systems Results.....	8-19
9. ALTCS-EPD Program-Level Comparative Results.....	9-1
Performance Measure Validation	9-1
ALTCS-EPD Program-Level Results	9-1
ALTCS-EPD Program-Level Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measure Validation	9-9
Performance Improvement Projects	9-12
Breast Cancer Screening PIP	9-12
ALTCS-EPD Program-Level Validation Results	9-13
ALTCS-EPD Program-Level Measure Results	9-14
ALTCS-EPD Program-Level Interventions.....	9-14
ALTCS-EPD Program-Level Strengths, Opportunities for Improvement, and Recommendations Related to Validation of Performance Improvement Projects	9-14
Compliance Reviews	9-15
ALTCS-EPD Program-Level Results	9-15
ALTCS-EPD Program-Level Strengths, Opportunities for Improvement, and Recommendations Related to Compliance Review	9-16
Network Adequacy Validation.....	9-17
ALTCS-EPD Program-Level Results	9-17
ALTCS-EPD Program Conclusions, Opportunities for Improvement, and Recommendations Related to Network Adequacy Validation	9-19
10. ALTCS-EPD Program Contractor-Specific Results	10-1
BUFC LTC	10-1
Validation of Performance Measures	10-1
Validation of Performance Improvement Projects.....	10-6
Compliance Reviews	10-9
Network Adequacy Validation	10-11
Mercy Care LTC	10-15
Validation of Performance Measures	10-15
Validation of Performance Improvement Projects.....	10-19
Compliance Reviews	10-22
Network Adequacy Validation	10-23
UHCCP LTC	10-27
Validation of Performance Measures	10-27
Validation of Performance Improvement Projects.....	10-32
Compliance Reviews	10-35
Network Adequacy Validation	10-37
11. ALTCS-DD Program Results	11-41
ALTCS-DD Program	11-41
Validation of Performance Measures	11-41
Validation of Performance Improvement Projects.....	11-55
Compliance Reviews	11-58

Network Adequacy Validation	11-60
12. Assessment of Follow-Up on Prior Year’s Recommendations	12-1
Introduction	12-1
Scoring.....	12-1
ACC Program Contractors’ Follow-Up on Prior Year’s Recommendations	12-2
AzCH-CCP ACC-RBHA	12-2
BUFC ACC	12-13
HCA ACC	12-24
Mercy Care ACC-RBHA.....	12-33
Molina ACC	12-39
UHCCP ACC	12-52
ACC-RBHA SMI-Designated Program Contractors’ Follow-Up on Prior Year’s Recommendations	12-61
AzCH-CCP ACC-RBHA	12-61
Mercy Care ACC-RBHA.....	12-73
DCS CHP Program Follow-Up on Prior Year’s Recommendations.....	12-81
DCS CHP	12-81
ALTCS-EPD Program Contractors’ Follow-Up on Prior Year’s Recommendations.....	12-86
BUFC LTC.....	12-86
Mercy Care LTC	12-93
UHCCP LTC.....	12-100
ALTCS-DD Program Follow-Up on Prior Year’s Recommendations	12-108
DES/DDD	12-109
Appendix A. Methodology	A-1
Appendix B. Combined Performance Measure Results for AzCH-CCP ACC-RBHA and Care1st ACC-RBHA.....	B-1
Appendix C. Acknowledgements and Copyrights	C-1

1. Executive Summary

Background

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, required states that contract with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) for administering Medicaid and Children's Health Insurance Program (CHIP) programs to contract with a qualified external quality review organization (EQRO) to provide an independent external quality review (EQR) of the domains of Quality, Timeliness, and Access to services provided by the contracted MCOs (also referred to as Contractors in this report). Revisions to the regulations originally articulated in the BBA were released in the May 2016 Medicaid and CHIP Managed Care Regulations,¹ with further revisions released in November 2020² and May 2024.³ The final rule is provided in Title 42 of the Code of Federal Regulations (CFR) Part 438 and cross-referenced in the CHIP regulations at 42 CFR Part 457. To comply with 42 CFR 438.358, the Arizona Health Care Cost Containment System (AHCCCS) has contracted with Health Services Advisory Group, Inc. (HSAG), a qualified EQRO. This technical report is intended to help AHCCCS:

- Identify areas for quality improvement (QI).
- Ensure alignment among the Contractors' Quality Management/Performance Improvement (QM/PI) Program Plan requirements, the State's Quality Strategy, and the annual EQR activities.
- Provide high-value care.
- Enhance performance of its healthcare delivery system for Medicaid and CHIP members.
- Improve AHCCCS' ability to oversee and manage its Contractors.
- Assist Contractors with improving their performance with respect to the quality, timeliness, and accessibility of care.

¹ Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. Available at: <https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicare-managed-care-chip-delivered>. Accessed on: Feb 18, 2026.

² Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care. Available at: <https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicare-and-childrens-health-insurance-program-chip-managed-care>. Accessed on: Feb 18, 2026.

³ Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality. Available at: <https://www.federalregister.gov/documents/2024/05/10/2024-08085/medicaid-program-medicare-and-childrens-health-insurance-program-chip-managed-care-access-finance>. Accessed on: Feb 18, 2026.

Contractors Reviewed

AHCCCS maintains managed care agreements with several Contractors to administer its Medicaid Managed Care program. A general description of each AHCCCS program and the associated Contractors reviewed are included below. No Contractors were exempt from EQR in contract year ending (CYE) 2025.

AHCCCS Complete Care (ACC) Program

The **ACC Program** provides integrated care addressing the physical and behavioral health needs for the majority of Medicaid (Title XIX) eligible children and adults as well as addressing the physical and behavioral health needs for the majority of CHIP KidsCare (Title XXI) eligible children (under age 19 years). Seven ACC Contractors were responsible for providing services under the ACC Program. Three of the ACC Contractors were also responsible for providing services for the Serious Mental Illness (SMI)-Designated population. These Contractors are referred to as ACC-Regional Behavioral Health Agreement (ACC-RBHA) Contractors. Throughout this report, ACC Program discussions are limited to the ACC and ACC-RBHA Contractors' Non-SMI-Designated population.

Table 1-1—ACC Program Contracted MCOs

ACC Program Contractors	
Contractor Name	Contractor Abbreviation
Arizona Complete Health – Complete Care Plan	AzCH-CCP ACC-RBHA*
Banner-University Family Care	BUFC ACC
Care1st Health Plan	Care1st ACC-RBHA ¹ *
Health Choice Arizona	HCA ACC
Mercy Care	Mercy Care ACC-RBHA*
Molina Healthcare	Molina ACC
UnitedHealthcare Community Plan	UHCCP ACC

* Contractor serves both the ACC and the ACC-RBHA SMI-Designated populations. Throughout this report, ACC Program discussions are limited to the ACC-RBHA Contractors' Non-SMI-Designated population.

ACC-Regional Behavioral Health Agreement (ACC-RBHA) Serious Mental Illness (SMI)-Designated Program

The **ACC-RBHA Program** provides integrated physical and behavioral health services to eligible Medicaid (Title XIX) and CHIP KidsCare (Title XXI) covered members determined to have a SMI designation. ACC-RBHA Contractors are also responsible for providing crisis services to all individuals, including but not limited to crisis telephone services, community-based mobile crisis teams, and facility-

based crisis stabilization services. Additionally, ACC-RBHA Contractors are responsible for providing services to the ACC Non-SMI-Designated population.

Table 1-2—ACC-RBHA SMI-Designated Program Contracted MCOs

ACC-RBHA SMI-Designated Program Contractors*	
Contractor Name	Contractor Abbreviation
Arizona Complete Health – Complete Care Plan	AzCH-CCP ACC-RBHA
Care1st Health Plan	Care1st ACC-RBHA ¹
Mercy Care	Mercy Care ACC-RBHA

*The ACC-RBHA Contractors serve both the SMI-Designated population (under the ACC-RBHA program) and the Non-SMI-Designated population (under the ACC program).

Arizona Department of Child Safety Comprehensive Health Plan (DCS CHP) Program

The **DCS CHP Program** provides physical, dental, and behavioral health services for children and youth in foster care throughout the State of Arizona.

Table 1-3—DCS CHP Program Contracted MCO

DCS CHP Program Contractor	
Contractor Name	Contractor Abbreviation
Arizona Department of Child Safety Comprehensive Health Plan	DCS CHP*

*DCS CHP provides services through a subcontracted MCO, Mercy Care Department of Child Safety Comprehensive Health Plan (Mercy Care DCS CHP). This report uses DCS CHP when referring to activities conducted by the DCS CHP Program and Mercy Care DCS CHP when referring to activities conducted by the DCS CHP subcontracted health plan (Mercy Care).

Arizona Long Term Care System Elderly and Physically Disabled (ALTCS-EPD) Program

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

Table 1-4—ALTCS-EPD Program Contracted MCOs

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

ALTCS Developmental Disabilities (ALTCS-DD) Program

The **ALTCS-DD Program** provides LTSS as well as integrated physical and behavioral health services to eligible members who have an intellectual/developmental disability (IDD) as outlined under Arizona State law.

Table 1-5—ALTCS-DD Program Contracted MCO

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

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

Program-Level Summary of Findings and Assessment

In this section, HSAG presents program-level strengths, weaknesses (referred to in this report as opportunities for improvement), and recommendations. Each strength, opportunity for improvement, and recommendation is derived from HSAG’s review of the EQR activity results. Table 1-6 below provides a timeline for conducting each of the EQR activities. For additional information related to key milestones and associated dates, please refer to [Appendix A. Methodology](#) for each activity.

Table 1-6—Timeline for EQR Activities

Activity	Start Date	End Date	Measurement/Lookback Period
Performance Measure Validation (PMV)	06/11/2025	04/01/2026	01/01/2024–12/31/2024
Performance Improvement Projects (PIPs)	08/29/2025	03/31/2026	01/01/2024–12/31/2024
Compliance Review	12/09/2024	12/01/2025	10/01/2024–03/31/2025
Network Adequacy Validation (NAV)	10/01/2024	12/19/2025	07/01/2024–09/30/2024
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) ⁴	10/01/2024	11/10/2025	07/01/2025–12/31/2025

⁴ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

ACC Program

Table 1-7 presents program-level strengths, opportunities for improvement, and recommendations for the ACC Program based on all EQR activities conducted. For additional information about ACC Program-level strengths, opportunities for improvement, and recommendations, see [Section 4. ACC Program-Level Comparative Results](#).

Table 1-7—ACC Program Strengths, Opportunities for Improvement, and Recommendations

Strengths, Opportunities for Improvement, and Recommendations	
Strengths	
HSAG identified the following strengths related to performance measure validation (PMV): - The rates for all seven ACC Program Contractors and the ACC Program Aggregate rate met or exceeded the National Committee for Quality Assurance (NCQA) Quality Compass⁵ national Medicaid health maintenance organization (HMO) mean for Healthcare Effectiveness Data and Information Set (HEDIS[®])⁶ measurement year (MY) 2024 for these measures: <i>Follow-Up After Emergency Department (ED) Visit for Substance Use—7-Day Follow-Up—Total (13+ Years) and 30-Day Follow-Up—Total (13+ Years)</i> measure rates [Quality, Timeliness, Access] <i>Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase (6–12 Years) and Continuation and Maintenance Phase (6–12 Years)</i> measure rates [Quality, Timeliness, Access] <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)</i> [Quality, Timeliness, Access] - The rates for six of seven ACC Program Contractors and the ACC Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 for these measures: <i>Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)</i> [Quality, Timeliness, Access] <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)</i> [Quality, Timeliness, Access] <i>Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years) and Engagement of SUD Treatment—Total—Total (13+ Years)</i> measure rate [Quality, Timeliness, Access] <i>Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)</i> [Quality] <i>Well-Child Visits in the First 30 Months of Life—First 15 Months—Six or More Well-Child Visits</i> [Quality]	

⁵ Quality Compass[®] is a registered trademark of NCQA.

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

Strengths, Opportunities for Improvement, and Recommendations

– Oral Evaluation, Dental Services—Total (0–20 Years) [Access]

HSAG identified the following strengths related to the validation of performance improvement projects (PIPs):

- For the *Back to Basics* PIP, five ACC Program Contractors were able to achieve statistically significant improvement for both performance indicators when comparing baseline rates to Remeasurement 3 rates. Additionally, another ACC Program contractor had statistically significant improvement for one of the two performance indicators. At Remeasurement 3, two ACC Program Contractors sustained the statistically significant improvement they achieved previously for both performance indicators. [Quality, Access]

HSAG identified the following strengths related to compliance reviews:

- All four ACC Program Contractors that underwent compliance reviews in CYE 2025 scored at or above 95 percent in the following standards:
 - Assurances of Adequate Capacity and Services [Timeliness, Access]
 - Coordination and Continuity of Care [Quality, Timeliness, Access]
 - Confidentiality [Quality]
 - Practice Guidelines [Quality]
 - Program Integrity [Quality]

HSAG identified the following strengths related to network adequacy validation (NAV):

- The ACC Program Contractors received *High Confidence* for both appointment availability and time/distance indicators. [Access]
- The applicable ACC Program Contractors met all minimum time/distance network standards in Cochise, Graham, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. [Access]
- The ACC Program Contractors consistently met Behavioral Health Residential Facility (BHRF); Cardiologist, Adult and Pediatric; Hospital; Obstetrician/Gynecologist (OB/GYN); and Primary Care Provider (PCP), Adult and Pediatric standards. [Access]

HSAG identified the following strengths related to the CAHPS results for the ACC Program’s adult Medicaid population:

- The ACC Program’s member experience ratings for *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Customer Service* were at or above the 90th percentile for the adult Medicaid population. [Quality]
- The ACC Program’s member experience rating for *Getting Needed Care* was between the 75th and 89th percentiles for the adult Medicaid population. [Quality, Access]

Strengths, Opportunities for Improvement, and Recommendations

- The ACC Program's member experience rating for *Rating of Personal Doctor* was statistically significantly higher than the NCQA national average for the adult Medicaid population. **[Quality]**
- The ACC Program's 2025 score for *Getting Needed Care* was statistically significantly higher than the 2024 score for the adult Medicaid population. **[Quality, Access]**

HSAG identified the following strengths related to the CAHPS results for the ACC Program's child Medicaid population:

- The ACC Program's member experience ratings for *Customer Service*, *Coordination of Care for Children with Chronic Conditions*, and *Access to Prescription Medicines* were at or above the 90th percentile for the CCC population. **[Quality, Access]**
- The ACC Program's member experience ratings for *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Needed Care*, and *Getting Care Quickly* were at or between the 75th and 89th percentiles for the general child population. **[Quality, Timeliness]**
- The ACC Program's 2025 score for *Getting Care Quickly* was statistically significantly higher than the NCQA national average for the general child population. **[Quality, Timeliness]**
- The ACC Program's 2025 score for *Coordination of Care for Children with Chronic Conditions* was statistically significantly higher than the NCQA national averages for the CCC population. **[Quality]**
- The ACC Program's 2025 score for *Customer Service* was statistically significantly higher than the 2024 score for the CCC population. **[Quality]**

HSAG identified the following strengths related to the CAHPS results for KidsCare:

- The KidsCare member experience rating for *How Well Doctors Communicate* was at or above the 90th percentile for the general child population. **[Quality]**
- The KidsCare member experience rating for *Access to Prescription Medicines* was at or above the 90th percentile for the CCC population. **[Quality, Access]**
- The KidsCare member experience ratings for *Rating of All Health Care* and *Rating of Personal Doctor* were at or between the 75th and 89th percentiles for the general child population. **[Quality]**
- The KidsCare member experience rating for *Rating of All Health Care* was at or between the 75th and 89th percentile for the CCC population. **[Quality]**
- The KidsCare 2025 score for *How Well Doctors Communicate* was statistically significantly higher than the NCQA national average for the general child population. **[Quality]**

Opportunities for Improvement and Recommendations

HSAG identified the following opportunities for improvement related to PMV:

Strengths, Opportunities for Improvement, and Recommendations

- The rates for all seven ACC Program Contractors and the ACC Program Aggregate rate fell below the NCQA Quality Compass national Medicaid HMO mean for MY 2024 and fell below the 25th percentile for the following measure:
 - *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years [Quality]*
 - *Prenatal and Postpartum Care—Postpartum Care [Quality, Timeliness, Access]*

Recommendations:

- Regarding the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years* measure, HSAG recommends that the ACC Program Contractors consider implementing one or more of the interventions that have been associated with increased medication adherence for members with schizophrenia. In a systematic review of medication adherence studies, several interventions that worked in studies were motivational interviewing, daily texts to individuals with schizophrenia, and other medication reminders. Other effective studies utilized Meds-Help, a pharmacy-based intervention, environmental support through home visits and reminders to adhere to medication, a psychoeducational program (Family Schizophrenia Psychoeducation Program [FSPP]), an intervention called Supervised Treatment in Outpatients for Schizophrenia (STOPS) that focuses on the importance of the supervisor's role for patients during treatment, and an individualized occupational therapy (IOT) program.⁷ In addition, HSAG recommends that ACC Program Contractors consider utilizing financial incentives offered to patients with severe mental illness to improve treatment adherence.
- Regarding the *Prenatal and Postpartum Care—Postpartum Care* measure, ACC Program Contractors are currently conducting the *Prenatal and Postpartum Care* PIP, which includes a root cause analysis and interventions to address this measure. HSAG recommends that the ACC Program Contractors continue monitoring the success of the interventions and submit the PIP results as required by AHCCCS.

HSAG identified no opportunities for improvement related to the *Back to Basics* PIP.

Recommendations: HSAG recommends that the Contractors consider the following for the future PIPs:

- Apply lessons learned from the *Back to Basics* PIP.

⁷ Cahaya N, Kristina SA, Widayanti AW, et al. Interventions to Improve Medication Adherence in People with Schizophrenia: A Systematic Review. Patient preference and adherence vol. 16 2431-2449. 1 Sep. 2022, doi:10.2147/PPA.S378951. Available at: <https://pubmed.ncbi.nlm.nih.gov/36072918/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

- Seek technical assistance from HSAG to understand the CMS EQR Protocol 1 requirements.
- Implement interventions with clearly defined intervention effectiveness measures.

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

- All four ACC Program Contractors that underwent compliance reviews in CYE 2025 scored below 95 percent in the following standards:
 - Disenrollment: Requirements and Limitations **[Quality]**
 - Coverage and Authorization of Services **[Quality, Timeliness, Access]**

Recommendations: HSAG recommends that the ACC Program Contractors address the elements scored as *Not Met* through the CAP process during CYE 2026.

HSAG identified the following opportunities for improvement related to NAV:

- Based on the NAV results, more than one ACC Program Contractor did not meet the standards for Dentist, Pediatric; and Pharmacy. **[Access]**

Recommendations: HSAG recommends that AHCCCS support each ACC Program Contractor in continuing to monitor and maintain its existing provider network coverage as of CYE 2024 Semiannual Review 2 (S2), with specific attention to ensuring the availability of the following provider categories for which more than one ACC Program Contractor did not meet the network requirement:

- Dentist, Pediatric in Apache, Greenlee, and La Paz counties
- Pharmacy in La Paz County

HSAG identified the following opportunities for improvement related to CAHPS results for the ACC Program's adult Medicaid population:

- The ACC Program's member experience ratings for *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* were below the 25th percentiles for the adult Medicaid population. **[Quality]**
- The ACC Program's member experience rating for *Coordination of Care* was at or between the 25th and 49th percentiles for the adult Medicaid population. **[Quality]**

Recommendations: HSAG recommends that the ACC Program Contractors explore what may be driving lower experience scores and develop initiatives designed to improve the quality of care, including a focus on improving adult members' overall experiences with their care coordination and medical assistance with quitting smoking and tobacco use.

HSAG identified the following opportunities for improvement related to CAHPS results for the ACC Program's child Medicaid population:

Strengths, Opportunities for Improvement, and Recommendations

- The ACC Program's member experience rating for *FCC: Personal Doctor Who Knows Child* was below the 25th percentile for the CCC population. **[Quality]**
- The ACC Program's member experience ratings for *Rating of Specialist Seen Most Often* and *Coordination of Care* were between the 25th and 49th percentiles for the general child population. **[Quality]**
- The ACC Program's member experience ratings for *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Access to Specialized Services*, and *FCC: Getting Needed Information* were between the 25th and 49th percentiles for the CCC population. **[Quality, Access]**
- The ACC Program's 2025 scores for *Rating of All Health Care* and *Access to Prescription Medicines* were statistically significantly lower than the 2024 scores for the CCC population. **[Quality, Access]**

Recommendations: HSAG recommends that the ACC Program Contractors explore what may be driving lower experience scores and develop initiatives designed to improve the quality of and access to care, including a focus on improving parents'/caretakers' overall experiences with their child's health care, child's specialist seen most often, personal doctor who knows child, coordination of care, getting needed information, and access to specialized services for child members.

HSAG identified the following opportunities for improvement related to CAHPS results for KidsCare:

- The KidsCare member experience ratings for *Rating of Specialist Seen Most Often* and *Customer Service* were below the 25th percentiles for the general child population. **[Quality]**
- The KidsCare member experience ratings for *Getting Care Quickly* and *FCC: Personal Doctor Who Knows Child* were below the 25th percentiles for the CCC population. **[Quality, Timeliness]**
- The KidsCare member experience ratings for *Getting Care Quickly* and *Coordination of Care* were between the 25th and 49th percentiles for the general child population. **[Quality, Timeliness]**
- The KidsCare member experience ratings for *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Customer Service*, and *Coordination of Care for Children with Chronic Conditions* were between the 25th and 49th percentiles for the CCC population. **[Quality, Access]**
- The KidsCare 2025 score for *Rating of Specialist Seen Most Often* was statistically significantly higher than the NCQA national average for the general child population. **[Quality]**

Recommendations: HSAG recommends that the KidsCare Contractors explore what may be driving lower experience scores and develop initiatives designed to improve the quality of, access to, and timeliness of care, including a focus on improving parents'/caretakers' overall experiences

Strengths, Opportunities for Improvement, and Recommendations

with the specialist their child sees the most, their child’s personal doctor knowing the child, coordination of care, customer service, and getting needed care in a timely manner.

ACC-RBHA SMI-Designated Program

Table 1-8 presents program-level strengths, opportunities for improvement, and recommendations for the ACC-RBHA SMI-Designated Program based on all EQR activities conducted. For additional information about ACC-RBHA SMI-Designated Program-level strengths, opportunities for improvement, and recommendations, see [Section 6—ACC-RBHA SMI-Designated Program-Level Comparative Results](#).

Table 1-8—ACC-RBHA Program Strengths and Opportunities for Improvement

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths related to PMV: • Rates for all of the ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Program Aggregate rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 for these measures: – <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years</i> [Quality] – <i>Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)</i> [Quality, Timeliness, Access] – <i>Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years) and 30-Day Follow-Up—Total (13+ Years)</i> – <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)</i> [Quality, Timeliness, Access] HSAG identified the following strengths related to PIP validation: • For the <i>Preventive Screening</i> PIP, both ACC-RBHA Contractors adhered to acceptable methodology through all phases of the PIP and were able to measure the effectiveness of interventions and perform accurate statistical testing between the baseline rate and the Remeasurement 3 rate. One ACC-RBHA Contractor was able to achieve statistically significant improvement for both performance indicators at Remeasurement 3. The second Contractor achieved statistically significant improvement for Performance Indicator 1 (<i>Breast Cancer Screening [BCS]</i>) when comparing the baseline rate to the Remeasurement 3 rate. [Quality, Access]

Strengths, Opportunities for Improvement, and Recommendations

HSAG did not identify any ACC-RBHA SMI-Designated Program strengths related to compliance reviews.

HSAG identified the following strengths related to NAV:

- The ACC-RBHA Program Contractors received *High Confidence* for both appointment availability and time/distance indicators. **[Access]**
- The applicable ACC-RBHA Program Contractors met all minimum time/distance network standards in Apache, Coconino, Gila, Graham, Greenlee, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. **[Access]**
- The ACC-RBHA Program Contractors' performance consistently met the BHRF; Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult and Pediatric; Hospital; OB/GYN; and PCP, Adult and Pediatric standards. **[Access]**

HSAG identified the following strengths related to the CAHPS results for the ACC-RBHA SMI-Designated Program's adult Medicaid population:

- The ACC-RBHA SMI-Designated Program's member experience ratings for *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* were at or between the 75th and 89th percentiles for the adult Medicaid population. **[Quality]**

Opportunities for Improvement and Recommendations

HSAG identified the following opportunities for improvement related to PMV:

- None of the ACC-RBHA Contractors' rates nor the ACC-RBHA SMI-Designated Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024, and all rates fell below the 25th percentile for these measures:
 - *Breast Cancer Screening (ECDS)—Total (50–74 Years)* **[Quality]**
 - *Cervical Cancer Screening—21–64 Years* **[Quality]**
 - *Cervical Cancer Screening (ECDS)—21–64 Years* **[Quality]**
 - *Plan All-Cause Readmissions—O/E Ratio—Total—18–64 Years* **[Quality]**
- The rates for two of the ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Program Aggregate rate did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and fell below the 25th percentile for *Use of Opioids at High Dosage—18+ Years*. **[Quality]**
- The rates for two of the ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Program Aggregate rate did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and fell below the 25th percentile for *Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care*. **[Quality, Timeliness]**

Strengths, Opportunities for Improvement, and Recommendations

Recommendations:

- Regarding the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measures, HSAG recommends that these Contractors continue to implement appropriate interventions to improve performance relative to prenatal and postpartum care. HSAG also recommends that the Contractors continue to monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measures. In addition, HSAG recommends that Contractors consider whether there are disparities/social determinants of health (SDOH) within their populations that contributed to lower access to care. A few strategies could include providing expanded access appointments outside of business hours to accommodate work schedules or childcare needs. Further, HSAG recommends that Contractors identify payment structure types that will incentivize quality care. Bundling payments may cause disincentives for postpartum care, as providers might receive the same payment regardless of whether the member attends the postpartum visit.⁸
- Regarding the *Use of Opioids at High Dosage—18+ Years* measure, HSAG recommends that these Contractors continue to implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse. HSAG also recommends that the ACC-RBHA Contractors monitor and expand on interventions currently in place to improve performance related to the *Use of Opioids at High Dosage—18+ Years* measure.
- Regarding the *Plan All-Cause Readmissions—O/E Ratio—Total—18–64 Years* measure, HSAG recommends that these Contractors continue to follow through on performance improvement strategies to increase provider and member outreach and improve follow-up care after discharge from an acute inpatient admission or observation. HSAG recommends that Contractors consider reviewing the Re-Engineered Discharge (RED), which has been shown to reduce readmissions and posthospital ED visits.⁹ Other interventions that might be effective include technology platforms, including artificial intelligence (AI) or machine learning, that can assist the plans in identifying members more at risk of readmission. HSAG recommends that Contractors utilize case management strategies which focus on person-centered techniques, addressing barriers and/or SDOH as needed.
- Regarding the *Cervical Cancer Screening—21–64 Years* and *Breast Cancer Screening (ECDS)—Total (50–74 Years)* measures, HSAG recommends that the ACC-RBHA Contractors leverage interventions and root cause analyses identified through the *Preventive Screening* PIP to improve performance related to preventive screenings. HSAG recommends that the Contractors monitor and expand on interventions currently in place to improve

⁸ Centers for Medicare & Medicaid Services. Lessons Learned about Payment Strategies to Improve Postpartum Care in Medicaid and CHIP. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/postpartum-payment-strategies.pdf>. Accessed on: Feb 11, 2026.

⁹ Agency for Healthcare Research and Quality. Re-Engineered Discharge (RED) Toolkit. Available at: <https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool1.html>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

performance related to these measures. HSAG recommends that Contractors consider utilizing one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve screening rates. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness.

- Starting as part of MY 2022 performance measure reporting, race and ethnicity stratifications (RES) were required based on NCQA HEDIS specifications. While HSAG did not identify Contractor-specific opportunities to improve RES, all ACC-RBHA Contractors could benefit from continuing to focus on refining RES reporting when required in keeping with measure specifications. **[Quality]**

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

HSAG identified the following opportunities for improvement related to PIP validation:

- One ACC-RBHA Contractor's Performance Indicator 2 (*Cervical Cancer Screening [CCS]*) rate remained below the baseline rate at Remeasurement 3 for the *Preventive Screening* PIP. **[Quality, Access]**

Recommendations: HSAG recommends that the Contractors consider the following for the future PIPs:

- Apply lessons learned from the *Preventive Screening* PIP.
- Seek technical assistance from HSAG to understand the CMS EQR Protocol 1 requirements.
- Implement interventions with clearly defined intervention effectiveness measures.

HSAG identified no program-level opportunities for improvement related to compliance reviews.

HSAG identified the following opportunities for improvement related to NAV:

- Based on the NAV results, one ACC-RBHA SMI-Designated Program Contractor did not meet the standard for Dentist, Pediatric in more than one county. **[Access]**

Recommendations: HSAG recommends that AHCCCS support the ACC-RBHA SMI-Designated Program Contractor in continuing to monitor and maintain its existing provider network coverage as of CYE 2024 S2, with specific attention to ensuring the availability of the following provider

Strengths, Opportunities for Improvement, and Recommendations

category for which one ACC-RBHA SMI-Designated Program Contractor did not meet the network requirement in more than one county:

- Dentist, Pediatric in Cochise and La Paz counties.

HSAG identified the following opportunities for improvement related to CAHPS results for the ACC-RBHA SMI-Designated Program’s adult Medicaid population:

- The ACC-RBHA SMI-Designated Program’s member experience ratings for *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care* were below the 25th percentiles for the adult Medicaid population. **[Quality]**
- The ACC-RBHA SMI-Designated Program’s member experience ratings for *Rating of Personal Doctor*, *Getting Needed Care*, and *Getting Care Quickly* were at or between the 25th and 49th percentiles for the adult Medicaid population. **[Quality, Timeliness, Access]**

Recommendations: HSAG recommends that the ACC-RBHA SMI-Designated Program Contractors explore what may be driving lower experience scores and develop initiatives designed to improve the quality of and access to care, including a focus on improving adult members’ overall experiences with their health plan, overall health care, the specialist they see most often, their doctor’s ability to communicate, coordination of care, customer service, and getting needed care in a timely manner.

DCS CHP Program

Table 1-9 presents program-level strengths, opportunities for improvement, and recommendations for the DCS CHP Program based on all EQR activities conducted. DCS CHP strengths, opportunities for improvement, and recommendations by EQR activity are provided in [Section 8. DCS CHP Program Results](#).

Table 1-9—DCS CHP Program Strengths, Opportunities for Improvement, and Recommendations

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths related to PMV: • DCS CHP met or exceeded the NCQA Quality Compass national Medicaid HMO mean and was at or above the 90th percentile for HEDIS MY 2024 for these measures: – <i>Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)</i> and <i>30-Day Follow-Up—Total (6+ Years)</i> [Quality, Timeliness, Access]

Strengths, Opportunities for Improvement, and Recommendations

- *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years) and 30-Day Follow-Up—Total (13+ Years) [Quality, Timeliness, Access]*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years) [Quality, Timeliness, Access]*
- *Follow-Up Care for Children Prescribed ADHD Medication (ECDS)—Initiation Phase (6–12 Years) and Continuation and Maintenance Phase (6–12 Years) [Quality, Timeliness, Access]*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years) [Quality, Timeliness, Access]*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years) [Quality]*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV) [Quality]*
- *Immunizations for Adolescents (ECDS)—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV) [Quality]*
- *Child and Adolescent Well-Care Visits—Total (3–21 Years) [Quality, Timeliness]*
- *Oral Evaluation, Dental Services—Total (0–20 Years) [Access]*

HSAG identified the following strengths related to PIP validation:

- DCS CHP adhered to acceptable methodology through all phases of the *Back to Basics* PIP. The Contractor achieved statistically significant improvement between the baseline rate and the Remeasurement 2 rate and sustained that statistically significant improvement at Remeasurement 3 for the *Child and Adolescent Well-Care Visits (WCV)* performance indicator. **[Quality, Access]**

HSAG identified the following strengths related to compliance reviews:

- DCS CHP successfully closed CAPs in the following focus areas:
 - Delivery Systems (DS) **[Timeliness, Access]**
 - Adult, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), and Maternal Child Health (MCH) **[Quality, Timeliness, Access]**
 - Quality Management (QM) **[Quality]**
 - Quality Improvement (QI) **[Quality, Access]**

HSAG identified the following strengths related to NAV:

- The DCS CHP subcontracted health plan received *High Confidence* for both appointment availability and time/distance indicators. **[Access]**
- The DCS CHP subcontracted health plan met all minimum network requirements for all assigned counties except Apache, Coconino, Greenlee, La Paz, and Pima counties. **[Access]**

Strengths, Opportunities for Improvement, and Recommendations

- The DCS CHP subcontracted health plan consistently met the Behavioral Health Outpatient and Integrated Clinic, Pediatric; Cardiologist, Pediatric; Hospital; OB/GYN; and PCP, Pediatric standards. **[Access]**

HSAG identified the following strengths related to the CAHPS results for DCS CHP:

- DCS CHP's member experience ratings for *Rating of All Health Care*, *Getting Care Quickly*, and *Customer Service* were at or above the 90th percentiles for the general child population. **[Quality, Timeliness]**
- DCS CHP's member experience ratings for *Getting Care Quickly* and *Access to Specialized Services* were at or above the 90th percentiles for the CCC population. **[Quality, Timeliness, Access]**
- DCS CHP's member experience ratings for *Rating of Personal Doctor*, *Getting Needed Care*, and *How Well Doctors Communicate* were at or between the 75th and 89th percentiles for the general child population. **[Quality, Access]**
- DCS CHP's member experience rating for *Customer Service* was at or between the 75th and 89th percentiles for the CCC population. **[Quality]**
- DCS CHP's 2025 scores for *Getting Care Quickly* and *Customer Service* were statistically significantly higher than the NCQA national averages for the general child population. **[Quality, Timeliness]**
- DCS CHP's 2025 scores for *Getting Care Quickly* and *Access to Specialized Services* were statistically significantly higher than the NCQA national averages for the CCC population. **[Quality, Timeliness, Access]**
- DCS CHP's 2025 score for *Getting Care Quickly* was statistically significantly higher than the 2024 score for the general child population. **[Quality, Timeliness]**
- DCS CHP's 2025 scores for *Getting Care Quickly*, *Access to Specialized Services*, *FCC: Personal Doctor Who Knows Child*, and *Access to Prescription Medicines* were statistically significantly higher than the 2024 scores for the CCC population. **[Quality, Timeliness, Access]**

Opportunities for Improvement and Recommendations

HSAG identified the following opportunities for improvement related to PMV:

- DCS CHP's performance measure rate for *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* remained below the 25th percentile, indicating that not all members were following the engagement period for SUD treatments. **[Quality, Timeliness, Access]**

Recommendation: HSAG recommends that DCS CHP continue all efforts being made to conduct a root cause analysis or focus study to determine why some members were not accessing SUD services or medication-assisted treatment (MAT) following their initiation visit. HSAG recommends that DCS CHP review patient data for any patterns present by ZIP Code and other

Strengths, Opportunities for Improvement, and Recommendations

demographics for case management prioritization. One study suggests that male members who have a schizophrenia spectrum disorder diagnosis are less likely to initiate treatment, while current drug dependence and recent arrest were associated with lowered odds of engaging in treatment. Current drug dependence is associated with factors that make scheduling and attending treatment appointments difficult, such as severe symptoms, chaotic living situations, and self-care and life functioning issues.¹⁰

- While DCS CHP was successful in reporting valid rates for all AHCCCS-required performance measures for its DCH CHP population, the audit identified the following recommendations for future years' reporting [Quality]:

Recommendation: HSAG recommends that DCS CHP/Mercy Care continue to ensure compliance with AHCCCS requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes AHCCCS requirements for members for whom DCS CHP does not hold the primary insurance contract. In addition, HSAG recommends that DCS CHP continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES.

HSAG identified no opportunities for improvement related to the *Back to Basics* PIP.

Recommendation: Although there were no opportunities for improvement identified, HSAG recommends that the Contractor consider the following for future PIPs:

- Apply lessons learned from the *Back to Basics* PIP.
- Seek technical assistance from HSAG to understand the CMS EQR Protocol 1 requirements.
- Implement interventions with clearly defined intervention effectiveness measures.

HSAG identified no program-level opportunities for improvement related to compliance reviews.

HSAG identified the following opportunities for improvement related to NAV:

- The DCS CHP subcontracted health plan did not meet standards for more than one county for Dentist, Pediatric and Pharmacy. [Access]

Recommendation: HSAG recommends that AHCCCS support the DCS CHP subcontracted health plan in continuing to monitor and maintain its existing provider network coverage as of CYE 2024 S2, with specific attention to ensuring the availability of the following provider category for which

¹⁰ National Committee for Quality Assurance. Initiation and Engagement of Substance Use Disorder (IET). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/initiation-and-engagement-of-substance-use-disorder-treatment-iet/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

the DCS CHP subcontracted health plan did not meet the network requirement in more than one county:

- Dentist, Pediatric in Apache, Greenlee, and La Paz counties.
- Pharmacy in Coconino and La Paz counties.

HSAG identified the following opportunities for improvement related to the CAHPS results for DCS CHP:

- DCS CHP's member experience ratings for *Coordination of Care, FCC: Personal Doctor Who Knows Child*, and *Coordination of Care for Children with Chronic Conditions* were below the 25th percentiles for the CCC population. **[Quality]**
- DCS CHP's member experience ratings for *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, and *Coordination of Care* were at or between the 25th and 49th percentiles for the general child population. **[Quality]**
- DCS CHP's member experience ratings for *Rating of Health Plan* and *Rating of Personal Doctor* were at or between the 25th and 49th percentiles for the CCC population. **[Quality]**

Recommendations: HSAG recommends that DCS CHP explore what may be driving lower experience scores and develop initiatives designed to improve the quality of care, including a focus on improving parents'/caretakers' overall experiences with the health plan, the specialist their child sees most often, access to care in a timely manner, and coordination of care for child members.

ALTCS-EPD Program

Table 1-10 presents program-level strengths, opportunities for improvement, and recommendations (as applicable) for the ALTCS-EPD Program based on all EQR activities conducted. For additional information about ALTCS-EPD Program-level results, see [Section 9. ALTCS-EPD Program-Level Comparative Results](#).

Table 1-10—ALTCS-EPD Program Strengths, Opportunities for Improvement, and Recommendations

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths related to PMV: • All three ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 for these measures:

Strengths, Opportunities for Improvement, and Recommendations

- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years [Quality]*
- *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years) and Effective Continuation Phase Treatment—Total (18+ Years) [Quality]*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years [Quality]*
- *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total (18–75 Years) [Quality]*
- *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total (18–64 Years) [Quality]*

HSAG identified the following strengths related to PIP validation:

- All ALTCS-EPD Contractors adhered to acceptable methodology through all phases of the *Breast Cancer Screening* PIP and were able to achieve statistically significant improvement when comparing the baseline rate to the Remeasurement 3 rate. Additionally, two Contractors achieved sustained statistically significant improvement at Remeasurement 3. **[Quality, Access]**

HSAG identified the following strengths related to compliance reviews:

- The two ALTCS-EPD Program Contractors that underwent reviews in CYE 2025 scored at or above 95 percent in the following standards:
 - Assurances of Adequate Capacity and Services **[Timeliness, Access]**
 - Availability of Services **[Timeliness, Access]**
 - Confidentiality **[Quality]**
 - Coordination and Continuity of Care **[Quality, Timeliness, Access]**
 - Practice Guidelines **[Quality]**
 - Program Integrity **[Quality]**

HSAG identified the following strengths related to NAV:

- The ALTCS-EPD Program Contractors received *High Confidence* for both appointment availability and time/distance indicators. **[Access]**
- All the applicable ALTCS-EPD Program Contractors met all minimum time/distance network standards in Apache, Cochise, Coconino, Gila, Graham, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. **[Access]**
- The ALTCS-EPD Program Contractors' performance consistently met the Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; BHRF; Cardiologist, Adult and Pediatric; Dentist, Pediatric; Hospital; Nursing Facility; OB/GYN; and PCP, Adult and Pediatric standards. **[Access]**

Strengths, Opportunities for Improvement, and Recommendations

Opportunities for Improvement and Recommendations

HSAG identified the following opportunities for improvement related to PMV:

- All three ALTCS-EPD Program Contractors' rates and the ALTCS-EPD Program Aggregate rate failed to meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and fell below the 25th percentile for these measures:
 - *Initiation and Engagement of Substance Abuse Disorder Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* [Quality, Timeliness, Access]
 - *Breast Cancer Screening (ECDS)—Total (50–74 Years)* [Quality]
 - *Cervical Cancer Screening—21–64 Years* [Quality]
 - *Cervical Cancer Screening (ECDS)—21–64 Years* [Quality]
 - *Use of Opioids at High Dosage—18+ Years* [Quality]

Recommendations:

- For the *Initiation and Engagement of Substance Abuse Disorder Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* measure, HSAG recommends that the ALTCS-EPD Program Contractors continue all efforts to conduct a root cause analysis or focus study to determine why some members are not accessing SUD services or MAT following their initiation visit. HSAG recommends that the ALTCS-EPD Program Contractors review patient data for any patterns present by ZIP Code and other demographics for case management prioritization. One study suggests that male members who have a schizophrenia spectrum disorder diagnosis are less likely to initiate treatment, while current drug dependence and recent arrest were associated with lowered odds of engaging in treatment. Current drug dependence is associated with factors that make scheduling and attending treatment appointments difficult, such as severe symptoms, chaotic living situations, and self-care and life functioning issues.¹¹
- Regarding the *Use of Opioids at High Dosage—18+ Years* measure, HSAG recommends that the ALTCS-EPD Program Contractors continue to evaluate their opioid prescription monitoring efforts to identify opportunities to enhance oversight of prescription opioids at a high dosage. Through this process, each ALTCS-EPD Program Contractor should determine if it is necessary to deploy additional mechanisms to identify members who may be at high risk for opioid overuse and misuse, as literature suggests there is a correlation between high dosages of prescription opioids and the risk of both fatal and nonfatal overdoses.¹² Each ALTCS-EPD Program Contractor should continue to report any completed prescription opioid monitoring effort enhancements to AHCCCS. HSAG also recommends that ALTCS-EPD

¹¹ National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/use-of-opioids-at-high-dosage-hdo/>. Accessed on: Feb 11, 2026.

¹² Brown CH, Bennett ME, Li L, Bellack AS. Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders. *Addictive Behaviors*. 2010;36(5):439-47.

Strengths, Opportunities for Improvement, and Recommendations

Program Contractors identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts.

- Regarding the *Breast Cancer Screening (ECDS)—Total (50–74 Years)* measure, ALTCS-EPD Program Contractors are currently conducting the *Breast Cancer Screening* PIP, which includes a root cause analysis and interventions to address this measure; therefore, HSAG recommends that the ALTCS-EPD Program Contractors continue all efforts to conduct a root cause analysis or focus study to determine why some female members are not receiving timely screenings for breast cancer.
- Regarding the *Cervical Cancer Screening—21–64 Years* and *Cervical Cancer Screening (ECDS)—21–64 Years* measures, HSAG recommends that ALTCS-EPD Program Contractors consider utilizing one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve cervical cancer screening rates. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that ALTCS-EPD Program Contractors provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge.
- Starting with CY 2022 performance measure reporting, RES is required based on NCQA HEDIS specifications. While HSAG noted that two of the three ALTCS-EPD Contractors could benefit from improvement in performance measure reporting using RES, all ALTCS-EPD Contractors could benefit from continuing to focus on refining RES reporting when required in keeping with measure specifications. **[Quality]**

Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors continue to explore data sources for the capture of race and ethnicity data to support performance measure reporting that requires stratifications related to RES. The ALTCS-EPD Program Contractors should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information.

HSAG identified no program-level opportunities for improvement or recommendations related to the *Breast Cancer Screening* PIP.

Recommendation: Although there were no opportunities for improvement identified, HSAG recommends that the Contractors consider the following for future PIPs:

- Apply lessons learned from the *Breast Cancer Screening* PIP.
- Seek technical assistance from HSAG to understand the CMS EQR Protocol 1 requirements.
- Implement interventions with clearly defined intervention effectiveness measures.

Strengths, Opportunities for Improvement, and Recommendations

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

- The two ALTCS-EPD Program Contractors that underwent compliance reviews in CYE 2025 scored below 95 percent in the following standards:
 - Coverage and Authorization of Services **[Quality, Timeliness, Access]**
 - Disenrollment: Requirements and Limitations **[Quality]**
 - Emergency and Poststabilization Services **[Quality, Timeliness, Access]**
 - Grievance and Appeal Systems **[Quality, Timeliness, Access]**
 - Quality Assessment and Performance Improvement Program **[Quality, Timeliness]**
 - Subcontractual Relationships and Delegation **[Quality]**

Recommendations: HSAG recommends that the two ALTCS-EPD Program Contractors that underwent compliance reviews in CYE 2025 continue to work on any outstanding CAPs during CYE 2026.

HSAG identified the following opportunities for improvement related to NAV:

- Based on the NAV results, one ALTCS-EPD Program Contractor did not meet the standard for Pharmacy in more than one county. **[Access]**

Recommendations: HSAG recommends that AHCCCS support the ALTCS-EPD Program Contractor in continuing to monitor and maintain its existing provider network coverage as of CYE 2024 S2, with specific attention to ensuring the availability of the following provider category for which one ALTCS-EPD Program Contractor did not meet the network requirement in more than one county:

- Pharmacy in Greenlee and La Paz counties.

ALTCS-DD Program

Table 1-11 presents program-level strengths, opportunities for improvement, and recommendations for the ALTCS-DD Program based on all EQR activities conducted. ALTCS-DD strengths, opportunities for improvement, and recommendations by EQR activity are provided in [Section 11. ALTCS-DD Program Results](#).

Table 1-11—ALTCS-DD Program Strengths, Opportunities for Improvement, and Recommendations

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths related to PMV:

Strengths, Opportunities for Improvement, and Recommendations

- DES/DDD's performance measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and were at or above the 90th percentile for these measures:
 - *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years* **[Quality]**
 - *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years) and Effective Continuation Phase Treatment—Total (18+ Years)* measure rates **[Quality]**
 - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years* **[Quality]**
 - *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)* **[Quality, Timeliness, Access]**
 - *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total (6+ Years)* **[Quality, Timeliness, Access]**
- DES/DDD's performance measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and were at or between the 75th and 89th percentile for these measures:
 - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)* **[Quality]**
 - *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* **[Quality, Timeliness, Access]**
 - *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* **[Quality, Timeliness, Access]**
 - *Colorectal Cancer Screening (ECDS)—Total (45–75 Years)* **[Quality]**
 - *Oral Evaluation, Dental Services—Total (0–20 Years)* **[Access]**

HSAG identified the following strengths related to the *Back to Basics* PIP:

- The DES/DDD Contractor was able to achieve statistically significant improvement at Remeasurement 3 when compared to the baseline rate, sustaining the statistically significant improvement achieved at Remeasurement 2. **[Quality, Access]**

HSAG identified the following strengths related to compliance reviews:

- DES/DDD achieved full compliance in five of the 14 focus areas reviewed, demonstrating strengths and adherence to all requirements measured in the following areas:
 - Claims and Information Standards **[Access]**
 - Grievance Systems **[Quality, Timeliness, Access]**
 - Adult; EPSDT; and Maternal Child Health **[Timeliness, Access]**

Strengths, Opportunities for Improvement, and Recommendations

- Reinsurance **[Quality]**
- Third-Party Liability **[Quality, Timeliness, Access]**

HSAG identified the following strengths related to NAV:

- The DES/DDD subcontracted health plans received *High Confidence* for both appointment availability and time/distance indicators. **[Access]**
- The DES/DDD subcontracted health plans met all minimum time/distance network standards for Cochise, Coconino, Graham, Maricopa, Mohave, Navajo, Pinal, Santa Cruz, Yavapai, and Yuma counties. **[Access]**
- The DES/DDD subcontracted health plans consistently met the Cardiologist, Pediatric; Hospital OB/GYN; and PCP, Adult and Pediatric standards. **[Access]**

Opportunities for Improvement and Recommendations

HSAG identified the following opportunities for improvement related to PMV:

- DES/DDD performance measure rates fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and the 25th percentile for these measures:
 - *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* **[Quality, Timeliness, Access]**
 - *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)* **[Quality]**
 - *Childhood Immunization Status—Combination 7 and Combination 10* **[Quality]**
 - *Childhood Immunization Status (ECDS)—Combination 7 and Combination 10* **[Quality]**
 - *Breast Cancer Screening (ECDS)—50–74 Years* **[Quality]**
 - *Cervical Cancer Screening—21–64 Years* **[Quality]**
 - *Cervical Cancer Screening (ECDS)—21–64 Years* **[Quality]**

Recommendations:

- Regarding the *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* measure, HSAG recommends that DES/DDD conduct a root cause analysis or focus study to determine why some members are not accessing SUD treatment services. HSAG recommends that DES/DDD review patient data for any patterns present by ZIP Code and other demographics for case management prioritization. One study suggests that male members who have a schizophrenia spectrum disorder diagnosis are less likely to initiate treatment, while current drug dependence and recent arrest were associated with lowered odds of engaging in treatment. Current drug dependence is associated with factors that make

Strengths, Opportunities for Improvement, and Recommendations

scheduling and attending treatment appointments difficult, such as severe symptoms, chaotic living situations, and self-care and life functioning issues.¹³

- Regarding the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)* measure, HSAG recommends that DES/DDD identify providers who may be overprescribing antipsychotics to children and adolescents. DES/DDD can collaborate with its pharmacy benefits manager (PBM) in conducting drug utilization reviews and then educate providers to ensure that members are receiving timely psychosocial care which includes a comprehensive treatment plan and behavioral and psychological therapies, in addition to medication management.¹⁴
- Regarding the *Childhood Immunization Status* measures, HSAG continues to recommend that DES/DDD identify best practices to support children in receiving preventive vaccinations according to recommended schedules. HSAG recommends that DES/DDD provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.
- Regarding the preventive screening measures, HSAG recommends that DES/DDD consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended cancer screenings and make appropriate health decisions. HSAG recommends that DES/DDD consider utilizing one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve cervical cancer screening rates. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that DES/DDD provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge. In addition, HSAG recommends that DES/DDD work with its subcontracted health plans to analyze their data and consider whether there are disparities within DES/DDD's populations that contributed to lower screening rates.

- While DES/DDD was successful in reporting valid rates for all AHCCCS-required performance measures for its ALTCS-DD population, and HSAG did not identify specific opportunities for DES/DDD to improve RES, DES/DDD could benefit from continuing to focus on refining RES reporting when required in keeping with measure specifications. **[Quality]**

Recommendations: HSAG recommends that DES DDD work with AHCCCS on collaborative efforts to improve the completion and accuracy of race/ethnicity data and explore other methods to

¹³ National Committee for Quality Assurance. Initiation and Engagement of Substance Use Disorder (IET). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/initiation-and-engagement-of-substance-use-disorder-treatment-iet/>. Accessed on: Feb 11, 2026.

¹⁴ Substance Abuse and Mental Health Services Administration (SAMHSA). Guidance on Strategies to Promote Best Practice in Antipsychotic Prescribing for Children and Adolescents. Available at: <https://library.samhsa.gov/sites/default/files/promote-best-practice-pep19-antipsychotic-bp.pdf>. Accessed on: Feb 18, 2026.

Strengths, Opportunities for Improvement, and Recommendations

augment enrollment data information. HSAG also recommends that DES DDD explore other potential data sources for the capture of race/ethnicity data to support future performance measure reporting that may require stratification related to RES. To ensure data reporting accuracy, HSAG recommends that DES DDD investigate conducting sample reviews on the subcontractor's reported rates prior to submission as a component of its ongoing quality review process, along with benchmark reviews of the individual subcontractor rates.

HSAG identified the following opportunities for improvement related to the *Back to Basics* PIP:

- The Contractor added a recalculated baseline rate in the narrative and used it for statistical testing between the baseline and Remeasurement 3 without explanation or updating the performance indicator data table. **[Quality]**
- Subcontractor statistical testing was conducted between the Intervention Year and Remeasurement 3 instead of between the baseline and Remeasurement 3 for Mercy Care. **[Quality]**
- The Contractor did not report intervention effectiveness data for ongoing Mercy Care interventions. **[Quality]**

Recommendations: HSAG recommends that for future selected PIPs, DES/DDD:

- Apply lessons learned from the *Back to Basics* PIP.
- Use the same baseline for all remeasurement period statistical testing.
- Implement interventions with clearly defined intervention effectiveness measures that are directly linked to the intervention to assess the effectiveness of each intervention.
- Track intervention effectiveness data for all subcontractor interventions.
- Seek technical assistance from HSAG to understand the CMS EQR Protocol 1 requirements.

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

- The areas with the greatest opportunity for improvement were related to the following, as these areas received performance scores under 95 percent:
 - Corporate Compliance **[Quality, Access]**
 - Case Management **[Quality, Access]**
 - General Administration **[Timeliness, Access]**
 - Medical Management **[Quality, Timeliness, Access]**
 - Member Information **[Quality]**
 - Quality Management **[Quality]**
 - Quality Improvement **[Quality, Access]**

Recommendation: HSAG recommends that DES/DDD continue to work with AHCCCS on closing remaining CAPs.

Strengths, Opportunities for Improvement, and Recommendations

HSAG identified the following opportunities for improvement related to NAV:

- Based on the NAV results, neither of the DES/DDD subcontracted health plans met the standards for Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult; and Dentist, Pediatric. **[Access]**

Recommendation: HSAG recommends that AHCCCS support each DES/DDD subcontracted health plan in continuing to monitor and maintain its existing provider network coverage as of CYE 2024 S2, with specific attention to ensuring the availability of the following provider categories for which neither DES/DDD subcontracted health plan met the network requirement:

- Behavioral Health Outpatient and Integrated Clinic, Adult in Apache County.
- Cardiologist, Adult in Apache County.
- Dentist, Pediatric in Greenlee County.

2. Introduction to the EQR Technical Report

This section provides the purpose and overview of this annual EQR technical report, the Centers for Medicare & Medicaid Services (CMS) definitions for Quality and Access, the National Committee for Quality Assurance (NCQA) and Agency for Health Care Research and Quality (AHRQ) definitions for Timeliness, and an overview of how this EQR technical report is organized.

Table 2-1 through Table 2-5 describe the activities reviewed for the Contractors in each program.

ACC Program

The **ACC Program** provides integrated care addressing the physical and behavioral health needs for the majority of Medicaid (Title XIX) eligible children and adults as well as addressing the physical and behavioral health needs for the majority of CHIP KidsCare (Title XXI) eligible children (under age 19 years). ACC and ACC-RBHA Contractors are responsible for providing services under the ACC Program.

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

Table 2-1—EQR Activities Presented in the CYE 2025 External Quality Review Annual Technical Report for the ACC Program

Contractors Reviewed	PMV	PIP Validation	Compliance Reviews (Operational Reviews)	NAV	CAHPS
AzCH-CCP ACC-RBHA*	✓	✓	✓	✓	✓
BUFC ACC	✓	✓	✓	✓	✓
Care1st ACC-RBHA* ¹	✓	✓		✓	
HCA ACC	✓	✓	✓	✓	✓
Mercy Care ACC-RBHA*	✓	✓	✓	✓	✓
Molina ACC	✓	✓	✓	✓	✓
UHCCP ACC	✓	✓	✓	✓	✓

* Contractor serves both the ACC and the ACC-RBHA SMI-Designated populations. Throughout this report, ACC Program discussions for AHCCCS-RBHA Contractors are limited to the ACC-RBHA Contractors' Non-SMI-Designated population.

¹ Care1st ACC-RBHA merged with AzCH-CCP ACC-RBHA effective October 1, 2024. Care1st ACC-RBHA was only required to participate in EQR activities related to CY 2024 performance measure data, network adequacy data, and performance improvement project data.

For additional information and Contractor-specific findings, see [Section 5. ACC Program Contractor-Specific Results](#).

ACC-RBHA SMI-Designated Program

The **ACC-RBHA Program** provides integrated physical and behavioral health services to eligible Medicaid (Title XIX) and CHIP KidsCare (Title XXI) covered members determined to have an SMI designation. ACC-RBHA Contractors are also responsible for providing crisis services to all individuals, including but not limited to crisis telephone services, community-based mobile crisis teams, and facility-based crisis stabilization services. Additionally, ACC-RBHA Contractors are responsible for providing services to the ACC Non-SMI-Designated population.

Table 2-2 presents the EQR activities reviewed in this report for ACC-RBHA Program Contractors.

Table 2-2—EQR Activities Presented in the CYE 2025 External Quality Review Annual Technical Report for the ACC-RBHA Program

Contractors Reviewed	PMV	PIP Validation	Compliance Reviews (Operational Reviews)	NAV	CAHPS
AzCH-CCP ACC-RBHA	✓	✓	✓	✓	✓
Care1st ACC-RBHA ¹	✓			✓	
Mercy Care ACC-RBHA	✓	✓	✓	✓	✓

¹ Care1st ACC-RBHA merged with AzCH-CCP ACC-RBHA effective October 1, 2024. Care1st ACC-RBHA was only required to participate in EQR activities related to CY 2024 performance measure data and network adequacy data. Care 1st ACC-RBHA was not required to participate in the PIP validation activity in CYE 2025 as CY 2024 was an intervention year for the *Prenatal and Postpartum Care* PIP.

For additional information and Contractor-specific findings, see [Section 7. ACC-RBHA SMI-Designated Program Contractor-Specific Results](#).

DCS CHP Program

The **DCS CHP Program** provides physical, dental, and behavioral health services for children and youth in foster care throughout the State of Arizona.

Table 2-3 presents the EQR activities reviewed in this report for the DCS CHP Program.

Table 2-3—EQR Activities Presented in the CYE 2025 External Quality Review Annual Technical Report for the DCS CHP Program

Contractors Reviewed	PMV	PIP Validation	Compliance Reviews (Operational Reviews)	NAV	CAHPS
DCS CHP	✓	✓	✓	✓	✓

For additional information and Contractor-specific findings see [Section 8. DCS CHP Program Results](#).

ALTCS-EPD Program

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

Table 2-4 presents the EQR activities reviewed in this report for ALTCS-EPD Program Contractors.

Table 2-4—EQR Activities Presented in the CYE 2025 External Quality Review Annual Technical Report for the ALTCS-EPD Program

Contractors Reviewed	PMV	PIP Validation	Compliance Reviews (Operational Reviews)	NAV
BUFC LTC	✓	✓	✓	✓
Mercy Care LTC	✓	✓	✓	✓
UHCCP LTC	✓	✓	✓	✓

For additional information and Contractor-specific findings, see [Section 10. ALTCS-EPD Program Contractor-Specific Results](#).

ALTCS-DD Program

The **ALTCS-DD Program** provides LTSS as well as integrated physical and behavioral health services to eligible members who have an IDD as outlined under Arizona State law.

Table 2-5 presents the EQR activities reviewed in this report for the ALTCS-DD Program.

Table 2-5—EQR Activities Presented in the CYE 2025 External Quality Review Annual Technical Report for the ALTCS-DD Program

Contractors Reviewed	PMV	PIP Validation	Compliance Reviews (Operational Reviews)	NAV
DES/DDD	✓	✓	✓	✓

For additional information and Contractor-specific findings, see [Section 11. ALTCS-DD Program Results](#).

Assessing Quality, Timeliness, and Access

HSAG used the following definitions to evaluate and draw conclusions about the performance of the Medicaid Contractors in each of the domains of Quality, Timeliness, and Access. For more information

on how HSAG assessed the Quality, Timeliness, and Access domains for each activity, see the How Conclusions Were Drawn subsection for each EQR-related activity in [Appendix A. Methodology](#).

Quality

CMS defines “Quality” in 42 CFR 438.320 as follows:

Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or primary care case management (PCCM) entity (described in 438.310[c][2]) increases the likelihood of desired outcomes of its enrollees through:

- Its structural and operational characteristics
- The provision of services that are consistent with current professional, evidence-based knowledge
- Interventions for performance improvement¹⁵

Timeliness

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.¹⁶ NCQA further discusses the intent of this standard as being to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other managed care provisions that impact services to beneficiaries and that require timely response by the Contractor—e.g., processing expedited appeals and providing timely follow-up care.

AHRQ defines “Timeliness” as follows:

Timeliness is the health care system’s capacity to provide health care quickly after a need is recognized. Timeliness includes the interval between identifying a need for specific tests and treatments and receiving those services.¹⁷

Access

CMS defines “Access” in the 2016 regulations at 42 CFR 438.320 as follows:

¹⁵ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

¹⁶ National Committee for Quality Assurance. 2024 Standards and Guidelines for Accreditation of Health Plans.

¹⁷ Agency for Healthcare Research and Quality. *National Healthcare Quality and Disparities Reports*. Elements of Access to Health Care: Timeliness. Available at: <https://www.ahrq.gov/research/findings/nhqrdp/chartbooks/access/elements3.html>. Accessed on: Feb 12, 2026.

Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 42 CFR 438.68 (Network adequacy standards) and 42 CFR 438.206 (Availability of services).¹⁸

Overview of the Report Sections

[Section 1—Executive Summary](#) describes the authority under which the report must be provided, as well as the Contractors reviewed during calendar year (CY) 2025. In addition, this section includes a program-level summary of strengths, opportunities for improvement, and recommendations for program-level performance improvement.

[Section 2—Introduction to the EQR Technical Report](#) provides the purpose and overview of this annual EQR technical report; CMS’ definitions for Quality and Access; the NCQA and AHRQ definitions for Timeliness; and an overview of how this EQR technical report is organized.

[Section 3—Overview of AHCCCS](#) provides a description of AHCCCS’:

- Medicaid Managed Care Program History
- Waivers and Legislative Updates
- Strategic Plan
- Key Initiatives and Accomplishments
- Medicaid and CHIP Quality Strategy as well as HSAG’s recommendations for targeting goals and objectives for QI

[Section 4—ACC Program-Level Comparative Results](#) includes ACC program-level comparative results organized by EQR-related activity, strengths, opportunities for improvement, and recommendations for program-level performance improvement. This section also includes aggregate CAHPS survey results for the KidsCare and ACC populations.

[Section 5—ACC Program Contractor-Specific Results](#) provides, by ACC and ACC-RBHA Contractor, activity-specific strengths, opportunities for improvement, and HSAG’s recommendations for performance improvement for the ACC population. ACC and ACC-RBHA Contractors are responsible for the provision of services under the ACC Program.

[Section 6—ACC-RBHA SMI-Designated Program-Level Comparative Results](#) includes ACC-RBHA program-level comparative results for the SMI-Designated population, organized by EQR-related activity, which includes strengths, opportunities for improvement, and HSAG’s recommendations for

¹⁸ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

program-level performance improvement. This section also includes aggregate CAHPS survey results for the ACC-RBHA SMI-Designated population.

[*Section 7—ACC-RBHA SMI-Designated Program Contractor-Specific Results*](#) provides, by ACC-RBHA Contractor, activity-specific strengths, opportunities for improvement, and HSAG’s recommendations for performance improvement.

[*Section 8—DCS CHP Program Results*](#) provides, by EQR activity, DCS CHP activity-specific strengths, opportunities for improvement, and HSAG’s recommendations for performance improvement. This section also includes CAHPS survey results for the DCS CHP Program. DCS CHP provides services through a subcontracted health plan, Mercy Care DCS CHP.

[*Section 9—ALTCS-EPD Program-Level Comparative Results*](#) includes ALTCS- EPD comparative results organized by EQR-related activity, strengths, opportunities for improvement, and HSAG’s recommendations (as applicable) for program-level performance improvement.

[*Section 10—ALTCS-EPD Program Contractor-Specific Results*](#) provides, by ALTCS-EPD Contractor, activity-specific strengths, opportunities for improvement, and HSAG’s recommendations (as applicable) for performance improvement.

[*Section 11—ALTCS-DD Program Results*](#) provides, by EQR activity, ALTCS-DD activity-specific strengths, opportunities for improvement, and HSAG’s recommendations for performance improvement.

[*Section 12—Assessment of Follow-Up on Prior Year’s Recommendations*](#) presents the Contractors’ follow up activities implemented and an assessment of how effectively the health plans addressed the improvement recommendations made by HSAG in the prior year.

[*Appendix A. Methodology*](#) presents, for each EQR activity:

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

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

[*Appendix B. CY 2024 Combined Performance Measure Results for AzCH-CCP ACC-RBHA and Care1st ACC-RBHA*](#)

[*Appendix C. Acknowledgements and Copyrights*](#)

3. Overview of AHCCCS

This section provides a description of AHCCCS’:

- Medicaid Managed Care Program History
- Waivers and Legislative Updates
- Strategic Plan
- Key Initiatives and Accomplishments
- Medicaid and CHIP Quality Strategy, as well as HSAG’s recommendations for targeting goals and objectives for QI

AHCCCS Medicaid Managed Care Program History

Since 1982, AHCCCS, the single state Medicaid agency for Arizona, has operated under the authority of the federal Medicaid Demonstration 1115 Waiver under Section 1115 of the Social Security Act, which has allowed for the operation of an integrated managed care model. AHCCCS uses federal, State, and county funds to administer pediatric, acute, long-term, and behavioral healthcare programs to the State’s Medicaid members. AHCCCS has an appropriated budget of approximately \$22.6 billion to administer its programs, which provide services for over two million individuals and families in Arizona through a provider network credentialed and contracted by its Contractors. The AHCCCS Acute Care Program began in 1982 and in 1988, AHCCCS added the Arizona Long Term Care System (ALTCS) Program for individuals with developmental disabilities, and then expanded the program in January 1989 to include individuals who are elderly and/or who have physical disabilities. ALTCS provides physical health services, behavioral health services, long-term care services, and Contractor-provided case management to AHCCCS members who are elderly, physically disabled, or developmentally disabled and who meet the criteria for receiving care in a home and community based setting. Services for individuals with IDD in ALTCS are offered through the Arizona Department of Economic Security, Division of Developmental Disabilities (DES/DDD). American Indian/Alaska Native (AI/AN) members may choose to receive services through the managed care structure or may opt to receive services through the fee-for-service (FFS) program. Services for children in the foster care system are offered through the DCS CHP Program (previously Comprehensive Medical and Dental Program or CMDP).

In October 1990, AHCCCS began coverage of comprehensive behavioral health services for children with a serious emotional disturbance (SED) younger than 18 years of age who required residential care. Through further expansion, AHCCCS added comprehensive behavioral health coverage for all Medicaid-eligible individuals. CHIP was incorporated in Arizona in 1998 and is known as KidsCare. In 2009, due to a persistently severe budget shortfall, a freeze was placed on enrollment in KidsCare. In 2016, Governor Ducey signed Senate Bill (SB) 1457 into law, ending the enrollment freeze on the

KidsCare Program. Children who qualify for KidsCare receive care through AHCCCS Contractors.¹⁹ In October 2013, children enrolled in the Acute Care Program who had a Children's Rehabilitative Services (CRS) qualifying diagnosis were enrolled into one integrated CRS Contractor, UHCCP. This was done to decrease fragmentation and reduce member confusion; ensure optimal access to primary, specialty, and behavioral health care; enhance coordination of all service delivery; improve member outcomes and satisfaction; and streamline administration. At the same time, children with CRS qualifying conditions who were enrolled in the ALTCS Program, other than in DDD, were fully integrated into their ALTCS-EPD Contractors' provided services, including all primary, specialty, long-term, and behavioral health care related to the members' CRS conditions. Beginning October 1, 2019, members enrolled with DES/DDD began to use their assigned DES/DDD subcontracted health plan for all of their CRS services. DES/DDD continues to provide long-term care services for these members.

Before the integration of services into a single Contractor that began in April 2014, a member with general mental health needs and those with an SMI designation had to coordinate with several healthcare systems to obtain services. As such, the physical health services were provided through the acute care Contractor; the behavioral health services through the Regional Behavioral Health Authority (RBHA) contracted through the Division of Behavioral Health Services (DBHS); the Medicare system, if the member was also eligible for Medicare; and Medicare Part D for medications.

On April 1, 2014, approximately 17,000 members with an SMI designation residing in Maricopa County were transitioned to a single plan, Mercy Maricopa Integrated Care, to manage both their behavioral and physical healthcare needs. Beginning October 1, 2015, members residing in other counties were transitioned to one of two additional integrated Contractors to provide both physical and behavioral health care services. RBHAs were also providing general behavioral health and substance use services to individuals in the DCS/CMDP foster care system and to DDD members. Beginning July 1, 2016, DBHS merged with AHCCCS, moving contractual oversight of the RBHAs to AHCCCS.

In March of 2017, new contracts were awarded to three Contractors throughout Arizona to administer the ALTCS-EPD Program. Awards were based on the bidder's proposed approaches for care and treatment of ALTCS individuals using a fully integrated care perspective at both the systemic and direct care levels (e.g., use of health homes, electronic health records [EHRs], coordinated case management, and collaboration between behavioral and physical health). Although Arizona's ALTCS model has historically provided integrated care that included behavioral health treatment, emphasis was added to promote greater use of Arizona's behavioral health model, particularly regarding individuals who have been determined to have an SMI designation. 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 allowed members who were not enrolled in an ALTCS-EPD Program to access physical as well as general mental health and substance use behavioral healthcare services, previously provided through a RBHA, through a single integrated delivery system model, ACC, with seven Contractors. In addition, on October 1, 2018, service

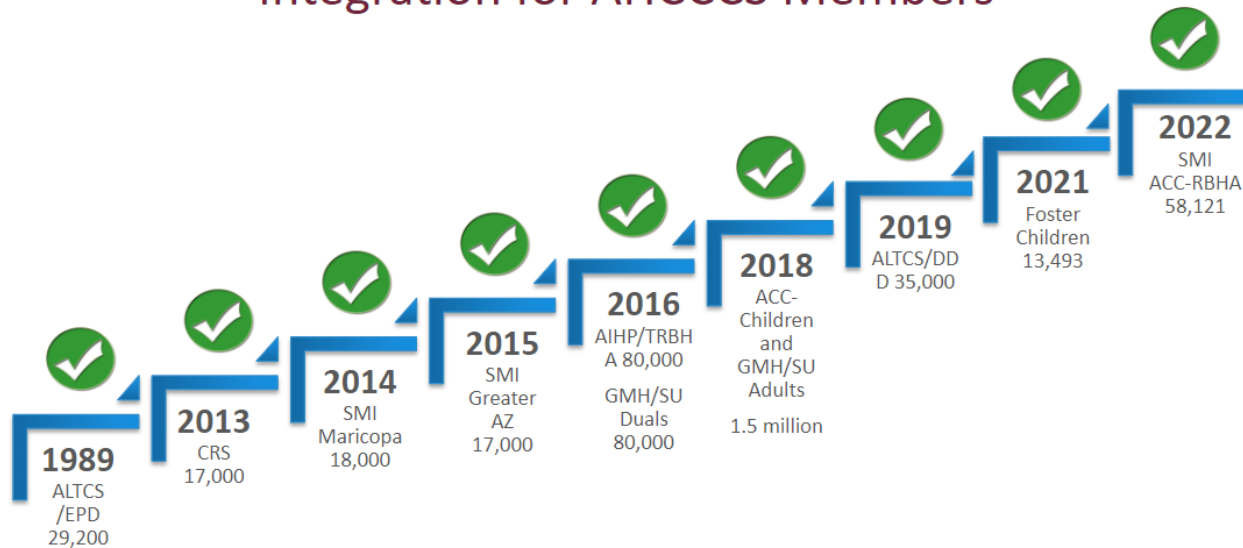
¹⁹ While most children who qualify for KidsCare receive care through AHCCCS Contractors, a small portion of children who qualify for KidsCare receive care through the FFS delivery system.

delivery was restructured into three geographic service areas (GSAs): North, Central, and South. Members continue to have a choice of Contractors in their GSA and to have access to a network of providers and the same array of covered services.

Effective October 1, 2019, DDD began providing integrated behavioral health services to its members, including individuals with an SMI designation. Effective April 1, 2021, DCS/CMDP began providing integrated behavioral health services to its members and changed its program name to DCS CHP.

Effective October 1, 2022, AHCCCS, through its competitive contract expansion (CCE), expanded the contracts for three ACC Contractors to include RBHA services, thus furthering integration efforts, under the AHCCCS Complete Care–Regional Behavioral Health Agreement (ACC-RBHA) Program. ACC-RBHAs continue to provide specific services to individuals with an SMI designation who are not in an ALTCS Program, as well as the first 24 hours of crisis services.²⁰

Integration for AHCCCS Members



²⁰ Effective October 1, 2022, the abbreviation “RBHA” changed from Regional Behavioral Health Authority to Regional Behavioral Health Agreement. Services are provided by AHCCCS Complete Care Contractors with Regional Behavioral Health Agreements (ACC-RBHAs).

AHCCCS Waivers and Legislative Updates

1115 Waiver Update

On October 14, 2022, AHCCCS received approval for its five-year renewal of Arizona's Demonstration project under Section 1115 of the Social Security Act. This renewal is effective through September 30, 2027. The current Demonstration exempts Arizona from particular provisions of the Social Security Act and includes expenditure authority permitting federal financial participation (FFP) for State expenditures that would not otherwise qualify for federal participation. Moreover, Demonstration projects, including Arizona's, must establish budget neutrality where Medicaid costs to the federal government are not expected to exceed in the absence of the Demonstration. The current 1115 Waiver approval continues the long-standing authorities and programs that have made Arizona's Medicaid program innovative, effective, and efficient, including integrated managed care for AHCCCS populations through:

- AHCCCS Complete Care (ACC).
- The Arizona Long Term Care System (ALTCS).
- The Department of Child Safety Comprehensive Health Plan (DCS CHP) for children in foster care.
- AHCCCS Complete Care Regional Behavioral Health Agreements (ACC-RBHAs) to provide integrated care for individuals with an SMI designation.

New Waiver Program Implementation Updates

Housing and Health Opportunities (H2O)

AHCCCS has launched the Housing and Health Opportunities (H2O) Program under its Section 1115 Research and Demonstration Waiver, approved by CMS in October 2022. This innovative initiative aims to address housing instability as a critical social determinant of health for Medicaid beneficiaries who are experiencing homelessness or at risk of homelessness.

The H2O Program is designed to enhance and expand housing-related services and supports for AHCCCS members, particularly those with an SMI designation, chronic physical health conditions, or those transitioning from correctional facilities. The program integrates housing interventions with health care services to increase housing stability for members, improve health outcomes, and reduce overall Medicaid expenditures.

Eligible members are identified through a data-driven referral process using criteria such as homelessness indicators [e.g., Z codes, Homeless Management Information System (HMIS) reports], SMI designation, chronic health diagnoses, and correctional release status. Once eligibility is confirmed by the H2O Program administrator (Solari), members are referred to contracted providers for services.

The H2O Program seeks to achieve the following objectives:

- **Improve health and wellbeing:** Stabilize mental health conditions, reduce substance use, increase

utilization of primary and preventive care, and enhance member care.

- **Reduce health care costs:** Lower reliance on crisis services, emergency departments, and inpatient hospitalizations by providing stable housing, intensive supportive services, and coordinated care.
- **Decrease homelessness:** Equip members with skills and supports to maintain housing stability and reintegrate into the community.

The program provides a suite of health-related social needs (HRSN) interventions, including the following:

- Outreach and education
- Transitional housing through enhanced shelter and short-term rental assistance
- Pre-Tenancy and Tenancy Sustaining Services (PTTS)
- Move-in assistance and eviction prevention
- Medically necessary home modifications

The H2O Program integrates Medicaid into Arizona's housing continuum, not as a standalone housing intervention, but as a contributor to broader system infrastructure. Its goal is to avoid duplicating efforts or creating silos within the housing continuum by coordinating with existing State and federal housing resources.

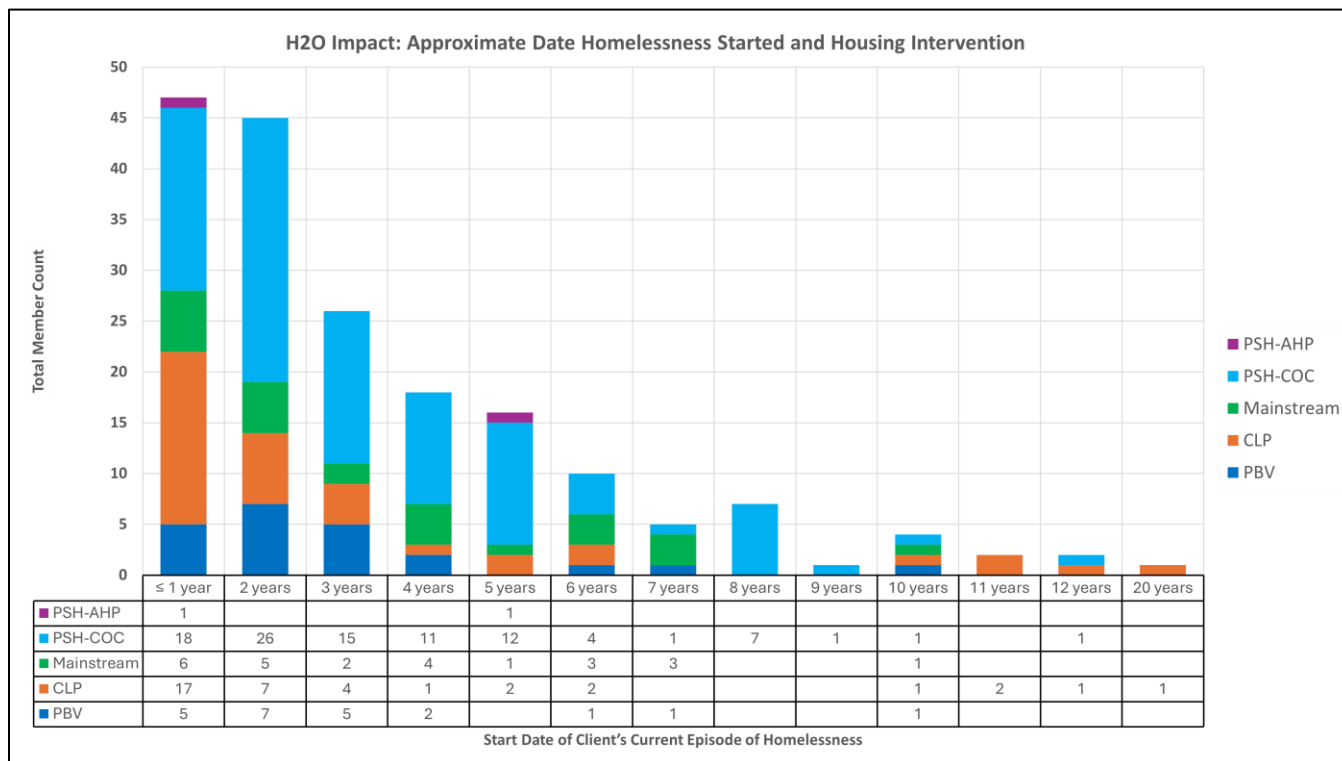
Instead of spending Medicaid dollars on repeated crisis care, such as emergency departments or inpatient hospitalizations, the program redirects funds to stabilize individuals in the community. This approach allows members to apply the skills learned in institutional settings within a safe, stable living environment, supporting long-term recovery and reintegration.

A key feature of the H2O Program is its strategic use of Medicaid funding to support short-term stabilization for high-acuity, vulnerable members. Rather than serving as a long-term housing solution, Medicaid plays a critical role in bridging members to permanent housing by funding the initial stabilization period and the ongoing dedicated supportive services, primarily behavioral health services.

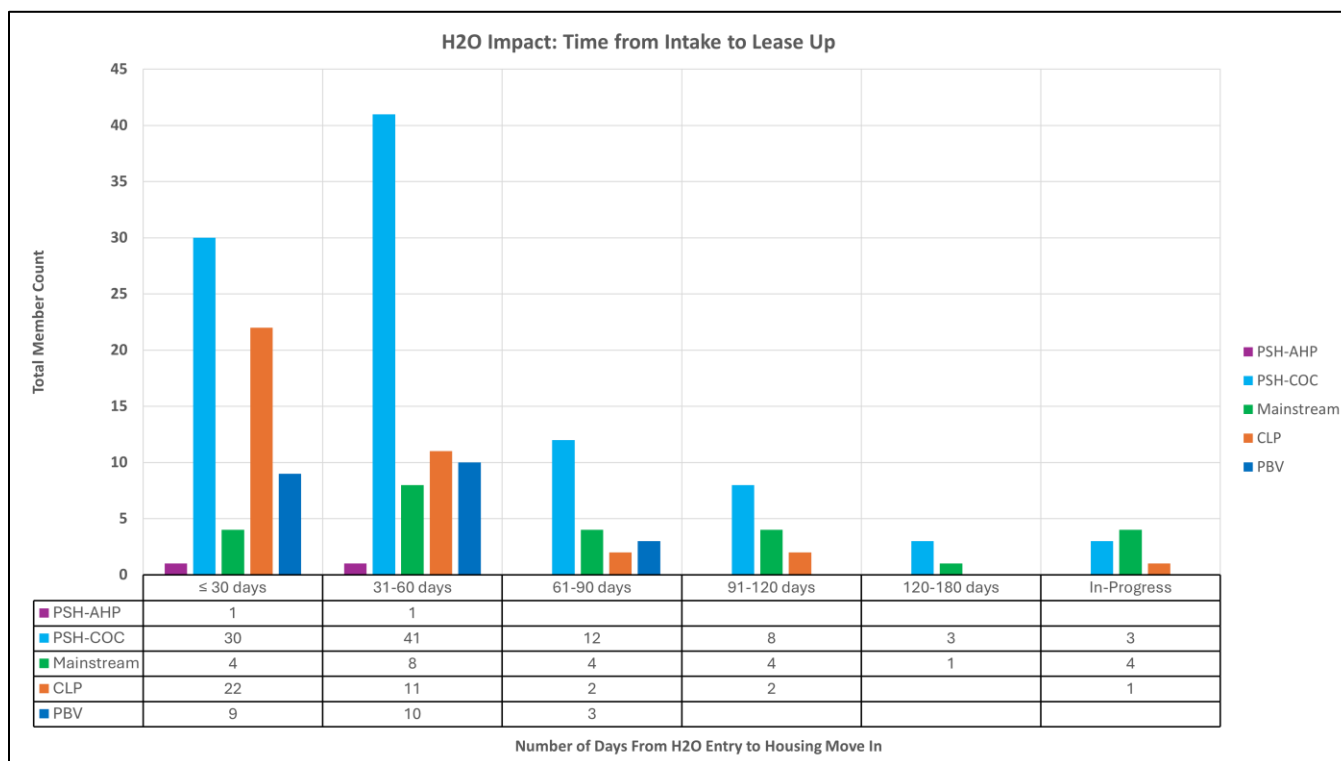
Once stabilized, members are transitioned to long-term housing subsidies funded through other sources designed for sustained support, such as Housing and Urban Development (HUD) Housing Choice Vouchers (HCVs), Continuum of Care (CoC) Permanent Supportive Housing (PSH) Vouchers, AHCCCS Housing Program (AHP) PSH Vouchers and Community Living Program (CLP), Project Based Vouchers (PBVs), and Mainstream Vouchers. This coordinated approach ensures that Medicaid remains focused on health-related services while leveraging other systems to secure lasting housing stability.

The graph below tells the story of the first 184 members successfully housed by H2O. The graph depicts the members' current episode of experiencing homelessness, leading up to their connection to H2O's identified permanent housing intervention, some of whom had historical housing insecurities as far back as 20 years. The graph depicts the achievement and outcomes of H2O, leveraging the connections and partnerships with federal and State long-term subsidy programs, to successfully transition members into

permanent supportive housing. H2O's Tenancy Supportive Services is designed to ensure retention outcomes for the housed members and long-term housing stabilization by working on individualized goals far beyond their housing goals, such as employment needs, community connections, and ongoing physical and mental health care needs. The H2O Program represents a strategic investment in upstream interventions that address housing insecurity, aiming to transform care delivery for Arizona's most vulnerable Medicaid populations.



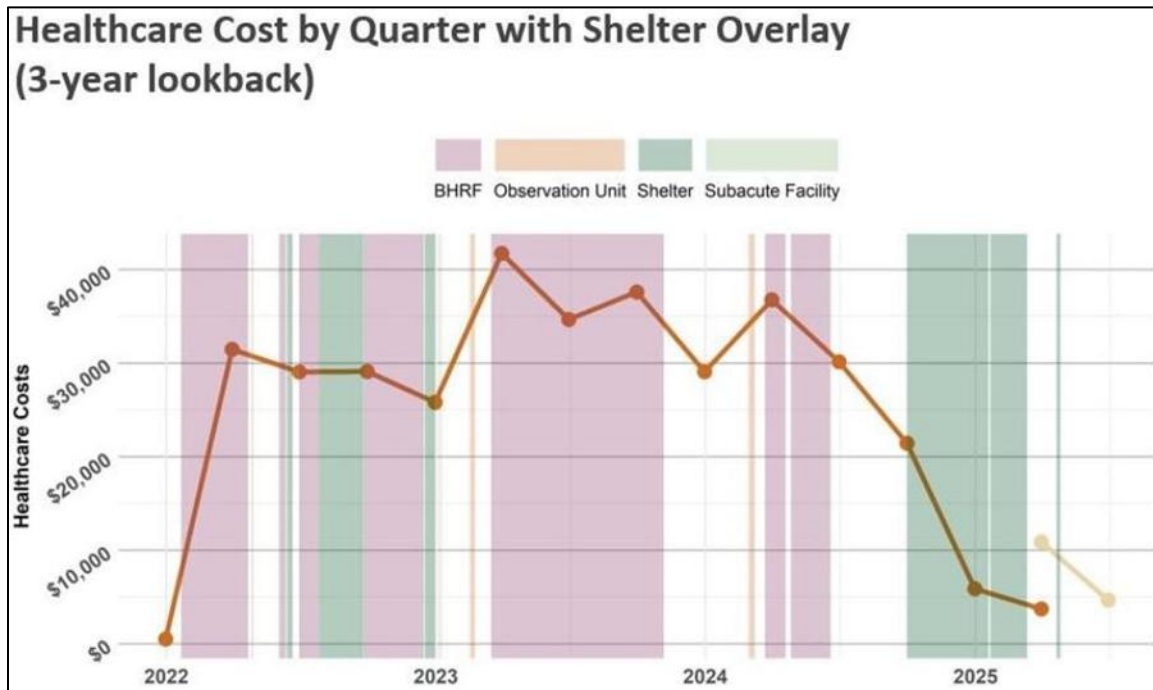
The graph below illustrates the time taken for H2O members to transition from program entry to successfully being housed in permanent supportive housing. The graph highlights the H2O Program's level of effectiveness in design of the model, implementation through intentional intensive service delivery based on individual needs, and the urgency in addressing homelessness. With a low staff-to-member caseload ratio of 1:15 for Pre-Tenancy Supportive Services, aligned with fidelity to the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Permanent Supportive Housing Evidence-Based Practice model, supportive services allow for the intended capacity needed for rapport and relationship building, responsiveness, and the frequency necessary to house members in a timely manner. This structure enables rapid identification of member needs, focused on housing searches and swift transitions into stable housing, turning the path from homelessness into measurable housing outcomes.



The H2O initiative has demonstrated compelling success in its first year of implementation, warranting both its continuation and strategic expansion. H2O’s model is designed to end chronic homelessness, improve mental health and substance use outcomes, increase community integration, promote long-term housing stability, and support recovery. The H2O Program is a system integration model that has paved the way for PSH through collaboration and alignment with the Housing Continuum, filling needs and gaps within the Housing Continuum to meet the needs of Arizona communities. The current investment has built an infrastructure designed to serve members across Arizona, with 14 contracted providers thus far in the H2O network and new providers currently in the process of being onboarded. H2O providers have hired over 100 direct care staff, with vacancies continuing to be filled, ensuring more members can be served with a low staff-to-member ratio throughout the State. The H2O Program has demonstrated a high level of engagement from members, with currently 1283 active members engaging in the program thus far, reflecting its accessibility and effective service delivery model. As provider capacity continues to grow, so will the number of members served, amplifying the program’s benefits across Arizona. 184 members experiencing homelessness have been successfully housed in PSH, some of whom had been unhoused for decades, which highlights the program’s reach, effectiveness, and sustainability.

One member’s journey exemplifies this impact. After 10 years of homelessness and repeated housing service interventions, the member was housed within 60 days of H2O Program entry and has remained stably housed since January 2025. This member’s Medicaid costs have dropped by over 65 percent, with notable reductions in behavioral health, pharmacy, physical health, and transportation expenses. This member case study illustrates how housing stability directly correlates with improved health outcomes and reduction in spending.

The graph below is a three-year lookback at the member case study, which demonstrates significant Medicaid cost reduction in utilization.



Targeted Investments (TI) 2.0

A summary of the implementation activities AHCCCS conducted for the TI 2.0 program in federal fiscal year (FFY) 2025 includes:

- Solicited participant and stakeholder input related to closed-loop referral processes and the CommunityCares Closed-Loop Referral System (CLRS), shared the feedback with the vendor, and discussed methods to prioritize and address concerns.
- Resumed a process for AHCCCS to review and provide feedback on TI 2.0 participants' NCQA Health Accreditation evidence prior to NCQA's official survey review.
- Further developed with Arizona State University (ASU) partners a portal, instructions, and templates to guide participants with new staff in evidence-based QI projects (i.e., Targeted Investments Program Quality Improvement Collaborative [QIC], TIPQIC, projects), including a project charter, process map, root cause analysis, and Plan-Do-Study-Act (PDSA) report related to TI initiatives.
- Updated machine learning algorithms to automatically score and provide feedback on the latest round of TIPQIC projects.
- Upgraded ASU's TI data dashboards for MCOs, Accountable Care Organizations (ACOs) and Clinically Integrated Networks (CINs), and participating providers to review aggregate and stratified (i.e., by geography and preferred language) trends of their rolling 12-month performance on select

NCQA HEDIS measures.

- Solicited input on NCQA HEDIS performance measures that will drive participants' payment in Year 4 and Year 5 of the program, including an assessment of AHCCCS' current performance (report period ending November 2024) and discussions to explore clinical data sharing to improve performance and technical assistance for digital quality measures. Drafted and posted Year 4 performance measures in August 2025 and provided a comment period for TI organizations, which was finalized September 2025.
- Engaged MCOs to understand and suggest recommendations to improve PCP assignment algorithms to ensure members are assigned to providers from whom they are seeking care (when applicable).
- Revised provider-organization attribution methodologies for primary care, justice involved adults, episodic behavioral health, and member-based behavioral health measures.
- Supported participants with collecting and submitting milestone evidence and attestations via the TI 2.0 Year 2 application portal.
- Led a QIC where subject matter experts and provider peers discussed initiatives, goals, best practices, and challenges related to identifying and addressing food insecurity.
- Continued validating TI 2.0 application data with address, licensing, and other statuses maintained by CMS (National Plan and Provider Enumeration System), AHCCCS (provider enrollment), and Arizona Department of Health Services (ADHS-licensure).
- Continued drafting document validation criteria that will be used to identify minimum elements for Year 3 processes.
- Began development of the TI 2.0 Year 3 application portal.
- Hosted more than 10 webinars related to the milestones, NCQA Accreditation, and general "office hours" to clarify requirements and provide assistance.
- Updated the Salesforce customer relationship management (CRM) tool to organize and track participation in and engagement with the program.
- Collaborated with Contexture (Arizona's Health Information Exchange [HIE]) and ASU, ADHS, and other data sources to explore future demographic data enrichment strategies, opportunities to prepare for electronic clinical quality measurement (eCQM), and complement mutual initiatives such as implementing the CLRS (CommunityCares).
- Refined TI requirements and addressed nuanced questions by engaging appropriate subject matter experts, such as Postpartum Support International for the postpartum behavioral health screening milestones, the Behavioral Health and Wellness Program and ADHS for the tobacco cessation milestones, health plans and ACOs for collecting and transmitting HRSN screening and referral data, health plans' cultural competency coalition for the Language Access Services milestone, NCQA Accreditation and milestones, and the Contexture and the CommunityCares teams for the HIE requirement and CLRS milestones.

Parents as Paid Caregivers (PPCG)

AHCCCS received approval from CMS for the PPCG demonstration on February 16, 2024. Approval of the PPCG program allows AHCCCS to continue to reimburse legally responsible parents of minor children for providing direct care to their minor children. The amendment also establishes a Family Support service as part of the Home and Community-Based Services (HCBS) benefit package. The extension of this program along with the new Family Support service aims to mitigate the direct care worker shortage, support primary caregivers, including parents, and improve access to timely, effective care in the home and community.

AHCCCS facilitated implementation planning with input from a multi-stakeholder workgroup composed of family members, providers, MCOs, and AHCCCS personnel. The workgroup provided input on the development of policy, forms, and tools necessary to support the operationalization of the waiver requirements, leveraging national research and experience from other states that have implemented similar models. The 1115 Waiver requirements included both Special Terms and Conditions (STCs) and commitments made to CMS in the State's waiver proposal. In April 2025, Arizona House Bill (HB) 2945 was signed into law that requires specific safeguards and guardrails for the PPCG service model in addition to the 1115 Waiver requirements and commitments.

The State implemented the waiver proposal in two distinct stages to comply with the STCs and the administration of safeguards/guardrails required in HB 2945. The first stage, beginning on July 1, 2025, required parent caregivers to comply with the 40-hour weekly reimbursement cap limit on parent-provided services. To support the transition to alternate caregivers, AHCCCS (with input from the workgroup) implemented plans, timelines, and communications to conduct extensive member, family, stakeholder, and case management engagement, notification, and education prior to the July 1, 2025, effective date. The second stage began on October 1, 2025, and entails the full-scale implementation of administrative policies and procedures related to this service delivery model.

Internal data show a significant growth in the number of parent providers being reimbursed for more than 40 hours per week of caregiving services. When AHCCCS submitted the 1115 Waiver proposal, 3,500 parents were utilizing the model. That number has since grown to 6,600 parents as of May 2025.

Implementation of the second phase of the proposal (administrative policies and procedures) commenced on October 1, 2025. This large-scale effort includes enhancing the service assessment process to incorporate the addition of an extraordinary care consideration and service model selection tool, developing strategies to maximize member-driven decision making and community integration as part of the person-centered service planning process, and updating caregiver oversight requirements for provider agency supervisory visits. Preparing for the full-scale implementation, AHCCCS led (and in partnership with MCOs) community engagement and public comment periods, provision of technical assistance for workforce development to provider agencies, and case manager training to support consistent and equitable use of these new tools and evaluation criteria. AHCCCS will prioritize the development of the family support service in 2026 after both phases of the PPCG implementation workplan have been fully implemented.

KidsCare Expansion

On February 16, 2024, AHCCCS received approval from CMS on the KidsCare Expansion Section 1115 Demonstration Amendment Proposal to raise the CHIP, KidsCare in Arizona, eligibility thresholds from 200% of the FPL to 225% FPL with the flexibility for KidsCare coverage to go up to and include 300% FPL, subject to approval by the state legislature. The KidsCare Expansion Demonstration aligns with Senate Bill (SB) 1726 that was passed in May 2023 by Arizona's 56th Legislature. The expanded income limit was implemented effective March 1, 2024. Since KidsCare eligibility is prospective, the earliest effective date of eligibility for the expansion was April 1, 2024. The number of kids enrolled under the expanded income limit is reported monthly in the AHCCCS Population Highlights report found on the population reports page.²¹ Original estimates projected that an additional 9,700 children would become enrolled in the KidsCare Expansion. This projection was exceeded in September 2024 with a growth of 13,233 enrolled children. Significant increases continued through November 2024 when an increase of 18,222 was achieved. Since then, the amount of newly enrolled children in the expansion has shown an increase of less than 3 percent per month, with 22,346 total enrolled children in September 2025.

Reentry Services

On November 22, 2024, AHCCCS resubmitted an updated 1115 Waiver Reentry Demonstration Initiative application in the CMS Pre-Print Format along with the State's Budget Neutrality workbook to CMS. On December 27, 2024, AHCCCS received approval for this program from CMS. Approval of this Demonstration amendment provides expenditure authority for the coverage of certain services furnished to eligible incarcerated individuals for up to 90 days immediately prior to the individual's expected date of release.

On August 1, 2025, AHCCCS submitted the Reentry Demonstration Implementation and Reinvestment plans to CMS. AHCCCS received initial feedback from CMS on September 17, 2025, and is now coordinating a response to the initial round of comments. Although federal approval for this program has been obtained, AHCCCS has not yet received the necessary State budget authority to begin implementation of the program and intends to seek approval during the 2026 Arizona Legislative Session.

Traditional Health Care Practices

After nearly a decade of work and partnership with Tribal Nations leaders, AHCCCS received approval from CMS to cover traditional healing services provided through Indian Health Service (IHS) and Tribally-operated health facilities on October 16, 2024. This approval will allow AHCCCS to establish a process and policies for reimbursement of services provided by traditional healers employed by or contracted with an IHS or Tribally-operated health center (commonly known as a 638 facility). Additionally, traditional healers employed by or contracted with an Urban Indian Organization may

²¹ AHCCCS Population Statistics. Available at: <https://www.azahcccs.gov/Resources/Reports/population.html>. Accessed on: Jan 23, 2026.

provide services through a care coordination agreement with an IHS/638 facility. Only AHCCCS members who are eligible to receive services through an IHS or 638 facility will be able to receive traditional healing services.

On June 27, 2025, AHCCCS received the necessary State legislative approval to further pursue traditional health care practices. Evaluation discussions have begun with AHCCCS' third-party independent evaluator, HSAG, and collaboration with Tribal Nations leaders will continue to ensure that a culturally appropriate evaluation of the program is completed. AHCCCS intends to go live with this program on October 1, 2025.

New Demonstration Waiver Amendment Proposals

Former Foster Youth Annual Automatic Renewal

On March 28, 2023, AHCCCS submitted the Former Foster Youth Annual Automatic Renewal Demonstration Waiver proposal in alignment with HB 2622 passed by Arizona's 55th Legislature. This proposal seeks authority to waive the condition of eligibility in 42 CFR 435.608 requiring Medicaid beneficiaries to apply for other cash benefits for the Former Foster Youth (FFY) population. AHCCCS currently offers transitional medical care for children leaving foster care between the ages of 18 and 26 years. AHCCCS refers to this group as the Young Adult Transitional Insurance (YATI) population.

On December 3, 2024, AHCCCS submitted an amendment to this existing waiver application wherein AHCCCS intends to extend eligibility for full Medicaid State plan benefits to FFY who are under age 26, who turned 18 on or before December 31, 2022, who were in foster care under the responsibility of another state or tribe on the date of attaining 18 years of age, were enrolled in Medicaid on the date of aging out of foster care, and are now applying for Medicaid in Arizona. On June 13, 2025, AHCCCS received CMS approval for this amendment. However, implementation of the program has not yet begun as the State does not yet have the needed state authority to provide this coverage for individuals who have aged out of foster care in a state other than Arizona.

AHCCCS Works Waiver Amendment Request

On December 19, 2017, AHCCCS submitted a formal 1115 Waiver Amendment Request, AHCCCS Works, in alignment with HB 1092 passed by Arizona's 55th Legislature in 2015. Pursuant to Arizona Revised Statutes (A.R.S.) §36-2903.09 and subject to approval from CMS, AHCCCS is required to pursue an 1115 Waiver to:

1. Institute a work requirement for all "able-bodied adults" receiving Medicaid services.
2. Place on "able-bodied adults" a lifetime limit of five years of Medicaid benefits.
3. Develop and impose meaningful cost-sharing requirements to deter both the nonemergency use of emergency departments and the use of ambulance services for nonemergency transportation or when it is not medically necessary.

This amendment request would require non-exempt “able-bodied adults” between the ages of 19 and 55 years to complete qualifying employment or educational activities for at least 20 hours per week to qualify for AHCCCS coverage.

On January 18, 2019, CMS approved Arizona’s AHCCCS Works request where the Demonstration STCs specified that the State would implement the AHCCCS Works requirement no sooner than January 1, 2020. Implementation work for the program began and then was later halted in October 2019 due to ongoing litigation of similar Medicaid Work Requirement 1115 Demonstration Waivers. This program was then further delayed by the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in January 2020. The approval and subsequent authority for AHCCCS Works was then rescinded by CMS on February 12, 2021.

In February 2025, AHCCCS resubmitted the AHCCCS Works Waiver Amendment Request due to the federal change in administration. On April 10, 2025, AHCCCS received confirmation from CMS stating that this request met the requirements for a complete amendment, as specified under STC 7. Furthermore, AHCCCS was informed that the 30-day federal public comment period for this request began on April 10, 2025. Negotiations are currently underway with CMS, and this request is being reviewed alongside new requirements established by House of Representatives 1 (H.R.1).

1115 Waiver Evaluation Update

Throughout AHCCCS’ 1115 Waiver Demonstration evaluation period (2022–2027), AHCCCS has contracted and collaborated with HSAG on numerous deliverables due to CMS.

On June 6, 2023, CMS approved Arizona’s application for continuous coverage for individuals determined ineligible for CHIP due to a change in circumstances. This amendment allowed Arizona to align its policies for young adults in Medicaid and CHIP, thereby preventing gaps in coverage during the COVID-19 PHE unwinding and redetermination period. On March 14, 2025, AHCCCS submitted the final evaluation report of this flexibility to CMS. AHCCCS received initial feedback from CMS in April and submitted a revised draft on June 4, 2025. AHCCCS received final approval of the final report from CMS on July 8, 2025.

Legislative Update

The 2025 Legislative Session began on January 13, 2025, and adjourned sine die on June 27, 2025. The General Effective Date (GED) is September 26, 2025. The Arizona Legislature passed several bills in the 2025 Legislative Session that impacted AHCCCS, including:

HB 2945 (“DD [developmental disabilities]; appropriations; waivers”) contains a number of provisions including, but not limited to the following: supplemental funding for the DD program, prohibits a parent caregiver from billing during and for specific tasks, requires the development of a strengthened assessment tool for extraordinary care, requires the implementation of the PPCG 40 hour per week per child limit, requires parent caregivers to be a resident of Arizona for at least six months for PPCG eligibility subject to CMS approval.

SB 1132 (“AHCCCS; continuous glucose monitors”) allows a member’s prescribing provider to determine the appropriate option (pharmacy benefit vs. durable medical equipment) for the member to receive a continuous glucose monitor (CGM) and requires AHCCCS to develop and post on its website a standalone document outlining CGM coverage criteria.

SB 1711 (“AHCCCS; obesity treatment; study committee”) establishes the Obesity Treatment Study Committee, requires the AHCCCS director or designee to participate, and requires the study committee to conduct a study to determine the cost, effectiveness, and value of extending the State’s Medicaid program to include comprehensive treatment for people living with obesity.

HB 2332 (“Postpartum health; education; advisory committee”) establishes the Advisory Committee on OB and Maternal Mental Health in Rural Communities, requires an AHCCCS representative to serve as a non-voting member of the advisory committee and to develop recommendations for ensuring availability of OB and maternal mental health services in low-volume and high-risk rural communities.

SB 1735/SB 1741 (Budget Bills)

- Continues Funding for Medicaid Enterprise System (MES) modernization.
- Continues Graduate Medical Education (GME) and Critical Access Hospital (CAH) funding.
- Directs AHCCCS to produce an implementation plan that contains recommendations for Secure Behavioral Health Residential Facilities (SBHRFs) and issue a request for proposal (RFP) for SBHRF funding.
- Adds cochlear implants and speech therapy services for adults covered by AHCCCS.
- Adds Duchenne muscular dystrophy to the State’s newborn screening panel.
- Authorizes and funds traditional healing services through or by IHS or a Tribal facility as a covered service to AHCCCS members who qualify.
- Authorizes limited pre-release services as AHCCCS-covered benefits for incarcerated individuals (subject to approval by CMS and available funding).

The next legislative session began on January 12, 2026.

AHCCCS’ Strategic Plan

AHCCCS has outlined its Strategic Plan for State Fiscal Years (SFYs) 2025–2029,²² setting the direction for healthcare initiatives, programs, and priorities. This plan aligns with AHCCCS’ mission and vision:

²² AHCCCS Fiscal Year 2025–2029 Strategic Plan. Available at: <https://www.azahcccs.gov/AHCCCS/Downloads/Plans/AHCCCS5YearStrategicPlanStateFY20252029.pdf>. Accessed on: Jan 23, 2026.

- Mission: Helping Arizonans live healthier lives by ensuring access to quality health care across all our communities.
- Vision: To be the recognized national leader in providing high quality whole-person public health care.

The plan focuses on five key strategic initiatives aimed at improving healthcare access, quality, and operational efficiency.

Annual Initiatives for SFY 2026:

1. Enhancing Member Access to Whole-Person Care

- Engage with providers to gather insights on system usability, identifying opportunities to enhance interfaces and streamline workflows for improved adoption.
- Conduct targeted outreach through the H2O program to expand access to whole-person care services, by proactively connecting individuals with available resources.

2. Addressing Enrollment Challenges

- Using newly acquired technologies, develop and implement data-driven outreach campaigns in high-eligibility areas to increase Medicaid enrollment among uninsured populations.
- Increase efforts to strengthen partnerships with community organizations to provide more hands-on support and guidance during Medicaid enrollment.
- Establish baselines for uninsured in targeted outreach areas to track impact of enrollment outreach in those areas.

3. Improving Provider Satisfaction

- Conduct ongoing analysis of provider and member satisfaction data to identify key areas for improvement and implement process changes that enhance overall experience.
- Expand feedback mechanisms to ensure ongoing engagement with providers and members about their support needs and overall satisfaction

4. Promoting Utilization of Preventive Care

- Engage with other states to learn from their successes in preventive care initiatives, adapting proven strategies to strengthen our own programs.

5. Enhancing Quality of Care and Reducing Fraud, Waste, and Abuse

- Continue monitoring of pre- and post-payment reviews to identify patterns of fraud, waste, and abuse more effectively.
- Implement the modernized MES to enhance ability to refine tracking mechanisms that assess fraud, waste, and abuse risks at both the provider and member level. The new MES will support oversight across the Medicaid system, ensuring more robust and data-driven monitoring capabilities.

Overarching Outcomes for SFY 2026:

- Increased Access to Whole-Person Care: More individuals will benefit from comprehensive, integrated healthcare services.
- Improved Enrollment and Coverage: Efforts will focus on reducing the uninsured population and increasing awareness of available benefits.
- Stronger Provider Network: Provider satisfaction will be prioritized to retain a high-quality workforce and improve service delivery.
- Greater Use of Preventive Services: More members will engage in preventive healthcare, leading to better long-term health outcomes.
- Enhanced Care Quality and Program Integrity: Fraud prevention measures and provider support will lead to more effective healthcare services.

Through these initiatives, AHCCCS aims to advance its commitment to equitable, high-quality, and sustainable healthcare for all Arizonans.

Key Initiatives and Accomplishments for AHCCCS

AHCCCS' current initiatives are aimed at building a more cohesive and effective healthcare system in Arizona by reducing fragmentation, structuring provider reimbursements to incentivize quality outcomes, leveraging health information technology (HIT), and working with private sector partners to further innovation. The AHCCCS webpage highlights ongoing and completed initiatives with links to more detailed information and is updated as more information becomes available. Following are highlights of AHCCCS' key initiatives and accomplishments in CYE 2025.²³

Accessing Behavioral Health Services in Schools

AHCCCS covers medically necessary behavioral health services for Medicaid-enrolled students. Many of these services are provided directly on school campuses, making it easier for students to get services where they are, and as soon as they need help.²⁴

Jake's Law and the Children's Behavioral Health Services Fund

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

²³ Arizona Health Care Cost Containment System. AHCCCS Initiatives and Best Practices (azahcccs.gov). Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/>. Accessed on: Mar 11, 2026.

²⁴ Arizona Health Care Cost Containment System. Accessing Behavioral Health Services in Schools (azahcccs.gov). Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/BehavioralHealthServices/>. Accessed on: Mar 11, 2026.

requires that schools develop a policy to refer students for behavioral health services, and to allow families to opt in or out of the referral process each year. Behavioral health services under this funding are provided to students by participating healthcare providers contracted with AHCCCS through the two ACC-RBHAs, Mercy Care (in Central Arizona) and AzCH-CCP (in Southern and Northern Arizona). Jake's Law was exhausted in May 2024. The Arizona legislature has not appropriated further funds for the Children's Behavioral Health Services Fund (CBHSF); therefore, there will not be any additional CBHSF allocation by AHCCCS in the foreseeable future.

Resource Guide

The Arizona Department of Education (ADE) and AHCCCS created the School and Behavioral Health Partnerships Resource Guide for principals, other education administrators, school mental health professionals and anyone who wishes to be a voice that promotes the need for school mental health resources in Arizona. Seven AHCCCS Contractors collaborated to provide a resource for each designated health plan's point of contact for Behavioral Health Services in Schools.²⁵

Arizona Olmstead Plan

Olmstead is a 1999 U.S. Supreme Court decision that provided a legal framework for the efforts of federal and state governments to integrate persons with disabilities into the communities in which they live. Olmstead is intended to remove unnecessary segregation of members from the broader community and to ensure that members receive services in the most integrated setting appropriate to their needs. In October 2023, the current Arizona Olmstead Plan (the Plan) was launched to enhance the service delivery system through integrated care and further ensure members live and receive services in the most appropriate integrated setting in their community. The population targeted to benefit from the Plan consists of individuals who may be at risk of institutionalization, including individuals with behavioral health needs and members of the ALTCS program, collectively referred to as "members" throughout the Plan. The intent of the design of the Plan is for it to be both an actionable and "living" plan that contains specific timelines for objectives that are directed at completing a specified process while also including, as applicable, performance targets to measure positive change resulting from the objectives. The Plan is updated and posted to the AHCCCS website quarterly. For additional information and to view the Plan, see the AHCCCS website.²⁶

Building an Integrated Health Care System and Improving Care Coordination

Today's health care system is a series of parts not yet connected to each other. Improving care coordination and communication, while reducing fragmentation, can weave these parts together to create

²⁵ Arizona Health Care Cost Containment System. School & Behavioral Health Partnerships: A Resource Guide. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/Initiatives/BehavioralHealthServices/SBH_ResourceGuide.pdf. Accessed on: Mar 11, 2026.

²⁶ Arizona Health Care Cost Containment System. Arizona Olmstead Plan. Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/ArizonaOlmsteadPlan/>. Accessed on: Mar 11, 2026.

a health care system with more effective outcomes. AHCCCS continues to integrate the care delivery systems and align incentives that are designed to transform the structure of the Medicaid program, improve health outcomes, and better manage limited resources.²⁷

Improving Behavioral Health and Physical Health Care Coordination for Individuals with a Serious Mental Illness Designation

On October 1, 2022, AHCCCS updated its contracts with health plans for health insurance coverage for individuals with an SMI designation. The contracts expanded select ACC Contractor responsibilities and designated these Contractors as ACC-RBHA Contractors. The contracts also include the provision of integrated care addressing physical and behavioral health and the first 24 hours of crisis services for members with an SMI designation. AHCCCS will continue to work collaboratively with the ACC-RBHAs to evaluate methods to reduce program complexity, administrative burden, and unnecessary administrative and medical costs; and to improve care coordination and disease/chronic care management.²⁸

Medicare and Medicaid Alignment Makes a Difference

Medicare presents one of the greatest challenges to states serving individuals dually eligible for Medicaid and Medicare. Medicare is its own distinct, complex system of care operated by the federal government with little to no interface with state Medicaid programs. For the over 180,000 Arizonans that are eligible for both Medicare and Medicaid, navigating these two separate systems of care can be overwhelming. Under these circumstances, it is more likely for people to be overlooked or forgotten, receive inefficient care, and not achieve optimal health outcomes.

AHCCCS continues developing integration initiatives to increase alignment and improve service delivery for individuals covered by both Medicare and Medicaid. This health system fragmentation often results in poor communication, uncoordinated health care decisions and a lack of a patient-centered perspective. AHCCCS has moved toward increasing the coordination of health service delivery between these two health programs by contracting with Medicare Advantage Dual Special Needs Plans (D-SNPs) that are each affiliated with its ACC Medicaid Contractors. Requiring each ACC Medicaid Contractor to offer a partner Medicare D-SNP promotes the enrollment or alignment of dual eligible members with the same Contractor for both Medicare and Medicaid services to the greatest possible extent. Enrolling in specialized Medicare plans allows dual eligible members to receive all of their health care services, including prescription drug benefits, from a single, integrated Contractor.²⁹

²⁷ Arizona Health Care Cost Containment System. Building an Integrated Health Care System and Improving Care Coordination. Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/>. Accessed on: Mar 11, 2026.

²⁸ Ibid.

²⁹ Arizona Health Care Cost Containment System. Individuals Covered By Both Medicare and Medicaid (Dual Eligible Members). Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/duals.html>. Accessed on: Mar 11, 2026.

Simplifying the System of Care for Children with Special Health Care Needs: Children's Rehabilitative Services (CRS)

CRS was started in 1929 to serve children with complex health care needs who require specialized services. Services for the treatment of CRS qualifying conditions were previously managed solely through the CRS program. Medicaid members would then have to access routine or other non-CRS specialty physical health care through their AHCCCS acute care Contractor and behavioral health through the RBHA. For children who were Medicare eligible, the family had one additional hurdle. Arizona families attempting to care for their child with special health care needs were being asked to navigate up to four systems of care.

On October 1, 2013, AHCCCS integrated all services for most children enrolled in the acute care program with CRS qualifying conditions through one CRS Contractor with the goals of improved member outcomes and satisfaction, reduced member confusion, improved care coordination, and streamlined administration.

Beginning October 1, 2018, members enrolled with DES/DDD began to use their assigned DES/DDD subcontracted health plan for all of their CRS services. DES/DDD continues to provide long-term care services for these members.

Members who qualify for a CRS designation and who are not enrolled with DES/DDD may receive integrated services through an ACC or ACC-RBHA Contractor in their service area for provision of CRS services; or Mercy Care DCS CHP for foster care members.³⁰

Justice System Transitions

AHCCCS has developed collaborative partnerships with a growing number of Arizona's justice system stakeholders. Shared goals include diverting individuals from entering the justice system when appropriate and providing effective and efficient health care resources to support men, women, and children in successfully transitioning out of the justice system.

A significant number of justice-involved individuals are in critical need of health care services, supports, and resources, and may be eligible for assistance through AHCCCS. Available services may include help with physical and behavioral health (e.g., mental health or substance use treatment), housing assistance, employment assistance, crisis services, and other supportive services.³¹

Electronic Visit Verification

AHCCCS uses electronic visit verification (EVV) to help track and monitor timely service delivery and access to care for members. In addition, EVV reduces provider administrative burden associated with

³⁰ Arizona Health Care Cost Containment System. What is a Children's Rehabilitative Services (CRS) Designation? Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/CRS.html>. Accessed on: Mar 11, 2026.

³¹ Arizona Health Care Cost Containment System. Support for Individuals Involved in the Justice System. Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/justiceinitiatives.html>. Accessed on: Mar 11, 2026.

scheduling and hard copy timesheet processing, as well as prevent, detect, and recover improper payments due to fraud, waste, and abuse.

Members and family members have the opportunity to choose which device is used to verify whether a service was received. Services subject to EVV include Attendant, Personal, and Companion Care; Homemaker; Home Health Services; Habilitation and Respite.³²

AHCCCS Housing Programs

AHCCCS provides several permanent supportive housing programs throughout Arizona alongside supportive health services to members experiencing homelessness or housing instability. Housing programs are provided to members with an SMI designation, and some services are provided for members with a General Mental Health/Substance Use Disorder (GMH/SUD). Providing supportive housing services supports members in gaining and maintaining stable housing. It also helps lower utilization of emergency and crisis services. AHCCCS provides supportive housing services to approximately 3,000 members across the State.³³

AHCCCS Payment Modernization

Today's reimbursement structure is based on higher production numbers; i.e., performing more services results in higher pay without regard to outcomes for the patient. To bend the cost curve, there must be a paradigm shift such that reimbursement favors the provider who achieves a quality health outcome. That is why payment modernization is a critical policy strategy for moving to a financially sustainable and value-based healthcare delivery system.

AHCCCS is continuing its pursuit to implement long-term strategies that bend the cost curve while improving member health outcomes. The overall mission is to leverage the AHCCCS managed care model toward value-based healthcare systems where patients' experiences and population health are improved through aligned incentives with Contractors and provider partners, and when there is a commitment to continuous QI and learning.³⁴

Medicaid Enterprise System (MES) Modernization Program

The AHCCCS MES Modernization Program started in 2019 to enhance understanding and optimize the utilization of healthcare access, services, and outcomes for our members. The goal of the program is to

³² Arizona Health Care Cost Containment System. Electronic Visit Verification. Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/EVV/>. Accessed on: Mar 11, 2026.

³³ Arizona Health Care Cost Containment System. AHCCCS Housing Programs. Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/AHP/>. Accessed on: Mar 11, 2026.

³⁴ Arizona Health Care Cost Containment System. AHCCCS Payment Modernization. Available at: <https://www.azahcccs.gov/PlansProviders/RatesAndBilling/PaymentModernization/>. Accessed on: Mar 11, 2026.

bring innovation to business and technical operations that provide high quality healthcare to AHCCCS communities. The work includes replacing legacy applications and processes by implementing modern technology solutions, implementing state-of-the-art systems and processes to improve business standards, bringing a strong and sturdy foundation to business and technical assets, and improving data accessibility.³⁵

Targeted Investments Program

TI 2.0 aligns with AHCCCS' strategic plan and Arizona's Section 1115 Waiver to support and incentivize providers to develop and enhance comprehensive whole-person care systems that effectively address the social risk factors that adversely affect health. Eligible Medicaid provider organizations that meet certain benchmarks will receive financial incentives through managed care plans for developing infrastructure and protocols to optimize coordination of services designed to meet the member's acute, behavioral, and HRSN as well as address identified health inequities among their patient population.³⁶

Telehealth Services

Telehealth is the use of digital technology, like computers, telephones, smartphones, and tablets, to access healthcare services remotely. AHCCCS members who cannot travel to an office or prefer telehealth visits can use these devices from their homes to attend healthcare appointments with their providers. Telehealth can make access to health care more convenient, saving time and transportation costs.

AHCCCS covers all major forms of telehealth services. Asynchronous (also called "store and forward") occurs when services are not delivered in real-time, but clinical information or images are uploaded by a provider and then retrieved for review and recommendation, usually by a specialist. Telephonic services (audio-only) use a traditional telephone to conduct healthcare appointments. Telemedicine involves interactive audio and video, in a real-time, synchronous communication. AHCCCS also covers telehealth for remote patient monitoring and teledentistry.³⁷

Using Technology to Improve Patient Care

AHCCCS envisions a whole-person integrated healthcare system in which HIT and HIE improve population health, enhance the patient experience, and lower costs. AHCCCS encourages all eligible laboratories, physical and behavioral health providers, State/local government agencies, and Contractors

³⁵ Arizona Health Care Cost Containment System. Medicaid Enterprise System (MES) Modernization Program. Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/MES/>. Accessed on: Mar 11, 2026.

³⁶ Arizona Health Care Cost Containment System. Targeted Investments 2.0 Program Overview. Available at: <https://www.azahcccs.gov/PlansProviders/TargetedInvestments/>. Accessed on: Mar 11, 2026.

³⁷ Arizona Health Care Cost Containment System. Telehealth Services. Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/Telehealth/>. Accessed on: Feb 12, 2026.

to adopt HIT resources that securely store and share EHRs, streamline the delivery of healthcare services, and improve member health outcomes.³⁸

Whole Person Care Initiative

The AHCCCS Whole Person Care Initiative is focused on improving essential HRSN of enrolled members. HRSN, also known as SDOH, have a direct impact on members' physical and mental health outcomes. HRSN include:

- Homelessness and Housing Instability
- Food Insecurity
- Employment Instability
- Social Isolation and Social Support
- Interpersonal Safety
- Environmental Safety
- Justice or Legal Involvement
- Education and Childhood Development
- Access to Outdoor Spaces and Parks

Research shows that HRSN contribute to 80 percent of health outcomes, while only 20 percent of health outcomes are from direct healthcare services. Across the Medicaid delivery system, AHCCCS is working to improve members' access to resources that can address their HRSN. For additional information about how AHCCCS is addressing HRSN, see the AHCCCS website.³⁹

2025 AHCCCS Year in Review

AHCCCS achieved major advancements in technology, policy, community engagement, and service delivery, streamlining operations and improving care quality for members statewide.

Member and Provider Services

- Expanded culturally grounded care through federally approved traditional healing services, enabling Medicaid reimbursement for qualified Tribal healers serving American Indian/Alaska Native members.

³⁸ Arizona Health Care Cost Containment System. Using Technology to Improve Patient Care. Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/HIT/>. Accessed on: Feb 12, 2026.

³⁹ Arizona Health Care Cost Containment System. AHCCCS Whole Person Care Initiative (WPCI). Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/AHCCCSWPCI/>. Accessed on: Mar 11, 2026.

- Added adult benefits for speech therapy and cochlear implants, improving access to rehabilitative and auditory services for members ages 21 years and older.
- Improved continuity of care for justice-involved youth by allowing eligible individuals to receive services up to 30 days prior to release.
- Strengthened transparency by managing high-volume media and stakeholder inquiries with timely, accurate responses.
- Deepened collaboration with Arizona's 22 Tribal Nations through multiple Tribal consultation sessions on policy, program design, and rural health priorities. Established quarterly leadership meetings with Urban Indian Organizations to improve communication.
- The AHCCCS Beneficiary Advisory Council (BAC) included:
 - 30 percent of members from rural centers.
 - 70 percent current or former Medicaid members.
 - 50 percent family members to a Medicaid member.
 - Select members span across a range of Medicaid populations, including long-term care and SMI. The BAC identified ways to streamline and enhance eligibility, scheduling, and provider integration/engagement.
- The Arizona State Medicaid Advisory Committee (SMAC) expanded the knowledge of preventive care, moved the needle on expanding access to care and rural engagement, and improved education on covered services and navigation.
- Through the Office of Individual and Family Affairs (OIFA), delivered legislatively required training on psychosis and anosognosia for peer and recovery support specialists, established credential reciprocity with Tribal Nations, and presented Jacob's Law sessions to nearly 500 community members.

Technology Enhancements

- Progressed the MES Modernization Program, including:
 - Electronic Data Interchange (EDI) translator testing (March 2026 launch)
 - Program Integrity upgrades: Fraud, Waste, and Abuse (FWA) Finder and Case Manager (March 31, 2026); Division of Fee for Service Management (DFSM) Claim Manager (June 28, 2026)
 - Customer Service System portal launch (April 2026)
- Launched a statewide AI-powered Opioid Treatment Locator with Google Cloud and Syntasa, providing real-time multilingual search and mapping.

Organizational Development and Employee Support

- Launched a new in-house careers site to improve recruitment, candidate experience, and internal mobility.
- Expanded outreach through 16+ community events statewide.

- Completed relocation to new headquarters at 150 N. 18th Avenue in Phoenix, improving accessibility for members and strengthening coordination to better serve Arizona communities.

Fraud, Waste and Abuse

- The Office of Inspector General (OIG) identified over \$1 billion in savings and recoveries across audit and investigative work.
- Nearly 4,500 cases were closed, and over 7,000 incoming referrals were processed.
- Nineteen criminal convictions resulted from OIG casework.
- Nearly 200 audits were completed.

Waiver, Policy, and Covered Service Enhancements

- Opened Pathways of Hope with Copa Health, a 50-bed transitional facility providing housing and whole-person care for adults with SMI who are experiencing homelessness.
- Advanced Rural Health Transformation Program efforts supporting federal funding for workforce development, telehealth, mobile clinics, maternal and behavioral health, and facility modernization beginning in 2026.
- Prepared for H.R.1-related Medicaid changes through coordinated policy, technology, and operational readiness across agencies, supported by fiscal year (FY) 2027 budget resources.

AHCCCS' Medicaid and CHIP Quality Strategy

In accordance with 42 CFR 438.340 and 42 CFR 457.1240(e), AHCCCS created the AHCCCS Quality Strategy and Quality Strategy Evaluation. The Quality Strategy provides a framework for improving and/or maintaining members' health status as well as fostering the increased resilience and functional health status of members with chronic conditions.

The AHCCCS Quality Strategy is a coordinated, comprehensive, and proactive approach to drive improved health outcomes by utilizing creative initiatives, ongoing assessment and monitoring, and result-based performance improvement. The AHCCCS Quality Strategy Evaluation is a companion document to the AHCCCS Quality Strategy for the purpose of evaluating the effectiveness of the previous AHCCCS Quality Strategy and informing necessary updates. AHCCCS completed its evaluation of quality strategy effectiveness in March 2024. Based on results of the Quality Strategy Evaluation, updates to the AHCCCS Quality Strategy were completed in July 2024.

In CYE 2026, AHCCCS expects to begin the process of drafting a new Quality Strategy Evaluation and updating its Quality Strategy to reflect changes in the Arizona Medicaid delivery system, and to incorporate feedback received from CMS related to the July 2024 submission. AHCCCS members, MCOs, the public, and stakeholders will have the opportunity to provide input and recommendations regarding the content and direction of the Quality Strategy through stakeholder presentations and public

comments. AHCCCS anticipates that the newly created Quality Strategy Evaluation and updated Quality Strategy will be posted on the Agency website and submitted to CMS by July 2027.

Quality Strategy Goals and Objectives

The AHCCCS Quality Strategy identifies goals and objectives for improving the health outcomes of Arizona’s Medicaid and CHIP members and maintaining and improving the managed care delivery system. The goals and supporting objectives take into consideration all populations served by AHCCCS.

AHCCCS’ Quality Strategy identifies the following four goals and associated objectives:⁴⁰

Table 3-1—Quality Strategy Goals and Objectives

Goals	Objectives
 Goal 1: Improve the member’s experience of care related to quality and satisfaction	Enriching the member experience through an integrated approach to service delivery and using strategies and approaches to assure coordinated service delivery.
	Driving the improvement of member-centered health outcomes using nationally recognized protocols, standards of care, and benchmarks, as well as the practice of collaborating with MCOs to reward providers based on implementation of clinical best practices and measurable improved health outcomes (as funding allows).
	Measuring member satisfaction with quality of and access to health care services through the implementation of nationally recognized surveys.
	Increasing AHCCCS’ understanding of survey trends, members’ cultural preferences, key drivers of member satisfaction, and opportunities to improve member experience by engaging the community.
 Goal 2: Improve the health of AHCCCS members	Increasing members’ access to integrated care that meets the members’ individual needs within their local communities.
	Supporting innovative reimbursement models, such as Alternative Payment Models (APMs), while promoting increased quality of care and services.

⁴⁰ Arizona Health Care Cost Containment System. Quality Strategy. July 1, 2024. Available at: <https://www.azahcccs.gov/PlansProviders/Downloads/QualityStrategyJuly2024Final.pdf>. Accessed on: Jan 23, 2026.

Goals	Objectives
	Building upon prevention and health maintenance efforts through targeted medical management: - Emphasizing disease and chronic care management, - Improving functionality in activities of daily living, - Planning patient care for special needs populations, - Identifying and sharing best practices, and - Expanding provider development of Centers of Excellence (COEs).
	Expanding access to specialized treatment providers across the state.
	Increasing care coordination between providers, MCOs, AHCCCS, CHWs, CBOs, and other entities involved with the member's care.
	Enhancing accessibility of a high-quality, culturally-sensitive provider network for AHCCCS members by collaborating with MCOs.
	Promoting member engagement in managing their care.
	Measuring health outcomes and comparing them to national benchmarks, at the aggregate or community level, as appropriate and applicable.
 Goal 3: Limit avoidable growth in healthcare costs while enhancing member access to quality care and services that address whole person care	Developing collaborative strategies and initiatives with state agencies and other external partners, such as: - Strategic partnerships to improve access to healthcare services and affordable healthcare coverage, - Partnerships with sister government agencies, MCOs, and providers to educate Arizonans on health issues, - Effective medical management for at-risk and vulnerable populations, - Build capacity in rural and underserved areas to address both professional and paraprofessional shortages, and - Streamline requirements and monitoring efforts. Evaluating new and existing agency initiatives, services, and processes that have, or are expected to, increase cost to determine if they enhance member access to quality services that address whole member care.

Goals	Objectives
	Identifying opportunities to streamline administrative functions related to healthcare, such as care management, through process improvement techniques (e.g., process mapping, root cause analyses, Plan-Do-Study-Act [PDSA]) and collaboration with national SMEs through the Targeted Investments Programs and other applicable AHCCCS programs. Evaluating current processes related to network oversight and preparing for network system improvements to align with new CMS access to care enhancements.
 Goal 4: Promote improvement in the care and services provided to members by enhancing data system and performance measure reporting capabilities	Increasing analytical capacity to make more informed clinical and policy-making decisions, as well as driving continuous delivery system performance through advanced data analytics and disparity analyses.
	Initiating implementation of a new data system infrastructure.
	Meeting CMS Core Set mandatory reporting requirements by: - Identifying and proposing potential solutions for system and process limitations that impact performance measure reporting and analysis capabilities, and - Enhancing data capture of member demographic criteria such as race, ethnicity, primary language, etc.
	Leveraging various data sources to produce comprehensive reliable data by: - Collaborating with external stakeholders to facilitate access to supplemental data sources such as the HIE, and - Exploring means for collecting and reporting performance measure data utilizing EHR methodologies and Electronic Clinical Data Systems (ECDS) methodologies.
	Increasing transparency by developing and implementing a CMS-compliant quality rating system, as well as enhancing public-facing dashboards and report cards.

Recommendations

- HSAG recommends that AHCCCS collaborate with the ACC Contractors to address lower performing *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures. Comparative analyses against national benchmarks indicate that ACC programs would benefit from targeted QI initiatives focused on these nine measure indicators.
- Behavioral health measures, specifically the *Initiation and Engagement of SUD Treatment* indicators, represent a key opportunity for improvement across the ALTCS-EPD and ALTCS-DD programs. HSAG recommends that AHCCCS partner with its Contractors in implementing structured improvement strategies, such as Plan-Do-Study-Act (PDSA) cycles, to identify systemic barriers and enhance performance outcomes.
- HSAG further recommends that AHCCCS and its Contractors continue prioritizing initiatives that strengthen members' experiences of care, particularly those related to quality and satisfaction. National CAHPS benchmark comparisons indicate that the ACC-RBHA and DCS CHP programs have opportunities to improve the *Coordination of Care* measure. Additionally, the ACC program can benefit from focused QI strategies addressing adult medical assistance with smoking and tobacco use cessation.

4. ACC Program-Level Comparative Results

The ACC Program provides integrated care addressing the physical and behavioral health needs for the majority of Medicaid (Title XIX) eligible children and adults as well as addressing the physical and behavioral health needs for the majority of CHIP KidsCare (Title XXI) eligible children (under age 19).

This section includes ACC program-level comparative results organized by EQR-related activity, strengths, opportunities for improvement, and recommendations for program-level performance improvement. This section also includes aggregate CAHPS survey results for the KidsCare and ACC populations.

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2025, HSAG evaluated each ACC Program Contractor's data system for processing of each data type used for reporting the Contractor's CY 2024 performance measure data in alignment with the CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023 audit requirements.⁴¹ A summary of these findings by ACC Program Contractor is provided in Table 4-1. Table 4-1 also displays whether or not each ACC Program Contractor met the assessed Information Systems (IS) standards, which demonstrates whether or not the Contractor had effective IS practices and control procedures for data reporting. Additional information about each ACC Program Contractor's general findings for each data type reviewed can be found in [Section 5. ACC Program Contractor-Specific Results](#). Additional information regarding the CMS EQR Protocol 2 audit requirements, including more information about the levels of scoring, can be found in the Validation of Performance Measures section of [Appendix A. Methodology](#).

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

Data Type	AzCH– CCP ACC– RBHA	BUFC ACC	Care1st ACC– RBHA	HCA ACC	Mercy Care ACC– RBHA	Molina ACC	UHCCP ACC
Medical Services Data	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>
Enrollment Data	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>
Provider Data	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>

⁴¹ The Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Feb 12, 2026.

Data Type	AzCH– CCP ACC- RBHA	BUFC ACC	Care1st ACC- RBHA	HCA ACC	Mercy Care ACC- RBHA	Molina ACC	UHCCP ACC
Medical Record Review Processes	Met	Met	Met	Met	Met	Met	Met
Supplemental Data	Met	Met	Met	Met	Met	Met	Met
Data Preproduction Processing	Met	Met	Met	Met	Met	Met	Met
Data Integration and Reporting	Met	Met	Met	Met	Met	Met	Met

ACC Program-Level Results

Performance Measure Results

Table 4-2 presents the CY 2024 performance measure rates for each ACC Program Contractor and the ACC Program Aggregate for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. Performance measure rate cells shaded green indicate that the Contractor met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the national Medicaid HMO mean are shaded green. Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 4-2—CY 2024 Performance Measure Results for ACC Program Contractors

Measure	AzCH–CCP ACC- RBHA	BUFC ACC	Care1st ACC- RBHA	HCA ACC	Mercy Care ACC- RBHA	Molina ACC	UHCCP ACC	Aggregate
Maternal and Perinatal Care								
Prenatal and Postpartum Care								
<i>Timeliness of Prenatal Care</i>	80.05% ⁺	84.18% ⁺	82.97% ⁺	87.85% ⁺⁺	86.37% ⁺⁺	84.91% ⁺⁺	85.89% ⁺⁺	84.63% ⁺
<i>Postpartum Care</i>	76.16% ⁺	74.21% ⁺	70.07% ⁺	79.17% ⁺	73.24% ⁺	70.07% ⁺	71.05% ⁺	73.97% ⁺
Behavioral Health								
Adherence to Antipsychotic Medications for Individuals With Schizophrenia								
<i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia</i>	47.89%	52.98%	57.05%	52.15%	52.72%	50.00%	49.66%	50.95%

Measure	AzCH—CCP ACC- RBHA	BUFC ACC	Care1st ACC- RBHA	HCA ACC	Mercy Care ACC- RBHA	Molina ACC	UHCCP ACC	Aggregate
Antidepressant Medication Management								
Effective Acute Phase Treatment	63.54%	66.13%^	64.50%^	64.52%^	53.52%	61.34%	64.47%^	62.53%
Effective Continuation Phase Treatment	44.18%	49.41%^	47.75%^	46.62%	38.43%	43.72%	46.32%	45.00%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications								
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.77%^	84.46%^	77.47%	82.72%^	82.91%^	82.23%	82.92%^	83.03%^
Follow-Up After Emergency Department Visit for Mental Illness								
7-Day Follow-Up—Total	45.93%^	37.06%	53.49%^	52.69%^	48.87%^	63.16%^	42.86%^	45.93%^
30-Day Follow-Up—Total	57.56%	48.45%	63.95%^	63.68%^	60.96%^	65.79%^	53.65%	57.08%
Follow-Up After Emergency Department Visit for Substance Use								
7-Day Follow-Up—Total	30.11%^	34.60%^	35.78%^	33.63%^	32.82%^	27.41%^	31.52%^	32.45%^
30-Day Follow-Up—Total	39.49%^	42.87%^	45.78%^	49.36%^	44.02%^	41.62%^	41.12%^	43.08%^
Follow-Up After Hospitalization for Mental Illness								
7-Day Follow-Up—Total	45.92%^	39.02%	48.59%^	70.35%^	47.32%^	46.80%^	46.34%^	48.42%^
30-Day Follow-Up—Total	63.98%^	55.39%	66.22%^	83.75%^	67.10%^	65.46%^	63.74%^	65.88%^
Follow-Up Care for Children Prescribed ADHD Medication								
Initiation Phase	60.37%^	57.46%^	63.32%^	57.29%^	56.43%^	67.39%^	57.21%^	58.11%^
Continuation and Maintenance Phase	68.03%^	64.60%^	76.06%^	67.12%^	63.98%^	73.53%^	65.57%^	66.14%^
Initiation and Engagement of Substance Use Disorder Treatment								
Initiation of SUD Treatment—Total—Total	49.40%^	51.33%^	42.27%	47.84%^	49.41%^	54.47%^	48.44%^	49.07%^
Engagement of SUD Treatment—Total—Total	19.22%^	21.63%^	15.17%	18.97%^	20.72%^	22.56%^	18.78%^	19.65%^

Measure	AzCH—CCP ACC- RBHA	BUFC ACC	Care1st ACC- RBHA	HCA ACC	Mercy Care ACC- RBHA	Molina ACC	UHCCP ACC	Aggregate
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics								
Total	71.50%^	62.02%^	74.42%^	71.61%^	65.34%^	64.10%^	68.74%^	68.02%^
Use of Opioids at High Dosage								
Use of Opioids at High Dosage*	6.08%	10.51%	5.28%^	5.34%^	8.68%	5.39%^	11.23%	8.62%
Care of Acute and Chronic Conditions								
Glycemic Status Assessment for Patients With Diabetes								
Glycemic Status <8.0%	54.32%	59.37% ⁺	46.80%	58.39% ⁺	64.23% ⁺	52.55% ⁺	58.39% ⁺	58.22%
Glycemic Status >9.0%*	36.91%	27.74% ⁺	46.13%	30.41% ⁺	27.25% ⁺	34.55% ⁺	29.44% ⁺	31.70%^
Pediatric Health								
Child and Adolescent Well-Care Visits								
Total	58.49%^	46.37%	44.96%	46.53%	56.00%^	49.54%	53.70%	52.88%
Childhood Immunization Status								
Combination 3	66.38%^	68.13% ⁺	54.32%	58.39% ⁺	66.42% ⁺	64.48% ⁺	68.13% ⁺	65.34%
Combination 7	58.88%^	61.56% ⁺	48.56%	52.55% ⁺	59.85% ⁺	55.47% ⁺	62.29% ⁺	58.80%^
Combination 10	25.04%	27.98% ⁺	17.03%	19.46% ⁺	24.82% ⁺	22.87% ⁺	23.60% ⁺	23.48%
Childhood Immunization Status (ECDS)								
Combination 3	66.38%^	66.60%^	54.32%	57.13%	65.91%^	63.57%^	65.52%^	64.64%^
Combination 7	58.88%^	59.69%^	48.56%	50.28%	57.16%^	55.31%^	57.85%^	57.02%^
Combination 10	25.04%^	27.87%^	17.03%	18.48%	22.18%	22.57%	23.45%	23.43%
Developmental Screening in the First Three Years of Life								
Total	15.41%	28.95% ⁺	12.75%	26.03% ⁺	36.25% ⁺	28.22% ⁺	33.09% ⁺	27.66%
Immunizations for Adolescents								
Combination 1	85.07%^	87.59% ⁺	70.43%	79.08% ⁺	89.29% ⁺	76.16% ⁺	86.13% ⁺	84.87%^
Combination 2	42.31%^	41.61% ⁺	29.34%	35.04% ⁺	42.58% ⁺	29.68% ⁺	43.07% ⁺	40.75%^
Immunizations for Adolescents (ECDS)								
Combination 1	85.07%^	86.15%^	70.43%	79.37%^	86.94%^	76.64%	85.56%^	84.40%^
Combination 2	42.31%^	42.29%^	29.34%	33.76%	40.61%^	30.09%	41.94%^	40.08%^
Metabolic Monitoring for Children and Adolescents on Antipsychotics								
Blood Glucose and Cholesterol Testing—Total	45.51%^	45.12%^	44.77%^	43.95%^	43.97%^	32.74%	47.58%^	45.11%^
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents								
BMI Percentile—Total	55.17%	81.75% ⁺	37.97%	70.07% ⁺	82.00% ⁺	80.05% ⁺	86.86% ⁺	73.28%

Measure	AzCH—CCP ACC- RBHA	BUFC ACC	Care1st ACC- RBHA	HCA ACC	Mercy Care ACC- RBHA	Molina ACC	UHCCP ACC	Aggregate
<i>Counseling for Nutrition—Total</i>	33.64%	70.32% ⁺	37.46%	60.58% ⁺	73.24% ⁺⁺	72.99% ⁺⁺	74.45% ⁺⁺	60.66%
<i>Counseling for Physical Activity—Total</i>	29.10%	67.15% ⁺	36.97%	55.23% ⁺	72.02% ⁺⁺	68.37% ⁺⁺	71.78% ⁺⁺	57.64%
Well-Child Visits in the First 30 Months of Life								
<i>Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	70.41% [^]	67.57% [^]	58.66%	68.53% [^]	72.26% [^]	68.68% [^]	69.20% [^]	69.48% [^]
<i>Well-Child Visits for Age 15 Months—30 Months—Two or More Well-Child Visits</i>	72.35%	66.58%	61.46%	63.85%	73.41% [^]	69.80%	71.37%	70.17%
Preventive Screening								
Breast Cancer Screening								
<i>Total (50-74 Years)</i>	58.57%	55.10%	39.82%	49.47%	57.90%	51.39%	61.08%	56.38%
Breast Cancer Screening (ECDS)								
<i>Breast Cancer Screening</i>	58.26% [^]	55.10%	39.77%	50.12%	57.90% [^]	52.15%	60.91% [^]	56.36% [^]
Cervical Cancer Screening								
<i>Cervical Cancer Screening</i>	50.01%	53.04% ⁺	37.69%	45.50% ⁺	54.74% ⁺	45.99% ⁺	56.69% ⁺	51.96%
Cervical Cancer Screening (ECDS)								
<i>Cervical Cancer Screening</i>	50.01%	47.32%	37.68%	43.79%	53.06% [^]	42.38%	51.84% [^]	49.23%
Colorectal Cancer Screening								
<i>Total</i>	41.80%	39.35%	29.76%	33.74%	45.12% [^]	29.38%	48.50% [^]	41.81%
Appropriate Utilization of Services								
Plan All-Cause Readmissions								
<i>O/E Ratio—18–64 Years*</i>	1.1770	1.1602 [^]	1.0657 [^]	1.1543 [^]	1.1283 [^]	NA	1.0772 [^]	1.1412 [^]
Oral Health								
Oral Evaluation, Dental Services								
<i>Total</i>	51.23% [^]	40.59%	54.08% [^]	52.90% [^]	56.94% [^]	44.07% [^]	52.70% [^]	51.48% [^]

* A lower rate indicates better performance for this measure.

** Table A-2 in [Appendix A. Methodology](#) outlines which immunizations are included within each combination.

+ Indicates the measure was reported using hybrid methodology.

NA⁺⁺ indicates the denominator was too small to report a valid rate, based on the applicable measure specification.

^N Measure has no NCQA Medicaid mean for comparison.

 and ^ indicates that the rate met or exceeded the MY 2024 national Medicaid mean.

Table 4-3 presents the CY 2023 and CY 2024 ACC Program Aggregate results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and/or MY 2024. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 4-3—CY 2023 and CY 2024 Performance Measure Aggregate Results for ACC Program Contractors

Measure	MY 2023 Performance	MY 2024 Performance	2023-2024 Comparison ¹	2024 Performance Level ²
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	81.50%	84.55%	↑	★★
Postpartum Care	73.39%	74.01%	→	★
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	46.77%	50.95%	↑	★
Antidepressant Medication Management				
Effective Acute Phase Treatment	60.47%	62.53%	↑	★★
Effective Continuation Phase Treatment	42.78%	45.00%	↑	★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.31%	83.03%^	↑	★★★★
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—Total	44.93%^	45.93%^	→	★★★★
30-Day Follow-Up—Total	56.36%^	57.08%	→	★★
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—Total	29.65%^	32.45%^	↑	★★★★
30-Day Follow-Up—Total	40.82%^	43.08%^	↑	★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total	48.49%^	48.42%^	→	★★★★
30-Day Follow-Up—Total	66.02%^	65.88%^	→	★★★★

Measure	MY 2023 Performance	MY 2024 Performance	2023-2024 Comparison ¹	2024 Performance Level ²
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	—	58.11% [^]	—	★★★★★
Continuation and Maintenance Phase	—	66.14% [^]	—	★★★★★
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation of SUD Treatment—Total—Total	49.90% [^]	49.07% [^]	↓	★★★
Engagement of SUD Treatment—Total—Total	19.13% [^]	19.65% [^]	→	★★★★★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Total	70.40% [^]	68.02% [^]	→	★★★
Use of Opioids at High Dosage				
Use of Opioids at High Dosage*	8.42%	8.62%	→	★
Care of Acute and Chronic Conditions				
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status <8.0%	61.18% [^]	58.42%	↓	★★
Glycemic Status >9.0%*	31.05% [^]	31.03% [^]	→	★★
Pediatric Health				
Child and Adolescent Well-Care Visits				
Total	49.55%	52.88%	↑	★★
Childhood Immunization Status				
Combination 3	61.59%	65.78%	↑	★★
Combination 7	53.66%	59.24% [^]	↑	★★★
Combination 10	24.25%	24.19%	→	★★
Childhood Immunization Status (ECDS)				
Combination 3	—	64.64% [^]	—	★★★
Combination 7	—	57.02% [^]	—	★★★
Combination 10	—	23.43%	—	★★
Developmental Screening in the First Three Years of Life				
Total	16.08%	27.87%	↑	NC [±]
Immunizations for Adolescents				
Combination 1	84.60% [^]	85.26% [^]	→	★★★
Combination 2	40.14% [^]	40.88% [^]	→	★★★
Immunizations for Adolescents (ECDS)				
Combination 1	—	84.40% [^]	—	★★★
Combination 2	—	40.08% [^]	—	★★★

Measure	MY 2023 Performance	MY 2024 Performance	2023-2024 Comparison ¹	2024 Performance Level ²
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total	—	45.11%^	—	★★★★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	76.25%	74.45%	↓	★
Counseling for Nutrition—Total	56.47%	61.99%	↑	★
Counseling for Physical Activity—Total	52.88%	58.95%	↑	★
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	65.24%^	69.48%^	↑	★★★★★
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	63.85%	70.17%	↑	★★
Preventive Screening				
Breast Cancer Screening				
Total (50-74 Years)	53.08%	56.38%	↑	NC
Breast Cancer Screening (ECDS)				
Breast Cancer Screening	—	56.36%^	—	★★★★
Cervical Cancer Screening				
Cervical Cancer Screening	51.70%	51.96%	→	★★
Cervical Cancer Screening (ECDS)				
Cervical Cancer Screening	—	49.23%	—	★★
Colorectal Cancer Screening				
Total	—	41.81%	—	★★★★
Appropriate Utilization of Services				
Plan All-Cause Readmissions				
O/E Ratio—18–64 Years*	—	1.1412^	—	★★★★
Oral Health				
Oral Evaluation, Dental Services				
Total	—	51.48%^	—	★★★★★

* A lower rate indicates better performance for this measure.

** Table A-2 in [Appendix A. Methodology](#) outlines which immunizations are included within each combination.

NC± indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

■ and ^ indicates that the rate met or exceeded the MY 2023 and/or MY 2024 national Medicaid mean.

— Indicates a 2023–2024 comparison is not presented in the CYE 2025 Annual Technical Report because either the CY 2023 rate was not presented in the CYE 2024 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

¹ Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.

² Performance Levels for CY 2024 were based on comparisons of the HEDIS MY 2024 measure rates to NCQA Quality Compass national Medicaid HEDIS MY 2024 benchmarks.

↑ Indicates statistically significant improvement of measure rates.

↓ Indicates statistically significant decline of measure rates.

→ Indicates no statistically significant change in measure rates.

Performance Levels for 2024 represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Table 4-4 highlights the ACC Program Contractors' performance for the current year by measure group. The table illustrates the Contractors' CY 2024 measure rates and their performance relative to the NCQA Quality Compass national Medicaid HEDIS MY 2024 percentiles, where applicable. The performance level star ratings are defined as follows:

★★★★★ = 90th percentile and above

★★★★ = 75th percentile to 89th percentile

★★★ = 50th percentile to 74th percentile

★★ = 25th percentile to 49th percentile

★ = Below the 25th percentile

Table 4-4—CY 2024 National Percentiles Comparison for ACC Program Contractors

Measure	AzCH—CCP ACC- RBHA	BUFC ACC	Care1st ACC- RBHA	HCA ACC	Mercy Care ACC- RBHA	Molina ACC	UHCCP ACC	Aggregate
Maternal and Perinatal Care								
Prenatal and Postpartum Care								
Timeliness of Prenatal Care	★	★★	★★	★★★	★★★	★★	★★	★★
Postpartum Care	★	★	★	★★	★	★	★	★
Behavioral Health								
Adherence to Antipsychotic Medications for Individuals With Schizophrenia								
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★	★	★	★	★	★	★	★
Antidepressant Medication Management								
Effective Acute Phase Treatment	★★	★★★	★★★	★★★	★	★★	★★★	★★
Effective Continuation Phase Treatment	★★	★★★	★★★	★★★	★	★★	★★	★★

Measure	AzCH-CCP ACC- RBHA	BUFC ACC	Care1st ACC- RBHA	HCA ACC	Mercy Care ACC- RBHA	Molina ACC	UHCCP ACC	Aggregate
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications								
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	★★★★	★★★★	★	★★	★★★★	★★	★★★★	★★★★
Follow-Up After Emergency Department Visit for Mental Illness								
7-Day Follow-Up—Total	★★★★	★★	★★★★★	★★★★★	★★★★	★★★★★	★★★★	★★★★
30-Day Follow-Up—Total	★★★★	★	★★★★	★★★★	★★★★	★★★★★	★★	★★
Follow-Up After Emergency Department Visit for Substance Use								
7-Day Follow-Up—Total	★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★	★★★★	★★★★
30-Day Follow-Up—Total	★★★★	★★★★	★★★★	★★★★★	★★★★	★★★★	★★★★	★★★★
Follow-Up After Hospitalization for Mental Illness								
7-Day Follow-Up—Total	★★★★	★★	★★★★	★★★★★	★★★★	★★★★	★★★★	★★★★
30-Day Follow-Up—Total	★★★★	★★	★★★★	★★★★★	★★★★	★★★★	★★★★	★★★★
Follow-Up Care for Children Prescribed ADHD Medication								
Initiation Phase	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
Continuation and Maintenance Phase	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
Initiation and Engagement of Substance Use Disorder Treatment								
Initiation of SUD Treatment—Total—Total	★★★★	★★★★★	★★	★★★★	★★★★	★★★★★	★★★★	★★★★
Engagement of SUD Treatment—Total—Total	★★★★	★★★★★	★★★★	★★★★	★★★★★	★★★★★	★★★★	★★★★★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics								
Total	★★★★★	★★	★★★★★	★★★★★	★★★★	★★★★	★★★★★	★★★★
Use of Opioids at High Dosage								
Use of Opioids at High Dosage*	★★	★	★★	★★	★	★★	★	★

Measure	AzCH-CCP ACC- RBHA	BUFC ACC	Care1st ACC- RBHA	HCA ACC	Mercy Care ACC- RBHA	Molina ACC	UHCCP ACC	Aggregate
Care of Acute and Chronic Conditions								
Glycemic Status Assessment for Patients With Diabetes								
Glycemic Status <8.0%	★	★★	★	★★	★★★★	★	★★	★★
Glycemic Status >9.0%*	★	★★★★	★	★★★★	★★★★	★★	★★★★	★★
Pediatric Health								
Child and Adolescent Well-Care Visits								
Total	★★★★	★	★	★	★★★★	★	★★	★★
Childhood Immunization Status								
Combination 3	★★	★★★★	★	★	★★	★★	★★★★	★★
Combination 7	★★★★	★★★★	★	★	★★★★	★★	★★★★	★★★★
Combination 10	★★	★★★★	★	★	★★	★★	★★	★★
Childhood Immunization Status (ECDS)								
Combination 3	★★★★★	★★★★★	★	★★	★★★★★	★★★★	★★★★	★★★★
Combination 7	★★★★★	★★★★★	★★	★★	★★★★	★★★★	★★★★★	★★★★
Combination 10	★★★★	★★★★	★	★	★★	★★	★★	★★
Immunizations for Adolescents								
Combination 1	★★★★	★★★★★	★	★★	★★★★★	★★	★★★★	★★★★
Combination 2	★★★★	★★★★	★	★★	★★★★	★	★★★★	★★★★
Immunizations for Adolescents (ECDS)								
Combination 1	★★★★★	★★★★★	★	★★	★★★★★	★★	★★★★★	★★★★
Combination 2	★★★★★	★★★★★	★	★★	★★★★★	★★	★★★★★	★★★★
Metabolic Monitoring for Children and Adolescents on Antipsychotics								
Blood Glucose and Cholesterol Testing— Total	★★★★★	★★★★★	★★★★★	★★★★	★★★★	★★	★★★★★	★★★★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents								
BMI Percentile— Total	★	★★	★	★	★★	★★	★★★★	★
Counseling for Nutrition—Total	★	★★	★	★	★★	★★	★★★★	★
Counseling for Physical Activity— Total	★	★★	★	★	★★★★	★★	★★★★	★
Well-Child Visits in the First 30 Months of Life								
Well-Child Visits in the First 15	★★★★★	★★★★★	★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★

Measure	AzCH-CCP ACC- RBHA	BUFC ACC	Care1st ACC- RBHA	HCA ACC	Mercy Care ACC- RBHA	Molina ACC	UHCCP ACC	Aggregate
<i>Months—Six or More Well-Child Visits</i>								
<i>Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits</i>	★★★★	★	★	★	★★★★	★★	★★	★★
Preventive Screening								
Breast Cancer Screening (ECDS)								
<i>Breast Cancer Screening</i>	★★★★	★★	★	★	★★★★	★★	★★★★	★★★★
Cervical Cancer Screening								
<i>Cervical Cancer Screening</i>	★	★★	★	★	★★	★	★★	★★
Cervical Cancer Screening (ECDS)								
<i>Cervical Cancer Screening</i>	★★	★★	★	★	★★★★	★	★★	★★
Colorectal Cancer Screening								
<i>Total</i>	★★★★	★★	★	★	★★★★	★	★★★★★	★★★★
Appropriate Utilization of Services								
Plan All-Cause Readmissions								
<i>O/E Ratio—18–64 Years*</i>	★★	★★	★★★★	★★	★★★★	NC	★★★★	★★★★
Oral Health								
Oral Evaluation, Dental Services								
<i>Total</i>	★★★★	★★	★★★★★	★★★★★	★★★★★	★★	★★★★★	★★★★★

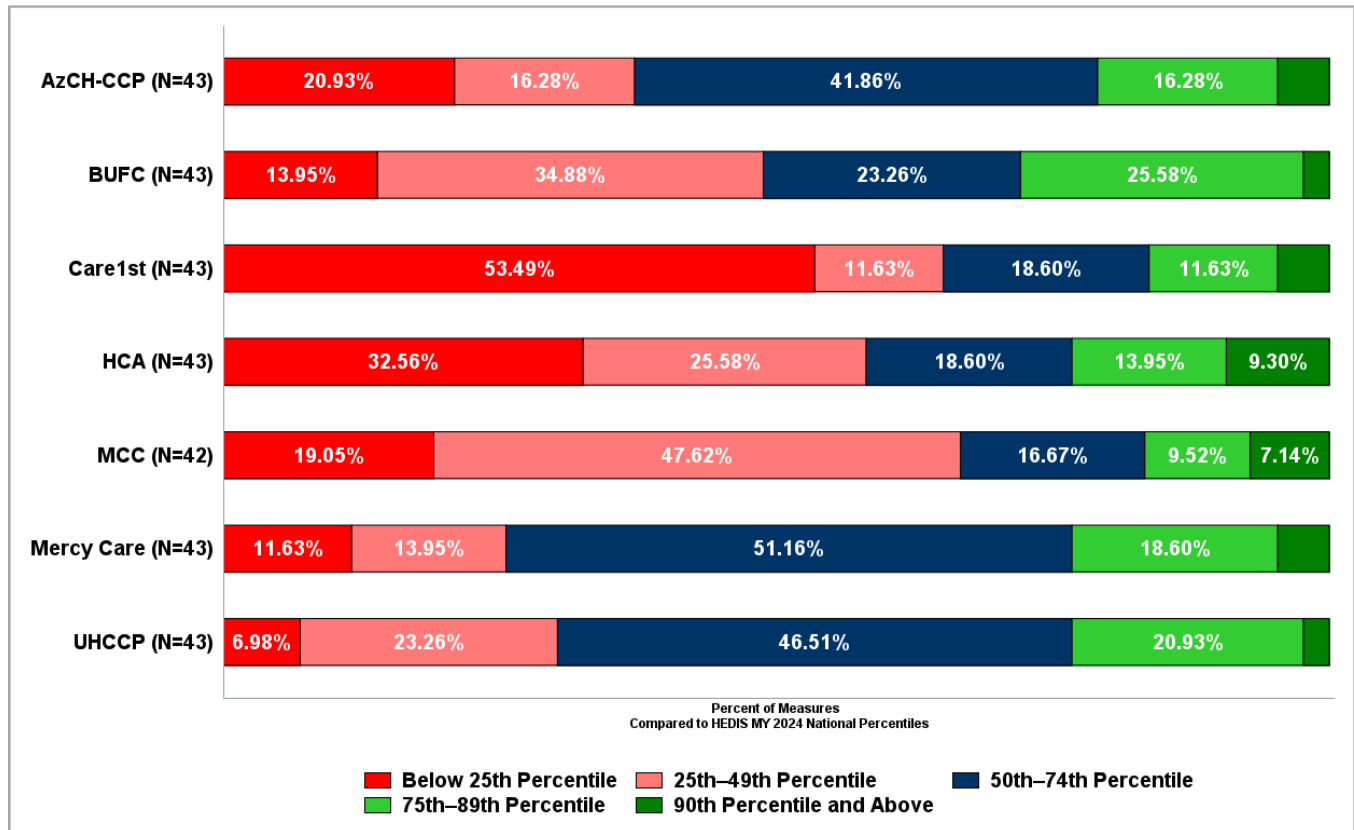
* A lower rate indicates better performance for this measure.

** Table A-2 in [Appendix A. Methodology](#) outlines which immunizations are included within each combination.

NC± indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

Figure 4-1 displays the ACC Program Contractors' HEDIS MY 2024 performance compared to NCQA MY 2024 National Percentiles. HSAG analyzed results from 26 performance measures for HEDIS MY 2024 for a total of 43 measure rates. Percentages in the figure may not total 100 percent due to rounding.

Figure 4-1—Comparison of Measure Rates to HEDIS Medicaid National Percentiles for ACC Program Contractors



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

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

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

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group: The <i>Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)</i> and <i>30-Day Follow-Up—Total (13+ Years)</i> measure rates for all seven ACC Program Contractors and the ACC Program Aggregate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. In 2022, 48.7 million Americans over 12 years of age (about 17.3

Strengths, Opportunities for Improvement, and Recommendations

percent of the population) were classified as having an SUD within the past year.⁴² High ED use for individuals with substance use may signal a lack of access to care or issues with continuity of care. Timely follow-up care helps individuals with SUD stay connected with the healthcare system. **[Quality, Timeliness, Access]**

- The *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)* measure rate for all seven ACC Program Contractors and the ACC Program Aggregate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. The MY 2024 results for this measure continued the prior year’s performance related to meeting or exceeding the national Medicaid HMO mean, indicating members newly prescribed antipsychotic medication typically received psychosocial care as the first line treatment. Research suggests that antipsychotic medications are associated with a number of potential adverse impacts, including weight gain and diabetes, which can have serious implications for future health outcomes. Children without primary indication for an antipsychotic and who are not given the benefit of a trial of psychosocial treatment first may unnecessarily incur the risks associated with antipsychotic medications. Mental health conditions in youth are associated with a number of potential adverse effects, including increased risk for substance use. To the extent that psychosocial interventions are associated with better outcomes, underuse of these therapies may lead to poorer mental and physical health outcomes.⁴³ **[Quality]**
- The *Follow-Up Care for Children Prescribed ADHD Medication (ECDS)—Initiation Phase (6–12 Years)* and *Continuation and Maintenance Phase (6–12 Years)* measure rates for all seven ACC Program Contractors and the ACC Program Aggregate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. These results indicate that members newly prescribed ADHD medication had at least three follow-up care visits within a 300-day (10 month) period, one of which was within 30 days of when the first ADHD medication was dispensed. Research indicates that ADHD is one of the more common chronic conditions of childhood. Children with ADHD may experience significant functional problems, such as school difficulties; academic underachievement; troublesome relationships with family members and peers; and behavioral problems. Given the high prevalence of ADHD among U.S. children (8.7 percent, or 5.3 million individuals), primary care clinicians will regularly encounter children with ADHD and should have a strategy for diagnosing and long-term management of this condition.⁴⁴ **[Quality, Timeliness, Access]**

⁴² National Committee for Quality Assurance. Diagnosed Substance Use Disorders. Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/initiation-and-engagement-of-substance-use-disorder-treatment-iet/>. Accessed on: Feb 11, 2026.

⁴³ National Committee for Quality Assurance. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics. Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/use-of-first-line-psychosocial-care-for-children-and-adolescents-on-antipsychotics-app/>. Accessed on: Feb 11, 2026.

⁴⁴ National Committee for Quality Assurance. Follow-Up Care for Children Prescribed ADHD Medication (ADD-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/follow-up-care-for-children-prescribed-adhd-medication-add-e/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

- The *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* measure rate for six of the seven ACC Program Contractors and the ACC Program Aggregate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. These results may indicate that members were receiving important timely follow-up visits for mental illness after an ED visit. Research suggests that follow-up care for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function, and increased compliance with follow-up instructions.⁴⁵ The MY 2024 results in this measure continued the prior year's high performance related to ensuring timely follow-up for members in accessing care after an ED visit for mental illness. **[Quality, Timeliness, Access]**
- The *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total (6+ Years)* measure rates for six of the seven ACC Program Contractors and the ACC Program Aggregate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. In 2019, nearly one in five adults ages 18 years and older in the U.S. had a diagnosed mental health disorder, but many of these individuals do not receive adequate follow-up care. Research suggests that follow-up care for individuals with mental illness after psychiatric hospitalization can improve overall outcomes, decrease the likelihood of rehospitalization, and reduce the cost of outpatient care.⁴⁶ **[Quality, Timeliness, Access]**
- The *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* and *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* measure rates for six of the seven ACC Program Contractors and the ACC Program Aggregate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. In 2022, 48.7 million individuals in the United States 12 years of age or older (approximately 17.3 percent of the population) were classified as having had an SUD within the past year.⁴⁷ Individuals with SUD are at increased risk of overdose, injury, soft tissue infections, and mortality. In 2021, drug overdose accounted for 106,699 deaths, representing a 14 percent increase in overdose deaths compared to 2020. Similarly, over 140,000 people die each year from excessive alcohol use. Early and regular SUD treatment, including medication therapy, has been demonstrated to improve outcomes for individuals with SUD, but less than 20 percent of individuals with a SUD receive this important specialty care. These results indicate that most members diagnosed with SUD may have initiated SUD treatment and had two or more additional SUD services or MAT within 34 days of the

⁴⁵ National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Mental Illness. Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/follow-up-after-emergency-department-visit-for-mental-illness-fum/>. Accessed on: Feb 11, 2026.

⁴⁶ National Committee for Quality Assurance. Follow-Up After Hospitalization for Mental Illness. Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/follow-up-after-hospitalization-for-mental-illness-fuh/>. Accessed on: Feb 11, 2026.

⁴⁷ National Committee for Quality Assurance. Initiation and Engagement of Substance Use Disorder (IET). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/initiation-and-engagement-of-substance-use-disorder-treatment-iet/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

initiation visit, which, in conjunction with counseling or other behavioral therapies, has been shown to reduce SUD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.⁴⁸ **[Quality, Timeliness, Access]**

In the Pediatric Health measure group:

- The *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)* measure rate for six of the seven ACC Program Contractors and the ACC Program Aggregate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. These results suggest that most children and adolescents with ongoing antipsychotic medication use had appropriate metabolic testing performed, which is consistent with the MY 2023 results as well. Antipsychotic prescribing for children and adolescents has increased rapidly in recent decades. These medications can elevate a child’s risk for developing serious metabolic health complications associated with poor cardiometabolic outcomes in adulthood. Metabolic monitoring (blood glucose and cholesterol testing) is an important component of ensuring appropriate management of children and adolescents on antipsychotic medications.⁴⁹ **[Quality]**
- The *Well-Child Visits in the First 30 Months of Life—First 15 Months—Six or More Well-Child Visits* measure rate for six of the seven ACC Program Contractors and the ACC Program Aggregate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. **[Quality, Access]**

In the Oral Health measure group, the *Oral Evaluation, Dental Services—Total (0–20 Years)* measure rate for six of the seven ACC Program Contractors and the ACC Program Aggregate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. These results suggest that members under 21 years of age received a comprehensive or periodic oral evaluation with a dental provider. Research indicates that oral examinations include physical examination, review of appropriate images, and evaluation for risk of tooth decay. Dental caries is the most common chronic disease in children in the United States. From 2015–2016, prevalence of total (untreated and treated) caries-related tooth decay was 46 percent for children 2–19 years of age. Identifying caries early on is important to reverse the disease process, prevent progression of caries, and reduce incidence of future lesions.⁵⁰ **[Quality]**

⁴⁸ National Committee for Quality Assurance. Diagnosed Substance Use Disorders (DSU). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/diagnosed-substance-use-disorders-dsu/>. Accessed on: Feb 11, 2026.

⁴⁹ National Committee for Quality Assurance. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/metabolic-monitoring-for-children-and-adolescents-on-antipsychotics-apm-e/>. Accessed on: Feb 11, 2026.

⁵⁰ National Committee for Quality Assurance. Oral Evaluation, Dental Services. Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/oral-evaluation-dental-services-oed/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

Opportunities for Improvement and Recommendations

In the Maternal and Perinatal Care measure group, rates for all seven ACC Program Contractors and the ACC Program Aggregate for the *Prenatal and Postpartum Care—Postpartum Care* measure indicator fell below both the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and the 25th percentile, indicating a continued opportunity to increase access to timely postpartum care. **[Quality, Timeliness, Access]**

Recommendation: As noted by the American College of Obstetricians (ACOG), all women should have contact with their obstetrician/gynecologist or other obstetric provider within three weeks postpartum, followed by ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth.⁵¹ To positively impact women in need of postpartum care, ACC Program Contractors are currently conducting the *Prenatal and Postpartum Care* PIP, which includes a root cause analysis and interventions to address this measure. HSAG recommends that ACC Program Contractors continue monitoring the success of interventions, and the ACC Program Contractors should submit results as required by AHCCCS.

In the Behavioral Health measure group, the rates for all seven ACC Program Contractors and the ACC Program Aggregate rate for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years* measure fell below both the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and the 25th percentile. These results indicate that some members with a diagnosis of schizophrenia or schizoaffective disorder were not receiving continuous medication treatment, which is consistent with the MY 2023 results as well. Effective medication treatment of antipsychotics can manage symptoms and improve psychosocial functioning. Medication adherence is necessary to improve symptoms and relapse. Non-adherence increases risk of rehospitalization, emergency psychiatric treatment, functional decline, and death. Medication non-adherence rates for schizophrenic patients ranges between 56 percent and 60 percent.⁵² **[Quality]**

Recommendation: HSAG recommends that the ACC Program Contractors consider clinical recommendations shown to improve adherence to antipsychotic medications, such as developing comprehensive intervention methods to address the factors associated with psychotropic medication non-adherence among patients. Healthcare professionals should pay attention to these aspects and consider developing specific strategies to promote adherence to medications while treating individuals with schizophrenia.⁵³

⁵¹ National Committee for Quality Assurance. Prenatal and Postpartum Care. Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/prenatal-and-postpartum-care-ppc/>. Accessed on: Feb 11, 2026.

⁵² National Committee for Quality Assurance. Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/adherence-to-antipsychotic-medications-for-individuals-with-schizophrenia-saa/>. Accessed on: Feb 11, 2026.

⁵³ Mohammed, F., Geda, B., Yadeta, T.A. et al. Antipsychotic medication non-adherence and factors associated among patients with schizophrenia in eastern Ethiopia. BMC Psychiatry 24, 108 (2024). Available at: <https://pubmed.ncbi.nlm.nih.gov/38326836/>. Accessed on: Feb 11, 2026.

Validation of Performance Improvement Projects

Back to Basics PIP

Well-care visits for children and adolescents aim to promote optimal health and development.⁵⁴ Ensuring that children and adolescents receive regular well-care visits is critical in disease prevention, early detection, and treatment. There are many benefits of well-child/well-care visits, including disease prevention, tracking growth and development, raising concerns, and establishing a team approach to assist with the development of optimal physical, mental, and social health of a child.⁵⁵ Adolescence is a critical stage of development during which physical, intellectual, emotional, and psychological changes occur.⁵⁶ Adolescent well-care visits assist with promoting healthy choices and behaviors, preventing risky behaviors, and detecting early the conditions that can inhibit an adolescent's development.

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Back to Basics* PIP for the ACC/KidsCare population. The objective of the *Back to Basics* PIP was to increase the number of child and adolescent well-child/well-care visits, as well as increase the number of children and adolescents receiving annual dental visits. In October 2023, AHCCCS amended the methodology for the *Back to Basics* PIP and removed the *Annual Dental Visit (ADV)* performance measure as NCQA retired this measure. AHCCCS monitors dental services through dental-focused CMS Core Set measures going forward.

ACC Program-Level Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG's confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. Table 4-6 presents the ACC program-level overall validation results for each Contractor for the *Back to Basics* PIP. Confidence levels for PIP methodology and significant improvement are described in the PIP section of [Appendix A. Methodology](#).

⁵⁴ American Academy of Pediatrics. AAP Schedule of Well-Child Care Visits. Available at: <https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx>. Accessed on: Feb 11, 2026.

⁵⁵ Ibid.

⁵⁶ Centers for Disease Control and Prevention. Adolescence: Preparing for Lifelong Health and Wellness. Available at: <https://archive.cdc.gov/#/details?url=https://www.cdc.gov/grand-rounds/pp/2015/20150818-adolescent-wellness.html>. Accessed on: Feb 11, 2026.

Table 4-6—ACC Program *Back to Basics* PIP Overall Confidence Levels for Remeasurement 3

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
AzCH-CCP ACC-RBHA	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>	100%	100%
BUFC ACC	<i>High Confidence</i>	100%	100%	<i>Moderate Confidence</i>	33%	100%
Care1st ACC-RBHA	<i>High Confidence</i>	100%	100%	<i>No Confidence</i>	33%	100%
HCA ACC	<i>Low Confidence</i>	87%	89%	<i>High Confidence</i>	100%	100%
Mercy Care ACC-RBHA	<i>Low Confidence</i>	73%	78%	<i>High Confidence</i>	100%	100%
Molina ACC	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>	100%	100%
UHCCP ACC	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>	100%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

ACC Program-Level Measure Results

Table 4-7 and Table 4-8 present indicator rates for each Contractor for the *Back to Basics* PIP during the baseline year, Remeasurement Year 1, Remeasurement 2, and Remeasurement Year 3.

Table 4-7—ACC Program Contractors' *Back to Basics* PIP Comparative Rates for Indicator 1

Contractor	PIP Indicator 1: <i>Well-Child Visits in the First 30 Months of Life (W30 Rate 1)</i>			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
AzCH-CCP ACC-RBHA	63.19%	60.74%	66.48%	70.41%
BUFC ACC	63.46%	58.11%	63.60%	67.57%
Care1st ACC-RBHA	70.46%	53.53%	54.76%	58.66%
HCA ACC	59.39%	56.13%	63.32%	68.53%
Mercy Care ACC-RBHA	64.96%	65.12%	67.87%	72.26%
Molina ACC	49.06%^	56.04%	63.07%	68.68%
UHCCP ACC	65.62%	61.85%	65.19%	69.20%

^In CYE 2019, the Molina ACC performance measure rate for indicator 1 had a small denominator, which did not allow for reporting of the measure. CY 2020 served as baseline for indicator 1 for Molina ACC. Molina ACC's baseline rate for indicator 1, for the purposes of this PIP, was 49.1%.

Table 4-8—ACC Program Contractors' *Back to Basics* PIP Comparative Rates for Indicator 2

Contractor	PIP Indicator 2: <i>Child and Adolescent Well-Care Visits (WCV)</i>			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
AzCH-CCP ACC-RBHA	46.90%	46.39%	53.19%	58.49%
BUFC ACC	46.65%	39.63%	44.04%	46.37%
Care1st ACC-RBHA	51.43%	33.71%	41.83%	44.96%
HCA ACC	43.60%	39.79%	43.22%	46.53%
Mercy Care ACC-RBHA	52.92%	49.57%	53.58%	56.00%
Molina ACC	33.85%	39.56%	43.53%	49.54%
UHCCP ACC	52.70%	47.44%	50.73%	53.70%

ACC Program-Level Interventions

For the *Back to Basics* PIP, all Contractors provided lists of interventions that were in place for this validation cycle. These lists detailed the identified population, the intervention(s) in place, and whether or not the intervention(s) will be continued. The most common interventions across Contractors included targeting members and providers for outreach and education related to well-care visits. Outreach methods included interactive voice response (IVR), person-to-person, and automated phone calls; text message campaigns; emails; member events; and mailing materials. Additionally, several Contractors

had physician and/or member incentives in place directly tied to closing gaps in care. Opportunity for Care reports were utilized to inform providers of members in need of well-care visits. These interventions were able to impact indicator performance during this validation cycle. For further descriptions of each Contractor’s interventions, see [Section 5—ACC Program Contractor-Specific Results](#).

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

Table 4-9 presents program-level strengths, opportunities for improvement, and recommendations for the ACC Program related to the *Back to Basics* PIPs.

Table 4-9—ACC Program Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIPs

Strengths, Opportunities for Improvement, and Recommendations
Strengths Five ACC Program Contractors were able to achieve statistically significant improvement for both performance indicators when comparing baseline rates to Remeasurement 3 rates. Additionally, another ACC Program contractor had statistically significant improvement for one of the two performance indicators. At Remeasurement 3, two ACC Program Contractors sustained the statistically significant improvement that they achieved at Remeasurement 1 and Remeasurement 2 for both performance indicators. [Quality, Access]
Opportunities for Improvement and Recommendations HSAG identified no opportunities for improvement related to the <i>Back to Basics</i> PIP. HSAG recommends that the Contractors consider the following for future PIPs: • Apply lessons learned from the <i>Back to Basics</i> PIP. • Seek technical assistance from HSAG to understand the CMS EQR Protocol 1 requirements. • Implement interventions with clearly defined intervention effectiveness measures.

Prenatal and Postpartum Care PIP

According to the Centers for Disease Control and Prevention (CDC), at least 50,000 women in the United States are affected by severe morbidity due to unexpected pregnancy-related health problems. In addition, more than 700 women die each year from pregnancy-related problems or delivery complications. Racial disparities exist among pregnancy-related deaths, as the CDC reports, “American Indian, Alaska Native, and Black women are two to three times more likely to die of pregnancy-related causes than White

women.”⁵⁷ Every death related to pregnancy is a tragedy, especially considering the CDC found that four in five of the deaths are preventable.⁵⁸

According to Healthy People 2030, “women’s health before, during, and after pregnancy can have a major impact on infants’ health and well-being.”⁵⁹ Strategies such as maintaining a healthy lifestyle, receiving proper health care, and adopting healthy habits before and during pregnancy help prevent pregnancy complications and improve health outcomes for women and their babies. In addition, these strategies may assist in promoting infant health, development, and overall well-being.

In CYE 2022 (October 1, 2021, through September 30, 2022), AHCCCS implemented the *Prenatal and Postpartum Care* PIP for the ACC-RBHA population. The objective of the *Prenatal and Postpartum Care* PIP is to improve health outcomes for members and infants. This PIP focuses on increasing the number and percentage of members with live birth deliveries that 1) received a prenatal care visit, and 2) received a postpartum visit.

ACC Program-Level Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG’s confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG’s confidence that the PIP’s performance indicator results demonstrated evidence of significant improvement. Table 4-10 presents the ACC program-level overall validation results for each Contractor for the *Prenatal and Postpartum Care* PIP. Confidence levels for PIP methodology and significant improvement are described in the PIP section of [Appendix A. Methodology](#).

⁵⁷ Centers for Disease Control and Prevention. Hear Her Campaign. Pregnancy-Related Deaths in the United States. Available at: <https://www.cdc.gov/hearher/pregnancy-related-deaths/index.html>. Accessed on: Sep 1, 2025.

⁵⁸ Ibid.

⁵⁹ U.S. Department of Health and Human Services. Healthy People 2030. Pregnancy and Childbirth. Available at: <https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth#:~:text=Women's%20health%20before%2C%20during%2C%20and%20after%20pregnancy%20can%20have%20a.and%20to%20have%20healthy%20babies>. Accessed on: Sep 1, 2025.

Table 4-10—ACC Program *Prenatal and Postpartum Care* PIP Overall Confidence Levels for Remeasurement 1

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
AzCH-CCP ACC-RBHA	<i>High Confidence</i>	100%	100%	<i>Moderate Confidence</i>	33%	100%
BUFC ACC	<i>High Confidence</i>	100%	100%	<i>Moderate Confidence</i>	67%	100%
Care1st ACC-RBHA	<i>High Confidence</i>	100%	100%	<i>Moderate Confidence</i>	67%	100%
HCA ACC	<i>Low Confidence</i>	81%	83%	<i>Moderate Confidence</i>	67%	100%
Mercy Care ACC-RBHA	<i>High Confidence</i>	100%	100%	<i>Low Confidence</i>	33%	100%
Molina ACC	<i>High Confidence</i>	100%	100%	<i>Moderate Confidence</i>	67%	100%
UHCCP ACC	<i>High Confidence</i>	100%	100%	<i>Moderate Confidence</i>	67%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

ACC Program-Level Measure Results

Table 4-11 and Table 4-12 present indicator rates for each Contractor for the *Prenatal and Postpartum Care* PIP during the baseline year and Remeasurement Year 1.

Table 4-11—ACC Program Contractors' Prenatal and Postpartum Care PIP Comparative Rates for Indicator 1

Contractor	PIP Indicator 1: Prenatal Care Visits	
	Baseline Year	Remeasurement 1
	CY 2022	CY 2024
AzCH-CCP ACC-RBHA	82.73%	80.05%
BUFC ACC	81.51%	84.18%
Care1st ACC-RBHA	75.43%	82.97%
HCA ACC	86.85%	87.85%
Mercy Care ACC-RBHA	84.91%	86.37%
Molina ACC	83.70%	84.91%
UHCCP ACC	82.48%	85.89%

Table 4-12—ACC Program Contractors' Prenatal and Postpartum Care PIP Comparative Rates for Indicator 2

Contractor	PIP Indicator 2: Postpartum Care Visit	
	Baseline Year	Remeasurement 1
	CY 2022	CY 2024
AzCH-CCP ACC-RBHA	66.42%	76.16%
BUFC ACC	69.83%	74.21%
Care1st ACC-RBHA	68.37%	70.07%
HCA ACC	65.26%	79.17%
Mercy Care ACC-RBHA	78.10%	73.24%
Molina ACC	64.23%	70.07%
UHCCP ACC	67.64%	71.05%

ACC Program-Level Interventions

For the *Prenatal and Postpartum Care* PIP, all Contractors provided AHCCCS with lists of interventions that were in place for this validation cycle. These lists detailed the identified population, the intervention(s) in place, and whether or not the interventions(s) will be continued. The most common new interventions across Contractors included data dashboards and technology advancements to support members' access to care and education materials. The most common continued interventions across Contractors included targeting members and providers for outreach and education related to prenatal and postpartum care visits. Outreach methods included person-to-person and automated phone calls, text message campaigns, emails, member events, and mailing materials. Additionally, several Contractors had physician and/or member incentives in place directly tied to closing gaps in care. Care gap reports

and notification of pregnancy (NOP) reports through provider portals were utilized to inform providers of members in need of well-care visits. Transportation assistance and pregnancy care programs were offered to pregnant women. The most common enhancements made to interventions included updating education, expanding the audience for outreach efforts, increasing frequency of notifications to members and providers, and improving processes to receive incentives for members and providers.

For further description of each Contractor’s interventions, see [Section 5. ACC Program Contractor-Specific Results](#).

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

Table 4-13 presents program-level strengths, opportunities for improvement, and recommendations for the ACC Program related to the *Prenatal and Postpartum Care* PIPs.

Table 4-13—ACC Program Strengths, Opportunities for Improvement, and Recommendations Related to the Prenatal and Postpartum Care PIPs

Strengths, Opportunities for Improvement, and Recommendations
Strengths
The ACC Program Contractors developed and implemented measurement systems for interventions that led to improvement in indicator outcomes at Remeasurement 1. Five Contractors had non-statistically significant improvement for both indicators, with two Contractors reporting statistically significant improvement for one indicator. [Quality, Access]
Opportunities for Improvement and Recommendations
HSAG identified no opportunities for improvement during the validation. Recommendations: Although HSAG identified no opportunities for improvement, to support successful progression of the PIP in the next calendar year, HSAG recommends that the ACC Program Contractors: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement, as necessary. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. • Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.

Compliance Reviews

AHCCCS contracted with HSAG to conduct compliance reviews of the ACC Program Contractors. CYE 2025 began a new three-year cycle of compliance reviews, referred to as operational reviews (ORs), for four of the six ACC Contractors.

For the CYE 2025 evaluation of the ACC Program, HSAG performed two types of activities. First, HSAG conducted a review of 15 standard areas using monitoring tools to assess and document compliance with federal and State requirements. The 15 standards for review were related to the federal Medicaid managed care regulations and associated State requirements. The compliance review included completing a desk review of documents, a review of the Contractor’s NCQA health plan accreditation reports and findings, file reviews, and an on-site review that included reviewing additional documents and conducting interviews with the Contractor. The second compliance review activity in CYE 2025 involved HSAG’s and AHCCCS’s evaluation of the ACC Contractor’s corrective action plans (CAPs) related to findings from the CYE 2025 compliance review.

ACC Program-Level Results

Table 4-14 summarizes the results from the 2025 compliance reviews. This table contains high-level results of the ACC Contractors’ performance on a set of requirements (federal Medicaid managed care regulations and State contract provisions) for each of the 15 operational standard areas reviewed.

Table 4-14—Standards and Compliance Scores

Standard #	Standard Name*	BUFC ACC	HCA ACC	Molina ACC	UHCCP ACC
I	Disenrollment: Requirements and Limitations	67%	89%	89%	89%
II	Member Rights and Member Information	95%	95%	91%	91%
III	Emergency and Poststabilization Services	85%	100%	100%	92%
IV	Availability of Services	100%	100%	92%	100%
V	Assurances of Adequate Capacity and Services	100%	100%	100%	100%
VI	Coordination and Continuity of Care	100%	100%	100%	100%
VII	Coverage and Authorization of Services	90%	90%	86%	87%
VIII	Provider Selection	86%	86%	86%	100%
IX	Confidentiality	100%	100%	100%	100%
X	Grievance and Appeal Systems	84%	95%	92%	84%
XI	Subcontractual Relationships and Delegation	60%	100%	80%	80%
XII	Practice Guidelines	100%	100%	100%	100%
XIII	Health Information Systems	89%	89%	100%	100%
XIV	Quality Assessment and Performance Improvement Program	89%	100%	100%	89%
XV	Program Integrity	100%	100%	100%	100%
Totals		90%	95%	93%	92%

Standard #	Standard Name*	BUFC ACC	HCA ACC	Molina ACC	UHCCP ACC
	Totals: The compliance scores were calculated by adding the Deemed elements and the Met elements and then dividing by the total number of applicable elements.				

* Table A-7 in [Appendix A, Methodology](#) outlines the compliance review standards and associated federal citations.

All four ACC Contractors submitted their CAPs as required. HSAG and AHCCCS evaluated the sufficiency of the CAPs for implementation of proposed interventions. Additionally, AHCCCS continued its monitoring of Mercy Care ACC-RBHA's CAPs from the CYE 2024 compliance review. On May 19, 2025, AHCCCS reviewed Mercy Care ACC-RBHA's CAP status and determined that all CAPs had been completed and approved for closure.

HSAG will conduct compliance reviews of AzCH-CCP ACC-RBHA and Mercy Care ACC-RBHA in CYE 2026, which starts a new three-year compliance review cycle for these two ACC contractors.

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

Table 4-15 presents program-level strengths, opportunities for improvement, and recommendations for the ACC Program related to compliance.

Table 4-15—ACC Program Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
All four ACC Program Contractors scored at or above 95 percent in the following standards: - Assurances of Adequate Capacity and Services [Timeliness, Access] - Coordination and Continuity of Care [Quality, Timeliness, Access] - Confidentiality [Quality] - Practice Guidelines [Quality] - Program Integrity [Quality]
Opportunities for Improvement and Recommendations
All four ACC Program Contractors scored below 95 percent in the following standards: - Disenrollment: Requirements and Limitations [Quality] - Coverage and Authorization of Services [Quality, Timeliness, Access] Recommendations: HSAG recommends that the ACC Program Contractors address the elements scored as <i>Not Met</i> through the CAP process during CYE 2026.

Network Adequacy Validation

ACC Program-Level Results

ISCA Results

HSAG completed an ISCA for each of the ACC Program Contractors contracted to deliver services to Medicaid managed care members in Arizona and this report presents findings and validation ratings based on the ACC Program Contractors' ISCA and live system demonstrations. For each of the ACC Program Contractors assessed, HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data systems. Additionally, HSAG determined that each ACC Program Contractor's data collection procedures were acceptable. For the ACC Program Contractors that used external delegated entities to complete network adequacy indicator reporting during the reporting period, no issues were identified.

Based on the results of the ISCA's combined with the detailed validation of each NAV indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and whether the ACC Program Contractors' interpretation of data was accurate. All ACC Program Contractors received *High Confidence* for both appointment availability and time/distance indicators. However, there were identified areas for improvement for some of the ACC Program Contractors; please refer to [Section 5. ACC Program Contractor-Specific Results](#).

NAV Results

HSAG's validation of the ACC Program Contractors' results showed minor discrepancies between the ACC Program Contractors' self-reported AHCCCS Contractors Operations Manual (ACOM) 436 results and HSAG's time/distance calculations for all ACC Program Contractors and programs in each quarter for which data could be compared. While minor differences (i.e., less than 1 percentage point) between HSAG's time/distance calculation results and each ACC Program Contractor's time/distance calculation results were common, these findings may be attributable to the timing of the input data, software versions used by each ACC Program Contractor, or due to a small number of members eligible for inclusion in time/distance calculations for the standard and county.

Table 4-16 summarizes HSAG's assessment of each ACC Program Contractor's compliance with AHCCCS' minimum time/distance network standards. A check mark indicates that the ACC Program Contractor met the minimum network standard for each Arizona county during the CYE 2024 S2 assessment, and an "X" indicates that the ACC Program Contractor did not meet one or more minimum network standards in any county. [Section 5. ACC Program Contractor-Specific Results](#) contains NAV results specific to each ACC Program Contractor.

Table 4-16—Summary of CYE 2024 S2 Compliance With Minimum Time/Distance Network Requirements for ACC Program Contractors

Minimum Network Requirement	AzCH-CCP	BUFC	Care1st	HCA	Mercy Care	Molina	UHCCP
Behavioral Health Outpatient and Integrated Clinic, Adult	✓	✓	X	✓	✓	✓	✓
Behavioral Health Outpatient and Integrated Clinic, Pediatric	✓	✓	X	✓	✓	✓	✓
BHRF	✓	✓	NA	✓	✓	✓	✓
Cardiologist, Adult	✓	✓	✓	✓	✓	✓	✓
Cardiologist, Pediatric	✓	✓	✓	✓	✓	✓	✓
Dentist, Pediatric	X	X	X	X	✓	✓	X
Hospital	✓	✓	✓	✓	✓	✓	✓
OB/GYN	✓	✓	✓	✓	✓	✓	✓
PCP, Adult	✓	✓	✓	✓	✓	✓	✓
PCP, Pediatric	✓	✓	✓	✓	✓	✓	✓
Pharmacy	X	X	✓	✓	✓	✓	✓

NA indicates the time/distance standard does not apply based on the program and county associated with each Contractor.

The ACC Program Contractors’ performance consistently met BHRF, Cardiologist, Adult and Pediatric; Hospital; OB/GYN; and PCP, Adult and Pediatric standards.

No isolated data issues were identified affecting the ACC Program Contractors’ compliance with time/distance standards.

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

Overall, the applicable ACC Program Contractors met all minimum time/distance network standards in Cochise, Graham, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. Based on the CYE 2024 S2 NAV results, Mercy Care ACC and Molina ACC were the only ACC Program Contractors that met all requirements for all standards in their respective counties.

Each ACC Program Contractor should continue to monitor and maintain its existing provider network as of CYE 2024 S2, with specific attention to ensuring the availability of the following provider categories for which more than one ACC Program Contractor did not meet the network requirement:

- Dentist, Pediatric in Apache, Greenlee, and La Paz counties.
- Pharmacy in La Paz County.

ACC Program Conclusions, Opportunities for Improvement, and Recommendations Related to Network Adequacy Validation

Table 4-17 presents program-level strengths, opportunities for improvement, and recommendations for the ACC Program related to NAV.

Table 4-17—ACC Program Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations	
Strengths	
HSAG identified the following strengths: • The ACC Program Contractors received <i>High Confidence</i> for both appointment availability and time/distance indicators. [Access] • The applicable ACC Program Contractors met all minimum time/distance network standards in Cochise, Graham, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. [Access] • The ACC Program Contractors consistently met BHRF, Cardiologist, Adult and Pediatric; Hospital; OB/GYN; and PCP, Adult and Pediatric standards. [Access]	
Opportunities for Improvement and Recommendations	
HSAG identified the following opportunities for improvement: • Based on the NAV results, more than one ACC Program Contractor did not meet the standards for Dentist, Pediatric; and Pharmacy. [Access] Recommendations: HSAG recommends that AHCCCS support each ACC Program Contractor in continuing to monitor and maintain its existing provider network coverage as of CYE 2024 S2, with specific attention to ensuring the availability of the following provider categories among the applicable ACC Program Contractors: • Dentist, Pediatric in Apache, Greenlee, and La Paz counties. • Pharmacy in La Paz County.	

Consumer Assessment of Healthcare Providers and Systems Results

ACC Program Adult Medicaid Results

HSAG administered member experience surveys on AHCCCS' behalf to adult members enrolled with an ACC Contractor from the statewide sample and the ACC oversample provided by AHCCCS. HSAG calculated results for four global rating questions, four composite measures, one individual item measure, and three medical assistance with smoking and tobacco use cessation items. Table 4-18 shows the scores, including the overall members' experience ratings, trend analysis, and national average comparison results for each CAHPS measure for the adult Medicaid population.

Table 4-18—ACC Program CAHPS Comparative Analyses

Measure	Adult Medicaid	
	2024	2025
Global Ratings		
<i>Rating of Health Plan</i>	★★★★ 63.6%	★★★★ 63.5%
<i>Rating of All Health Care</i>	★★ 52.4%	★★★★ 60.0%
<i>Rating of Personal Doctor</i>	★★★★ 71.6%	★★★★★ 77.1% H
<i>Rating of Specialist Seen Most Often</i>	★★ 65.2%	★★★★★ 74.4%
Composite Measures		
<i>Getting Needed Care</i>	★ 76.6%	★★★★★ 85.0% ▲
<i>Getting Care Quickly</i>	★★ 77.0%	★★★★ 81.9%
<i>How Well Doctors Communicate</i>	★★★★ 93.9%	★★★★ 93.2%
<i>Customer Service</i>	★ 85.9%	★★★★★ 92.2% ⁺
Individual Item Measure		
<i>Coordination of Care</i>	★★★★ 86.1%	★★ 83.5% ⁺

Measure	Adult Medicaid	
	2024	2025
Medical Assistance with Smoking and Tobacco Use Cessation Items		
<i>Advising Smokers and Tobacco Users to Quit</i>	★ 67.1% ⁺	★ 67.1% ⁺
<i>Discussing Cessation Medications</i>	★ 45.7% ⁺	★ 45.7% ⁺
<i>Discussing Cessation Strategies</i>	★ 37.0% ⁺	★ 39.5% ⁺

Star Assignments Based on Percentiles:

★★★★★ 90th or Above ★★★★★ 75th-89th ★★★★★ 50th-74th ★★ 25th-49th ★ Below 25th

▲ Indicates the 2025 score is statistically significantly higher than the 2024 score.

▼ Indicates the 2025 score is statistically significantly lower than the 2024 score.

H Indicates the 2025 score is statistically significantly higher than the NCQA national average.

L Indicates the 2025 score is statistically significantly lower than the NCQA national average.

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

ACC Program Strengths, Opportunities for Improvement, and Recommendations Related to the Adult Medicaid Consumer Assessment of Healthcare Providers and Systems Results

Table 4-19 presents program-level strengths, opportunities for improvement, and recommendations for the ACC Program related to the 2025 ACC program-level CAHPS results for adult Medicaid.

Table 4-19—ACC Program Strengths, Opportunities for Improvement, and Recommendations Related to CAHPS

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: - The ACC Program’s member experience ratings for <i>Rating of Personal Doctor</i>, <i>Rating of Specialist Seen Most Often</i>, and <i>Customer Service</i> were at or above the 90th percentile for the adult Medicaid population. [Quality] - The ACC Program’s member experience rating for <i>Getting Needed Care</i> was between the 75th and 89th percentiles for the adult Medicaid population. [Quality, Access] - The ACC Program’s member experience rating for <i>Rating of Personal Doctor</i> was statistically significantly higher than the NCQA national average for the adult Medicaid population. [Quality] - The ACC Program’s 2025 score for <i>Getting Needed Care</i> was statistically significantly higher than the 2024 score for the adult Medicaid population. [Quality, Access]

Strengths, Opportunities for Improvement, and Recommendations
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: - The ACC Program’s member experience ratings for <i>Advising Smokers and Tobacco Users to Quit</i>, <i>Discussing Cessation Medications</i>, and <i>Discussing Cessation Strategies</i> were below the 25th percentiles for the adult Medicaid population. [Quality] - The ACC Program’s member experience rating for <i>Coordination of Care</i> was at or between the 25th and 49th percentiles for the adult Medicaid population. [Quality] Recommendations: HSAG recommends that the ACC Program Contractors explore what may be driving lower experience scores and develop initiatives designed to improve the quality of care, including a focus on improving adult members’ overall experiences with their care coordination and medical assistance with quitting smoking and tobacco use.

ACC Program Child Medicaid Results

HSAG administered member experience surveys on AHCCCS’ behalf to child members enrolled with an ACC Contractor from the statewide sample and the ACC oversample provided by AHCCCS. HSAG calculated results for four global rating questions, four composite measures, one individual item measure, and five CCC composites/items (CCC population only).

Children with chronic conditions were identified by five sets of survey questions in the survey instrument. These questions focus on specific health care needs and conditions that constitute a CCC screener. The survey responses for child members in the general child sample and the CCC supplemental sample were analyzed to determine which child members had chronic conditions (those in the CCC population) and which did not. The general population of children (i.e., those in the general child sample) could have included children with chronic conditions if parents/caretakers answered the CCC survey screener questions affirmatively (i.e., a positive CCC screener). Therefore, the results of the CCC population are composed of child members within both the general child sample and the CCC supplemental sample whose parents/caretakers answered affirmatively to the CCC screener questions.

Table 4-20 shows the 2024 and 2025 scores, including the overall members’ experience ratings, trend analysis, and national average comparison results for each CAHPS measure for both the general child and CCC Medicaid populations.

Table 4-20—ACC Program CAHPS Comparative Analyses

Measure	General Child Medicaid		CCC Medicaid	
	2024	2025	2024	2025
Global Ratings				
<i>Rating of Health Plan</i>	★★★★★ 77.1%	★★★ 72.8%	★★★★★ 73.4%	★★★ 67.3%
<i>Rating of All Health Care</i>	★★★★★ 71.7%	★★★★★ 73.8%	★★★★★ 77.1%	★★ 65.3% ▼
<i>Rating of Personal Doctor</i>	★★★ 77.6%	★★★★★ 82.0%	★★★★★ 78.3%	★★★ 77.8%
<i>Rating of Specialist Seen Most Often</i>	★★ 70.5% ⁺	★★ 73.1% ⁺	★★★★★ 78.9% ⁺	★★ 68.8% ⁺
Composite Measures				
<i>Getting Needed Care</i>	★★★ 85.6%	★★★★★ 87.8% ⁺	★★★ 86.8% ⁺	★★★ 86.4%
<i>Getting Care Quickly</i>	★★★★★ 91.4% ⁺	★★★★★ 91.3% ⁺ H	★★★★★ 91.9% ⁺	★★★ 90.4% ⁺
<i>How Well Doctors Communicate</i>	★★★ 94.5%	★★★ 95.3%	★★★ 95.2% ⁺	★★★ 95.2%
<i>Customer Service</i>	★★★★★ 93.6% ⁺	★★★ 89.7% ⁺	★ 81.0% ⁺	★★★★★ 93.9% ⁺ ▲
Individual Item Measure				
<i>Coordination of Care</i>	★★ 82.5% ⁺	★★ 82.3% ⁺	★★ 83.6% ⁺	★★★ 84.5% ⁺
CCC Composite Measures and Items				
<i>Access to Specialized Services</i>	NA	NA	★ 62.5% ⁺	★★ 66.1% ⁺
<i>FCC: Personal Doctor Who Knows Child</i>	NA	NA	★ 88.0% ⁺	★ 89.3%
<i>Coordination of Care for Children with Chronic Conditions</i>	NA	NA	★★★★★ 81.8% ⁺	★★★★★ 81.9% ⁺ H
<i>Access to Prescription Medicines</i>	NA	NA	★★★★★ 99.1%	★★★★★ 93.2% ▼

Measure	General Child Medicaid		CCC Medicaid	
	2024	2025	2024	2025
<i>FCC: Getting Needed Information</i>	NA	NA	★★★★★ 96.2%	★★★ 90.2%

Star Assignments Based on Percentiles:

★★★★★ 90th or Above ★★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

▲ Indicates the 2025 score is statistically significantly higher than the 2024 score.

▼ Indicates the 2025 score is statistically significantly lower than the 2024 score.

H Indicates the 2025 score is statistically significantly higher than the NCQA national average.

L Indicates the 2025 score is statistically significantly lower than the NCQA national average.

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

NA Indicates that this measure is not applicable for the population.

ACC Program Strengths, Opportunities for Improvement, and Recommendations Related to the Child Medicaid Consumer Assessment of Healthcare Providers and Systems Results

Table 4-21 presents program-level strengths, opportunities for improvement, and recommendations for the ACC Program related to the 2025 ACC program-level CAHPS results for child Medicaid.

Table 4-21—ACC Program Strengths, Opportunities for Improvement, and Recommendations Related to CAHPS

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: - The ACC Program’s member experience ratings for <i>Customer Service</i>, <i>Coordination of Care for Children with Chronic Conditions</i>, and <i>Access to Prescription Medicines</i> were at or above the 90th percentile for the CCC population. [Quality, Access] - The ACC Program’s member experience ratings for <i>Rating of All Health Care</i>, <i>Rating of Personal Doctor</i>, <i>Getting Needed Care</i>, and <i>Getting Care Quickly</i> were at or between the 75th and 89th percentiles for the general child population. [Quality, Timeliness] - The ACC Program’s 2025 score for <i>Getting Care Quickly</i> was statistically significantly higher than the NCQA national average for the general child population. [Quality, Timeliness] - The ACC Program’s 2025 score for <i>Coordination of Care for Children with Chronic Conditions</i> was statistically significantly higher than the NCQA national averages for the CCC population. [Quality] - The ACC Program’s 2025 score for <i>Customer Service</i> was statistically significantly higher than the 2024 score for the CCC population. [Quality]
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement:

Strengths, Opportunities for Improvement, and Recommendations

- The ACC Program’s member experience rating for *FCC: Personal Doctor Who Knows Child* was below the 25th percentile for the CCC population. **[Quality]**
- The ACC Program’s member experience ratings for *Rating of Specialist Seen Most Often* and *Coordination of Care* were between the 25th and 49th percentiles for the general child population. **[Quality]**
- The ACC Program’s member experience ratings for *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Access to Specialized Services*, and *FCC: Getting Needed Information* were between the 25th and 49th percentiles for the CCC population. **[Quality, Access]**
- The ACC Program’s 2025 scores for *Rating of All Health Care* and *Access to Prescription Medicines* were statistically significantly lower than the 2024 scores for the CCC population. **[Quality, Access]**

Recommendations: HSAG recommends that the ACC Program Contractors explore what may be driving lower experience scores and develop initiatives designed to improve the quality of and access to care, including a focus on improving parents’/caretakers’ overall experiences with their child’s health care, child’s specialist seen most often, personal doctor who knows child, coordination of care, getting needed information, and access to specialized services for child members.

KidsCare Results

HSAG administered member experience surveys on AHCCCS’ behalf to members enrolled in the AHCCCS’ KidsCare program. KidsCare is Arizona’s CHIP for eligible children (under 18 years of age) who do not qualify for other AHCCCS health insurance. AHCCCS contracted with HSAG to administer and report the results of the CAHPS Health Plan Survey for the KidsCare program. The goal of the CAHPS Health Plan Survey is to provide performance feedback that is actionable and will aid in improving overall member experience. HSAG calculated results for four global ratings, four composite measures, one individual item measure, and five CCC composites/items (CCC population only).

Children with chronic conditions were identified by five sets of survey questions in the survey instrument. These questions focus on specific health care needs and conditions that constitute a CCC screener. The survey responses for child members in the general child sample and the CCC supplemental sample were analyzed to determine which child members had chronic conditions (those in the CCC population) and which did not. The general population of children (i.e., those in the general child sample) could have included children with chronic conditions if parents/caretakers answered the CCC survey screener questions affirmatively (i.e., a positive CCC screener). Therefore, the results of the CCC population are composed of child members within both the general child sample and the CCC supplemental sample whose parents/caretakers answered affirmatively to the CCC screener questions.

Table 4-22 shows the 2024 and 2025 scores, including the overall members experience ratings and national average comparison results for each CAHPS measure for both the general child and CCC KidsCare populations.

Table 4-22—ACC KidsCare CAHPS Comparative Analyses

Measure	General Child Medicaid		CCC Medicaid	
	2024	2025	2024	2025
Global Ratings				
<i>Rating of Health Plan</i>	★★★★★ 76.1%	★★★★ 71.7%	★★★★★ 71.3%	★★★★ 70.9%
<i>Rating of All Health Care</i>	★★★★★ 71.7% ⁺	★★★★★ 74.8%	★★★★ 68.8%	★★★★★ 72.7%
<i>Rating of Personal Doctor</i>	★★★★ 78.5%	★★★★★ 81.4%	★★★★★ 80.2%	★★★★ 78.3%
<i>Rating of Specialist Seen Most Often</i>	★★★★ 73.5%	★ 58.3% ⁺ L	★★★★★ 77.2% ⁺	★★ 68.2% ⁺
Composite Measures				
<i>Getting Needed Care</i>	★★★★ 86.2%	★★★★ 85.6%	★★★★ 87.1%	★★ 82.9% ⁺
<i>Getting Care Quickly</i>	★★★★★ 90.2%	★★ 86.5%	★★★★ 90.6% ⁺	★ 83.3% ⁺
<i>How Well Doctors Communicate</i>	★★★★★★ 96.9%	★★★★★★ 97.0% H	★★★★★★ 97.9%	★★★★ 94.7% ⁺
<i>Customer Service</i>	★★★★★★ 91.5%	★ 83.3% ⁺	★★ 88.6% ⁺	★★ 88.0% ⁺
Individual Item Measure				
<i>Coordination of Care</i>	★★★★ 85.8%	★★ 83.9% ⁺	★★ 82.9% ⁺	★★★★ 84.1% ⁺
CCC Composite Measures and Items				
<i>Access to Specialized Services</i>	NA	NA	★ 58.8% ⁺	★★★★ 72.4% ⁺
<i>FCC: Personal Doctor Who Knows Child</i>	NA	NA	★★★★★ 92.5% ⁺	★ 89.9% ⁺
<i>Coordination of Care for Children with Chronic Conditions</i>	NA	NA	★★★★★★ 82.9% ⁺	★★ 73.9% ⁺

Measure	General Child Medicaid		CCC Medicaid	
	2024	2025	2024	2025
<i>Access to Prescription Medicines</i>	NA	NA	★★ 89.9%	★★★★★ 93.5%
<i>FCC: Getting Needed Information</i>	NA	NA	★★★★ 93.6%	★★★ 92.6%

Star Assignments Based on Percentiles:

★★★★★ 90th or Above ★★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

H Indicates the 2025 score is statistically significantly higher than the NCQA national average.

L Indicates the 2025 score is statistically significantly lower than the NCQA national average.

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

NA Indicates that this measure is not applicable for the population.

KidsCare Strengths, Opportunities for Improvement, and Recommendations Related to Consumer Assessment of Healthcare Providers and Systems Results

Table 4-23 presents program-level strengths, opportunities for improvement, and recommendations for the ACC Program related to the 2025 KidsCare Program-Level CAHPS results.

Table 4-23—ACC KidsCare Program Strengths, Opportunities for Improvement, and Recommendations Related to CAHPS

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: - The KidsCare member experience rating for <i>How Well Doctors Communicate</i> was at or above the 90th percentile for the general child population. [Quality] - The KidsCare member experience rating for <i>Access to Prescription Medicines</i> was at or above the 90th percentile for the CCC population. [Quality, Access] - The KidsCare member experience ratings for <i>Rating of All Health Care</i> and <i>Rating of Personal Doctor</i> were at or between the 75th and 89th percentiles for the general child population. [Quality] - The KidsCare member experience rating for <i>Rating of All Health Care</i> was at or between the 75th and 89th percentiles for the CCC population. [Quality] - The KidsCare 2025 score for <i>How Well Doctors Communicate</i> was statistically significantly higher than the NCQA national average for the general child population. [Quality]
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: The KidsCare member experience ratings for <i>Rating of Specialist Seen Most Often</i> and <i>Customer Service</i> were below the 25th percentiles for the general child population. [Quality]

Strengths, Opportunities for Improvement, and Recommendations

- The KidsCare member experience ratings for *Getting Care Quickly* and *FCC: Personal Doctor Who Knows Child* were below the 25th percentiles for the CCC population. **[Quality, Timeliness]**
- The KidsCare member experience ratings for *Getting Care Quickly* and *Coordination of Care* were between the 25th and 49th percentiles for the general child population. **[Quality, Timeliness]**
- The KidsCare member experience ratings for *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Customer Service*, and *Coordination of Care for Children with Chronic Conditions* were between the 25th and 49th percentiles for the CCC population. **[Quality, Access]**
- The KidsCare 2025 score for *Rating of Specialist Seen Most Often* was statistically significantly higher than the NCQA national average for the general child population. **[Quality]**

Recommendations: HSAG recommends that the KidsCare Contractors explore what may be driving lower experience scores and develop initiatives designed to improve the quality of, access to, and timeliness of care, including a focus on improving parents'/caretakers' overall experiences with the specialist their child sees the most, their child's personal doctor knowing the child, coordination of care, customer service, and getting needed care in a timely manner.

5. ACC Program Contractor-Specific Results

ACC and ACC-Regional Behavioral Health Agreement (ACC-RBHA) Contractors are responsible for the provision of services under the ACC Program.

This section provides, by ACC and ACC-RBHA Contractor, activity-specific strengths, opportunities for improvement, and HSAG’s recommendations for performance improvement for the ACC population. This section also includes information about the extent to which each Contractor was able to address the prior year’s recommendations for each activity.

AzCH-CCP ACC-RBHA

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2025, HSAG evaluated AzCH-CCP ACC-RBHA’s data system for processing of each data type used for reporting the Contractor’s CY 2024 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that AzCH-CCP ACC-RBHA followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-1 displays HSAG’s PMV findings for each data type reviewed during CYE 2025 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 5-1—CYE 2025 PMV Findings

Data Type	HSAG Findings
Medical Services Data	<i>No identified concerns</i>
Enrollment Data	<i>No identified concerns</i>
Provider Data	<i>No identified concerns</i>
Medical Record Review Process	<i>No identified concerns</i>
Supplemental Data	<i>No identified concerns</i>
Data Integration	<i>No identified concerns</i>

Results for Performance Measures

Table 5-2 presents the CY 2023 and CY 2024 AzCH-CCP ACC-RBHA performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for

HEDIS MY 2023 and MY 2024. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and/or MY 2024. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 5-2—CY 2023 and CY 2024 AzCH-CCP ACC-RBHA Performance Measure Results

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
<i>Timeliness of Prenatal Care</i>	76.64% ⁺	80.05% ⁺	→	★
<i>Postpartum Care</i>	76.64% ⁺	76.16% ⁺	→	★
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
<i>18+ Years</i>	43.73%	47.89%	→	★
Antidepressant Medication Management				
<i>Effective Acute Phase Treatment—Total (18+ Years)</i>	62.24%	63.54%	→	★★
<i>Effective Continuation Phase Treatment—Total (18+ Years)</i>	43.26%	44.18%	→	★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
<i>18–64 Years</i>	81.50% [^]	83.77% [^]	↑	★★★★
Follow-Up After ED Visit for Mental Illness				
<i>7-Day Follow-Up—Total (6+ Years)</i>	48.64% [^]	45.93% [^]	→	★★★★
<i>30-Day Follow-Up—Total (6+ Years)</i>	59.33% [^]	57.56%	→	★★★★
Follow-Up After ED Visit for Substance Use				
<i>7-Day Follow-Up—Total (13+ Years)</i>	29.00% [^]	30.11% [^]	→	★★★★
<i>30-Day Follow-Up—Total (13+ Years)</i>	39.35% [^]	39.49% [^]	→	★★★★
Follow-Up After Hospitalization for Mental Illness				
<i>7-Day Follow-Up—Total (6+ Years)</i>	45.67% [^]	45.92% [^]	→	★★★★
<i>30-Day Follow-Up—Total (6+ Years)</i>	63.92% [^]	63.98% [^]	→	★★★★
Follow-Up Care for Children Prescribed ADHD Medication (ECDS)				
<i>Initiation Phase (6–12 Years)</i>	—	60.37% [^]	—	★★★★★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
<i>Continuation and Maintenance Phase (6–12 Years)</i>	—	68.03%^	—	★★★★★
Initiation and Engagement of SUD Treatment				
<i>Initiation of SUD Treatment—Total—Total (13+ Years)</i>	48.95%^	49.40%^	→	★★★
<i>Engagement of SUD Treatment—Total—Total (13+ Years)</i>	18.22%^	19.22%^	→	★★★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
<i>Total (1–17 Years)</i>	75.06%^	71.50%^	→	★★★★★
Use of Opioids at High Dosage				
<i>18+ Years*</i>	6.33%	6.08%	→	★★
Care of Acute and Chronic Conditions				
Glycemic Status Assessment for Patients With Diabetes				
<i>Glycemic Status <8.0%—Total (18–75 Years)</i>	62.04% ^{+^}	54.32%	↓	★
<i>Glycemic Status >9.0%—Total (18–75 Years)*</i>	30.66% ^{+^}	36.91%	↓	★
Pediatric Health				
Child and Adolescent Well-Care Visits				
<i>Total (3–21 Years)</i>	53.19%^	58.49%^	↑	★★★
Childhood Immunization Status**				
<i>Combination 3</i>	62.53% ⁺	66.38%^	→	★★
<i>Combination 7</i>	55.96% ^{+^}	58.88%^	→	★★★
<i>Combination 10</i>	24.09% ⁺	25.04%	→	★★
Childhood Immunization Status (ECDS)**				
<i>Combination 3</i>	—	66.38%^	—	★★★★★
<i>Combination 7</i>	—	58.88%^	—	★★★★★
<i>Combination 10</i>	—	25.04%^	—	★★★
Developmental Screening in the First Three Years of Life				
<i>Total (0–3 Years)</i>	15.82%	15.41%	→	NC [±]
Immunizations for Adolescents**				
<i>Combination 1 (Meningococcal, Tdap)</i>	87.10% ^{+^}	85.07%^	→	★★★
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	41.85% ^{+^}	42.31%^	→	★★★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Immunizations for Adolescents (ECDS)**				
Combination 1 (Meningococcal, Tdap)	—	85.07%^	—	★★★★★
Combination 2 (Meningococcal, Tdap, HPV)	—	42.31%^	—	★★★★★
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	—	45.51%^	—	★★★★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total (3–17 Years)	71.29% ⁺	55.17%	↓	★
Counseling for Nutrition—Total (3–17 Years)	67.88% ⁺	33.64%	↓	★
Counseling for Physical Activity—Total (3–17 Years)	66.67% ^{+^}	29.10%	↓	★
Well-Child Visits in the First 30 Months of Life				
First 15 Months—Six or More Well-Child Visits	66.48%^	70.41%^	↑	★★★★★
15 Months–30 Months—Two or More Well-Child Visits	63.15%	72.35%	↑	★★★★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	54.56%^	58.57%	↑	NC [±]
Breast Cancer Screening (ECDS)				
Total (50–74 Years)	—	58.26%^	—	★★★★
Cervical Cancer Screening				
21–64 Years	51.82% ⁺	50.01%	→	★
Cervical Cancer Screening (ECDS)				
21–64 Years	—	50.01%	—	★★
Colorectal Cancer Screening (ECDS)				
Total (45–75 Years)	—	41.80%	—	★★★★
Appropriate Utilization of Services				
Plan All-Cause Readmissions				
Observed/Expected (O/E) Ratio—Total (18–64 Years)*	—	1.1770	—	★★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Oral Health				
Oral Evaluation, Dental Services				
Total (0–20 Years)	—	51.23% [^]	—	★★★

* A lower rate indicates better performance for this measure.

** Table A-2 in [Appendix A. Methodology](#) outlines which immunizations are included within each combination.

NC± indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

+ Indicates the measure was reported using hybrid methodology.

 and [^] indicates that the rate met or exceeded the MY 2023 and/or MY 2024 national Medicaid mean.

— Indicates a 2023–2024 comparison is not presented in the CYE 2025 Annual Technical Report because either the CY 2023 rate was not presented in the CYE 2024 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

¹Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.

²Performance Levels for CY 2024 were based on comparisons of the HEDIS MY 2024 measure rates to NCQA Quality Compass national Medicaid HEDIS MY 2024 benchmarks.

↑ Indicates statistically significant improvement of measure rates.

↓ Indicates statistically significant decline of measure rates.

→ Indicates no statistically significant change in measure rates.

Performance Levels for 2024 represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

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

Table 5-3—AzCH-CCP ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group: - Eleven of 16 AzCH-CCP ACC-RBHA measure rates (68.75 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. [Quality, Timeliness, Access] <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years</i>

Strengths, Opportunities for Improvement, and Recommendations

- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)*
- *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years) and 30-Day Follow-Up—Total (13+ Years)*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)*
- *Follow-Up Care for Children Prescribed ADHD Medication (ECDS)—Initiation Phase (6–12 Years) and Continuation and Maintenance Phase (6–12 Years)*
- *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Total (13+ Years) and Engagement of SUD Treatment—Total—Total (13+ Years)*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)*
- AzCH-CCP ACC-RBHA’s performance measure rates for eight of these measures were at or between the 50th and 74th percentile. The measure rate for *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)* was at or between the 75th and 89th percentile, indicating good follow-up and continuity of care provided to members with substance use or mental illness, whether hospitalized or in the ED. In addition, the results indicate that most members diagnosed with SUD initiated treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth treatment, or MAT within 14 days of diagnosis and had two or more additional SUD services or medications within 34 days of the initiation visit.⁶⁰ **[Quality, Timeliness, Access]**
- AzCH-CCP ACC-RBHA’s performance measure rates for *Follow-Up Care for Children Prescribed ADHD Medication (ECDS)—Initiation Phase (6–12 Years) and Continuation and Maintenance Phase (6–12 Years)* were at or above the 90th percentile. These results indicate that members newly prescribed ADHD medication had at least three follow-up care visits within a 300-day (10 month) period, one of which was within 30 days of when the first ADHD medication was dispensed. Research indicates that ADHD is one of the more common chronic conditions of childhood. Children with ADHD may experience significant functional problems, such as school difficulties, academic underachievement, troublesome relationships with family members and peers, and behavioral problems. Given the high prevalence of ADHD among U.S. children (8.7 percent, or 5.3 million individuals), primary care clinicians will regularly encounter children with ADHD and should have a strategy for diagnosing and long-term management of this condition.⁶¹ **[Quality, Timeliness, Access]**

In the Pediatric Health measure group:

⁶⁰ National Committee for Quality Assurance. Initiation and Engagement of Substance Use Disorder (IET). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/initiation-and-engagement-of-substance-use-disorder-treatment-iet/>. Accessed on: Feb 11, 2026.

⁶¹ National Committee for Quality Assurance. Follow-Up Care for Children Prescribed ADHD Medication (ADD-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/follow-up-care-for-children-prescribed-adhd-medication-add-e/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

- Twelve of 18 AzCH-CCP ACC-RBHA measure rates (66.67 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. **[Quality, Timeliness, Access]**
 - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)*
 - *Childhood Immunization Status—Combination 3 and Combination 7*
 - *Childhood Immunization Status (ECDS)—Combination 3, Combination 7, and Combination 10*
 - *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)*
 - *Immunizations for Adolescents (ECDS)—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)*
 - *Well-Child Visits in the First 30 Months of Life—First 15 Months—Six or More Well-Child Visits*
 - *Child and Adolescent Well-Care Visits—Total (3–21 Years)*
- AzCH-CCP ACC-RBHA’s performance measure rates for *Immunizations for Adolescents (ECDS)—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)* were at or between the 75th and 89th percentile, indicating that most adolescents were receiving one dose of meningococcal vaccine, one Tdap [tetanus, diphtheria, pertussis] vaccine, and the complete HPV vaccine series by their 13th birthday. Receiving recommended vaccinations is the best defense against serious vaccine-preventable diseases, including meningococcal meningitis, tetanus, diphtheria, pertussis (whooping cough), and HPV.⁶² In addition, AzCH-CCP ACC-RBHA’s performance measure rates for *Childhood Immunization Status (ECDS)—Combination 3 and Combination 7* were at or between the 75th and 89th percentile, indicating that most children were receiving the appropriate doses of the DTaP [tetanus, diphtheria, pertussis], IPV, MMR, HiB, hepatitis B, VZV, and pneumococcal vaccines. **[Quality, Access]**
- AzCH-CCP ACC-RBHA’s performance measure rate for *Well-Child Visits in the First 30 Months of Life—First 15 Months—Six or More Well-Child Visits* was at or between the 75th and 89th percentile, indicating that most children who turned 15 months old during the measurement year had at least six well-child visits with a PCP.⁶³ **[Quality, Access]**
- AzCH-CCP ACC-RBHA’s performance measure rate for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)* was at or between the 75th and 89th percentile, indicating that most children and adolescents with

⁶² National Committee for Quality Assurance. Immunizations for Adolescents (IMA-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/immunizations-for-adolescents-ima-e/>. Accessed on: Feb 11, 2026.

⁶³ National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (WCV). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/child-and-adolescent-well-care-visits-wcv/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

ongoing antipsychotic medication use had metabolic testing performed. Metabolic monitoring (blood glucose and cholesterol testing) is an important component of ensuring appropriate management of children and adolescents on antipsychotic medications.⁶⁴ **[Quality]**

In the Preventive Screening measure group, one of four AzCH-CCP ACC-RBHA measure rates (25.00 percent), *Breast Cancer Screening (ECDS)—Total (50–74 Years)*, met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and was at or between the 50th and 74th percentile. These results indicate that most members recommended for routine breast cancer screening were receiving timely mammograms to screen for breast cancer. **[Quality, Timeliness, Access]**

In the Oral Health measure group, AzCH-CCP ACC-RBHA’s one measure rate (100 percent), *Oral Evaluation, Dental Services—Total (0–20 Years)*, met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and was at or between the 50th and 74th percentile. These results indicate that members under 21 years of age are receiving a comprehensive or periodic oral evaluation with a dental provider during the measurement year. **[Access]**

Opportunities for Improvement and Recommendations

While AzCH-CCP ACC-RBHA was successful in reporting valid rates for all AHCCCS-required performance measures for its ACC population, the audit identified some considerations and recommendations for future years’ reporting. **[Quality]**

Recommendations: HSAG recommends that AzCH-CCP ACC-RBHA continue to work with AHCCCS to explore additional data sources for capturing race and ethnicity information from members to support performance measure reporting. This could involve investigating supplemental data sources and implementing new collection strategies to ensure more complete member profiles. In addition, HSAG recommends that AzCH-CCP ACC-RBHA continue to ensure compliance with AHCCCS’ requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes AHCCCS’ requirements for MCO-enrolled members who switch product lines and members for whom AzCH-CCP ACC-RBHA does not hold the primary insurance contract.

In the Maternal and Perinatal Care measure group, AzCH-CCP ACC-RBHA’s performance measure rate for both *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, indicating an opportunity to increase access to timely prenatal and postpartum care. **[Quality, Timeliness, Access]**

Recommendations: HSAG recommends that AzCH-CCP ACC-RBHA continue to implement appropriate interventions to improve performance relative to prenatal and postpartum care. HSAG also recommends that AzCH-CCP ACC-RBHA monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Postpartum Care*

⁶⁴ National Committee for Quality Assurance. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/metabolic-monitoring-for-children-and-adolescents-on-antipsychotics-apm/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

measure indicator, while adding interventions as appropriate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care*.

In the Behavioral Health measure group:

- AzCH-CCP ACC-RBHA's performance measure rate for *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years* fell below the 25th percentile for MY 2024 and fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024, indicating opportunities to improve psychotropic medication compliance for members.
[Quality]

Recommendations: Schizophrenia is a chronic and disabling psychiatric disorder that requires ongoing treatment and monitoring. Symptoms include hallucinations, illogical thinking, memory impairment, and incoherent speech. Medication nonadherence is common and a major concern in the treatment of schizophrenia. Using antipsychotic medications as prescribed reduces the risk of relapse or hospitalization.⁶⁵ In a systematic review of medication adherence studies, several interventions that worked in studies were motivational interviewing, daily texts to individuals with schizophrenia, and other medication reminders. Other effective studies utilized Meds-Help, a pharmacy-based intervention, environmental support through home visits and reminders to adhere to medication, a psychoeducational program (FSPP), an intervention called STOPS that focuses on the importance of the supervisor's role for patients during treatment, and an IOT program.⁶⁶ HSAG recommends that AzCH-CCP ACC-RBHA consider or continue implementing one or more of these interventions that have been associated with increased medication adherence for members with schizophrenia. In addition, HSAG recommends that AzCH-CCP ACC-RBHA consider or continue utilizing financial incentives offered to patients with severe mental illness to improve treatment adherence.

- AzCH-CCP ACC-RBHA's performance measure rate for *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total (18+ Years)* fell below the 50th percentile for MY 2024 and below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024. These results indicate that some members with a diagnosis of major depression were not receiving continuous medication treatment, which is consistent with the MY 2023 results as well. Effective medication treatment of major depression can improve a person's daily functioning and well-being

⁶⁵ National Committee for Quality Assurance. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/adherence-to-antipsychotic-medications-for-individuals-with-schizophrenia-saa/>. Accessed on: Feb 11, 2026.

⁶⁶ Cahaya N, Kristina SA, Widayanti AW, et al. Interventions to Improve Medication Adherence in People with Schizophrenia: A Systematic Review. Patient preference and adherence vol. 16 2431-2449. 1 Sep. 2022, doi:10.2147/PPA.S378951. Available at: <https://pubmed.ncbi.nlm.nih.gov/36072918/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated as well.⁶⁷ **[Quality]**

Recommendations: HSAG recommends that AzCH-CCP ACC-RBHA consider clinical recommendations shown to improve adherence to antidepressants, such as assessing depressive symptoms at baseline and at each follow-up, as well as providing psychoeducation to the member and family.⁶⁸

- AzCH-CCP ACC-RBHA's performance measure rate for *Use of Opioids at High Dosage—18+ Years* fell below the 50th percentile for MY 2024 and below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024, indicating opportunities to identify trends leading to higher opioid use. **[Quality]**

Recommendations: HSAG recommends that AzCH-CCP ACC-RBHA ensure providers are following the CDC Clinical Practice Guideline for Prescribing Opioids for Pain. The guidelines provide recommendations for clinicians to determine whether to initiate opioids for pain, select opioids and dosages, manage the duration of initial opioid prescriptions, and assess the risks and potential harms of opioid use. The guidelines are based on systematic reviews of scientific evidence and reflect considerations of benefits and harms, patient and clinician values and preferences, and resource allocation. They aim to improve communication between clinicians and patients about pain treatments; enhance the effectiveness and safety of pain treatment; and reduce risks associated with opioid pain therapy, including opioid use disorder, overdose, and death.⁶⁹ HSAG also recommends that AzCH-CCP ACC-RBHA identify provider-specific trends in opioid prescribing to determine if certain providers are prescribing opioids at higher rates and/or amounts.

In the Care of Acute and Chronic Conditions measure group, AzCH-CCP ACC-RBHA's performance measure rates for *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total (18–75 Years)* and *Glycemic Status >9.0%—Total (18–75 Years)* fell below the 25th percentile, indicating poor control over diabetes. **[Quality]**

- Recommendation: Diabetes is a complex group of diseases marked by high blood glucose (blood sugar) due to the body's inability to make or use insulin. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease,

⁶⁷ National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/antidepressant-medication-management-amm/>. Accessed on: Feb 11, 2026.

⁶⁸ Solmi M, Miola A, Croatto G, et al. How can we improve antidepressant adherence in the management of depression? A targeted review and 10 clinical recommendations. *Brazilian Journal of Psychiatry*. 2021;43(2):189–202.

⁶⁹ Dowell D, Ragan KR, Jones CM, et al. CDC Clinical Practice Guideline for Prescribing Opioids for Pain. United States, 2022. Available at: <https://www.cdc.gov/overdose-prevention/hcp/clinical-guidance/index.html>. Accessed on: Mar 16, 2026.

Strengths, Opportunities for Improvement, and Recommendations

diseases of the nervous system, amputations, and premature death. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life. With support from health care providers, patients can manage their diabetes with self-care, taking medications as instructed, eating a healthy diet, being physically active, and quitting smoking.⁷⁰ HSAG recommends outreach and engagement with members diagnosed with diabetes to ensure they are controlling their HbA1c levels and have received education on managing their condition through the appropriate use of medications, diet and nutrition, or physical activity.

In the Pediatric Health measure group, AzCH-CCP ACC-RBHA's performance measure rates for all indicators for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure fell below the 25th percentile, indicating opportunities for children 3–17 years of age to have an outpatient visit with a PCP or OB/GYN with evidence of BMI percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year.⁷¹ **[Quality, Access]**

Recommendations: Since AzCH-CCP ACC-RBHA's rates decreased from MY 2023, HSAG recommends that AzCH-CCP ACC-RBHA continue to monitor and expand existing interventions or implement new interventions to improve performance across the continuum of preventive care, including BMI assessment and nutrition and physical activity counseling for children and adolescents. HSAG also recommends that AzCH-CCP ACC-RBHA conduct a root cause analysis to determine why providers are not routinely completing and/or documenting weight assessments and nutrition counseling.

In the Preventive Screening measure group, AzCH-CCP ACC-RBHA's performance measure rate for *Cervical Cancer Screening—21–64 Years* fell below the 25th percentile. **[Quality]**

Recommendations: HSAG recommends that AzCH-CCP ACC-RBHA identify disparities or SDOH within the plan's populations that contributed to preventive screening rates. Upon identification of a root cause, HSAG recommends that AzCH-CCP ACC-RBHA implement appropriate interventions to reduce barriers to care. Further, HSAG recommends that AzCH-CCP ACC-RBHA provide scheduled reminder messages and utilize personalized outreach for overdue patients. Communication should be clear and concise and include information on the procedure time. Some of these interventions might include a mobile clinic to conduct the screening, transportation assistance, and adjusting hours for visits to accommodate those with job/childcare concerns.

⁷⁰ National Committee for Quality Assurance. Glycemic Status Assessment for Patients with Diabetes (GSD). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/glycemic-status-assessment-for-patients-with-diabetes-gsd/>. Accessed on: Feb 11, 2026.

⁷¹ National Committee for Quality Assurance. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/weight-assessment-and-counseling-for-nutrition-and-physical-activity-for-children-adolescents-wcc/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

In the Appropriate Utilization of Services measure group, AzCH-CCP ACC-RBHA's performance measure rate for *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total (18–64 Years)* fell at or between the 25th and 49th percentile, indicating that members who were admitted for an acute inpatient and observation stay might have followed that stay with an unplanned acute readmission for any diagnosis within 30 days.⁷² **[Quality]**

Recommendations: HSAG recommends that AzCH-CCP ACC-RBHA consider reviewing and referencing the RED, which has been shown to reduce readmissions and posthospital ED visits.⁷³ Other interventions that might be effective include technology platforms, including AI or machine learning, that can assist the plan in identifying members more at risk of readmission. HSAG recommends that AzCH-CCP ACC-RBHA utilize case management strategies that focus on person-centered techniques, addressing barriers and/or SDOH as needed.

Validation of Performance Improvement Projects

Back to Basics PIP

In CYE 2025, AzCH-CCP ACC-RBHA continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 3, PIP validation activities focused on improvement from the baseline results. AzCH-CCP ACC-RBHA submitted Remeasurement 3 performance indicator results and interventions implemented during CY 2024 along with the status of interventions, focus, and rationale for changes to or discontinuation of the interventions.

HSAG conducted an annual validation of the third remeasurement year reflective of CY 2024 (January 1, 2024, through December 31, 2024) using AHCCCS-calculated and validated indicator rates. HSAG evaluated AzCH-CCP ACC-RBHA's performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of [Appendix A. Methodology](#).

Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG's confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data

⁷² National Committee for Quality Assurance. Plan All-Cause Readmissions (PCR). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/plan-all-cause-readmissions-pcr/>. Accessed on: Feb 11, 2026.

⁷³ Agency for Healthcare Research and Quality. Re-Engineered Discharge (RED) Toolkit. Available at: <https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool1.html>. Accessed on: Feb 11, 2026.

analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG’s confidence that the PIP’s performance indicator results demonstrated evidence of significant improvement. Table 5-4 displays the overall confidence levels for the AzCH-CCP ACC-RBHA *Back to Basics* PIP.

Table 5-4—AzCH-CCP ACC-RBHA *Back to Basics* PIP Overall Confidence Levels for Remeasurement 3

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
AzCH-CCP ACC-RBHA	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>	100%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Measure Results

Table 5-5 and Table 5-6 provide the *Back to Basics* PIP baseline, Remeasurement Year 1, Remeasurement Year 2, and Remeasurement Year 3 rates for each indicator for AzCH-CCP ACC-RBHA.

Table 5-5—AzCH-CCP ACC-RBHA *Back to Basics* PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: <i>W30 Rate 1</i>			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
AzCH-CCP ACC-RBHA	63.19%	60.74%	66.48%	70.41%

Table 5-6—AzCH-CCP ACC-RBHA *Back to Basics* PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: WCV			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
AzCH-CCP ACC-RBHA	46.90%	46.39%	53.19%	58.49%

Interventions

Table 5-7 presents PIP interventions for AzCH-CCP ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-7—AzCH-CCP ACC-RBHA *Back to Basics* PIP Interventions

Contractor	Interventions
AzCH-CCP ACC-RBHA	- AzCH-CCP ACC Data Analytics provided a report indicating all children and adolescents who completed their well visits and dental visits, and the percentage of children who completed their well visits and dental visits. The EPSDT team and the Quality Improvement team analyzed the data quarterly. - Revamped the EPSDT first and second reminder and changed it from a letter to an age-specific postcard, adding developmental screenings at appropriate periodicity. - The outreach call spreadsheet now includes a reminder task for the EPSDT coordinator to remind the parent of a developmental screening. - The EPSDT coordinator conducts 20 provider site visits per month. These visits educate providers about scheduling well visits, completing developmental screenings, and referring children to the dentists for their assigned members. During the site visit, the EPSDT coordinator gives the PCP a list of their members with a periodicity schedule and EPSDT materials. - The EPSDT team presents about completing well visits, referring to the dentist, and completing a developmental tool at the provider forums. - Retrained the EPSDT staff to engage the member by conducting a three-way call to the doctor's office. - Addressed barriers when a member did not show up to a scheduled appointment, including transportation. - Promoted the AzCH My Health Pays Rewards (MHP) program. - Conducted provider fax blast communications which educated providers about the available developmental screening tools. - Utilized community outreach workers to engage members in the community.

Contractor	Interventions
	• Path to 5 was distributed to providers to educate them on quality and performance measures. • Outreached to members via Short Message Service (SMS) text messaging. • Conducted dental workgroups which reviewed ongoing provider performance. • Back to School event outreached members to encourage them to attend events to help complete needed screenings. • Medicaid Push Project is a collaboration with strategic partners to implement a multi-prong outreach campaign to reach members to close <i>W15</i> and <i>WCV</i> gaps through in-home visits or telehealth visits. • Population Health Workgroup to advance the health of populations, improve member experience, and deliver systemwide transformation to better serve member population health needs. • The health plan maintains a report gap analysis on KidsCare versus ACC to complete specific outreach to KidsCare members with open care gaps. • Collaborated with providers through Provider Office Outreach and looked closely at KidsCare engagement around annual visits. • Through member outreach (e.g., SMS texts, emails, postcards, and telephone) identified KidsCare members and encouraged and educated on the importance of annual visits.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-8 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC-RBHA related to the *Back to Basics* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-8—AzCH-CCP ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • AzCH-CCP ACC-RBHA adhered to acceptable methodology through all phases of the PIP. [Quality, Access] • AzCH-CCP ACC-RBHA developed and implemented interventions that led to statistically significant improvement in indicator outcomes between the baseline and Remeasurement 2, sustaining the statistically significant improvement at Remeasurement 3. [Quality, Access]
Opportunities for Improvement and Recommendations
HSAG identified no opportunities for improvement related to the <i>Back to Basics</i> PIP.

Strengths, Opportunities for Improvement, and Recommendations

Recommendations: Although there were no opportunities for improvement identified, HSAG recommends that AzCH-CCP ACC-RBHA apply lessons learned from conducting the *Back to Basics* PIP to future PIPs.

Prenatal and Postpartum Care PIP

In CYE 2025, AzCH-CCP ACC-RBHA submitted Remeasurement 1 results for the *Prenatal and Postpartum Care* PIP, which was initiated in CY 2022. AzCH-CCP ACC-RBHA submitted Remeasurement 1 performance indicator results and interventions implemented.

HSAG conducted an annual validation of Remeasurement Year 1 reflective of CY 2024 (January 1, 2024, through December 31, 2024) using AHCCCS-calculated and validated indicator rates. HSAG evaluated AzCH-CCP ACC-RBHA's performance indicator results based on an analysis of improvement strategies implemented as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of [Appendix A. Methodology](#).

Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG's confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. Table 5-9 displays the overall confidence levels for the AzCH-CCP ACC-RBHA *Prenatal and Postpartum Care* PIP.

Table 5-9—AzCH-CCP ACC-RBHA *Prenatal and Postpartum Care* PIP Overall Confidence Levels for Remeasurement 1

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements Met ²	Percentage Score of Critical Elements Met ³	Confidence Level ¹	Percentage Score of Evaluation Elements Met ²	Percentage Score of Critical Elements Met ³
AzCH-CCP ACC-RBHA	<i>High Confidence</i>	100%	100%	<i>Moderate Confidence</i>	33%	100%

- ¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.
- ² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).
- ³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Measure Results

Table 5-10 and Table 5-11 provide the *Prenatal and Postpartum Care* PIP baseline and Remeasurement 1 rates for each indicator for AzCH-CCP ACC-RBHA.

Table 5-10—AzCH-CCP ACC-RBHA *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: <i>Timeliness of Prenatal Care</i>	
	Baseline Year	Remeasurement 1
	CY 2022	CY 2024
AzCH-CCP ACC-RBHA	82.73%	80.05%

Table 5-11—AzCH-CCP ACC-RBHA *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: <i>Postpartum Care</i>	
	Baseline Year	Remeasurement 1
	CY 2022	CY 2024
AzCH-CCP ACC-RBHA	66.42%	76.16%

Interventions

Table 5-12 presents PIP interventions for AzCH-CCP ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-12—AzCH-CCP ACC-RBHA *Prenatal and Postpartum Care* PIP Interventions

Contractor	Interventions
AZCH-CCP ACC-RBHA	- Start Smart for Your Baby (SSFB) program, enrollment into care management (until six weeks after delivery). - A mobile application provides specialized care plan (based on certain tracks) for members with specialized daily health check list; provider alerts, care gaps, and progress tracking to CMs; allows for two-way video/text communication with Care Management.

Contractor	Interventions
	- PPC Workgroup is an internal work group to include CM, QM, and other departments to increase prenatal/postpartum outcome measures. - A mobile application to address loneliness and social isolation, assist in developing a support system, and provide resources to address SDOH. - OB/GYN specialty outreach. Provider quality liaisons engage high-volume OB/GYN providers with education and resources to support improvement in both <i>PPC</i> indicator rates. Education and resources include (but are not limited to) NOP forms and where to find them in the AzCH Provider Portal, Path to 5 Stars pages for measures including <i>PPC</i>, the group's performance rates for prenatal/postpartum care, postpartum care gaps for assigned members, coding guidance, information on medical records submission, and appointment availability flyer. - Partner with Community Health Worker (CHW) program in Yuma County to complete face-to-face outreach for high-risk OB members that the health plan has been unable to reach to try to engage them in care management. - Member incentive. Implement new incentive for completing a prenatal visit within the first trimester or 42 days of joining the health plan. - HEDIS Stratification Dashboard—will provide an NCQA directed RES of applicable HEDIS performance measures.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-13 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC-RBHA related to the *Prenatal and Postpartum Care* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-13—AzCH-CCP ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to the *Prenatal and Postpartum Care* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: AzCH-CCP ACC-RBHA developed and implemented measurement systems for interventions that may lead to statistically significant improvement in the postpartum care indicator outcome at Remeasurement 1. [Quality, Access]
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: Indicator 1 declined at Remeasurement 1; 80.05 percent of women had a prenatal care visit in the first trimester during CYE 2024 compared to 82.73 at baseline. [Quality, Access]

Strengths, Opportunities for Improvement, and Recommendations

Recommendations: As the PIP progresses, HSAG recommends that AzCH-CCP ACC-RBHA:

- Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.
- Continue implementing identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.
- Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.

Compliance Reviews

AzCH-CCP ACC-RBHA was found to be fully compliant with all AHCCC OR focus areas in CYE 2024; therefore, no compliance review activities were required in CYE 2025. HSAG will conduct a compliance review of AzCH-CCP ACC-RBHA in 2026, which starts a new three-year compliance review cycle.

Network Adequacy Validation

ISCA Results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if AzCH-CCP ACC-RBHA's interpretation of data was accurate.

Table 5-14 summarizes HSAG's validation ratings for AzCH-CCP ACC-RBHA by indicator type.

Table 5-14—Summary of AzCH-CCP ACC-RBHA's Validation Ratings by Indicator Type

Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Appointment Availability	100%	0%	0%	0%
Time/Distance	100%	0%	0%	0%

Of the network adequacy indicators assessed, AzCH-CCP ACC-RBHA received *High Confidence* for both appointment availability and time/distance indicator types.

NAV Results

HSAG evaluated AzCH-CCP ACC-RBHA’s compliance results with AHCCCS’ time/distance standards by GSA and county. This section presents CYE 2024 S2 validation findings specific to the ACC Program, with one results table for each of the following GSAs:

- Central GSA: Gila, Maricopa, and Pinal counties
- South GSA: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma counties

Each Contractor-specific table summarizes validation results containing the percentage of members meeting each time/distance standard by county, with color coding to identify whether the time/distance standard was “Met” or “Not Met.”

Table 5-15—Time/Distance Validation Results for AzCH-CCP ACC-RBHA Central GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^	99.1^	100.0^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0^	99.2^Y	100.0^
BHRF	NA	99.1 ^Y	NA
Cardiologist, Adult	100.0^	100.0^Y	100.0^
Cardiologist, Pediatric	100.0^	100.0^	100.0^
Dentist, Pediatric	100.0 ^Y	99.3 ^Y	100.0 ^Y
Hospital	100.0	99.8	100.0
OB/GYN	100.0	100.0	100.0
Pharmacy	100.0 ^Y	99.0 ^Y	100.0
PCP, Adult	100.0^	99.7^	100.0^
PCP, Pediatric	100.0^	99.6^	100.0^

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

Table 5-16—Time/Distance Validation Results for AzCH-CCP ACC-RBHA South GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Cochise	Graham	Greenlee	La Paz	Pima	Santa Cruz	Yuma
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^	100.0^	100.0	100.0^	96.8^Y	100.0^	100.0^Y

Provider Category	Cochise	Graham	Greenlee	La Paz	Pima	Santa Cruz	Yuma
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0 [^]	100.0 [^]	100.0	100.0 [^]	97.1 ^{^Y}	100.0 [^]	100.0 ^{^Y}
BHRF	NA	NA	NA	NA	91.0 ^Y	NA	NA
Cardiologist, Adult	100.0 [^]	100.0 [^]	100.0	100.0 [^]	99.2 [^]	100.0 [^]	100.0 [^]
Cardiologist, Pediatric	100.0 [^]	100.0 [^]	100.0	100.0 [^]	99.9 [^]	100.0 [^]	100.0 [^]
Dentist, Pediatric	94.2 ^Y	98.1 ^Y	65.7 ^R	52.7 ^R	98.5 ^Y	100.0	99.9
Hospital	100.0	100.0	100.0	100.0	99.4 ^Y	100.0	100.0
OB/GYN	100.0	100.0	100.0	100.0	99.6	100.0	100.0
Pharmacy	99.7 ^Y	99.7 ^Y	99.9	83.2 ^R	98.2 ^Y	100.0	99.8 ^Y
PCP, Adult	99.8 [^]	99.8 [^]	99.8 [^]	99.5 [^]	99.7 ^{^Y}	100.0 [^]	99.9 [^]
PCP, Pediatric	99.8 [^]	99.8 ^{^Y}	100.0 [^]	99.5 ^{^Y}	99.8 [^]	100.0 [^]	99.9 [^]

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

Strengths, Opportunities for Improvement, and Recommendations

Table 5-17 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC-RBHA related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-17—AzCH-CCP ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: AzCH-CCP ACC-RBHA established robust processes to ensure provider data remain accurate and up to date. These processes include several key initiatives, such as ongoing collaboration with providers through on-site visits; use of the business intelligence tools; the biannual Preferences and Trends report; and multiple internal quality reports used to monitor, identify errors, and assess the accuracy of provider data. Additionally, AzCH-CCP ACC-RBHA has partnered with an external vendor to conduct quarterly reviews of key demographic data, further supporting the integrity and accuracy of provider data elements. [Access]

Strengths, Opportunities for Improvement, and Recommendations
- AzCH-CCP ACC-RBHA met all minimum network requirements for all assigned counties except in Greenlee and La Paz counties. [Access] - AzCH-CCP ACC-RBHA met all minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; BHRF; Cardiologist, Adult and Pediatric; Hospital; OB/GYN; and PCP, Adult and Pediatric. [Access] Note: AzCH-CCP ACC-RBHA provides coverage in the following counties: Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Santa Cruz, and Yuma.
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: AzCH-CCP ACC-RBHA did not meet the minimum network requirements for Dentist, Pediatric and Pharmacy. [Access] Recommendation: HSAG recommends that AzCH-CCP ACC-RBHA maintain current compliance with network standards and continue to address network gaps, as applicable.

Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)

Results

HSAG administered member experience surveys on AHCCCS' behalf to members enrolled in AzCH-CCP ACC-RBHA's KidsCare program.

Table 5-18 shows the 2025 scores including the overall member experience ratings, national average comparisons, and program comparisons for each CAHPS measure for both the AzCH-CCP ACC-RBHA general child and CCC populations.

Table 5-18—AzCH-CCP ACC-RBHA CAHPS Comparative Analyses

Measure	2025 General Child KidsCare	2025 CCC KidsCare
Global Ratings		
<i>Rating of Health Plan</i>	★★★★★ 79.0% H	★★★★★ 72.6% ⁺
<i>Rating of All Health Care</i>	★★★★ 71.4%	★★★ 63.6% ⁺
<i>Rating of Personal Doctor</i>	★★★ 76.0%	★★ 67.2% ⁺

Measure	2025 General Child KidsCare	2025 CCC KidsCare
<i>Rating of Specialist Seen Most Often</i>	★★★★ 74.1% ⁺	★★ 70.3% ⁺
Composite Measures		
<i>Getting Needed Care</i>	★ 79.8%	★ 77.4% ⁺
<i>Getting Care Quickly</i>	★★★★ 91.9% ⁺ H	★★★★ 92.5% ⁺
<i>How Well Doctors Communicate</i>	★★ 94.1%	★★★★ 95.2% ⁺
<i>Customer Service</i>	★★★★ 89.0% ⁺	★ 82.8% ⁺
Individual Item Measure		
<i>Coordination of Care</i>	★★ 83.8% ⁺	★ 79.5% ⁺
CCC Composite Measures and Items		
<i>Access to Specialized Services</i>	NA	★★★★★ 81.8% ⁺ H
<i>FCC: Personal Doctor Who Knows Child</i>	NA	★★★★ 92.4% ⁺
<i>Coordination of Care for Children with Chronic Conditions</i>	NA	★★★★★ 83.3% ⁺ H
<i>Access to Prescription Medicines</i>	NA	★★★★★ 97.9% ⁺ H
<i>FCC: Getting Needed Information</i>	NA	★★★★★ 96.9% ⁺ H

Star Assignments Based on Percentiles:

★★★★★ 90th or Above ★★★★★ 75th-89th ★★★★ 50th-74th ★★★ 25th-49th ★ Below 25th

↑ Indicates the 2025 score is statistically significantly higher than the KidsCare MCO Aggregate.

↓ Indicates the 2025 score is statistically significantly lower than the KidsCare MCO Aggregate.

H Indicates the 2025 score is statistically significantly higher than the NCQA national average.

L Indicates the 2025 score is statistically significantly lower than the NCQA national average.

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

NA Indicates that this measure is not applicable for the population.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-19 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC-RBHA related to CAHPS, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-19—AzCH-CCP ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to CAHPS

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: - AzCH-CCP ACC-RBHA’s member experience rating for <i>Rating of Health Plan</i> was at or above the 90th percentile for the general child population. [Quality] - AzCH-CCP ACC-RBHA’s member experience ratings for Access to Specialized Services, Coordination of Care for Children with Chronic Conditions, Access to Prescription Medicines, and FCC: Getting Needed Information were at or above the 90th percentiles for the CCC population. [Quality, Access] - AzCH-CCP ACC-RBHA’s member experience rating for <i>Getting Care Quickly</i> was at or between the 75th and 89th percentiles for the general child population. [Quality, Timeliness] - AzCH-CCP ACC-RBHA’s member experience ratings for <i>Rating of Health Plan</i> and <i>Getting Care Quickly</i> were at or between the 75th and 89th percentiles for the CCC population. [Quality, Timeliness] - AzCH-CCP ACC-RBHA’s 2025 scores for <i>Rating of Health Plan</i> and <i>Getting Care Quickly</i> were statistically significantly higher than the NCQA national averages for the general child population. [Quality, Timeliness] - AzCH-CCP ACC-RBHA’s 2025 scores for Access to Specialized Services, Coordination of Care for Children with Chronic Conditions, Access to Prescription Medicines, and FCC: Getting Needed Information were statistically significantly higher than the NCQA national averages for the CCC population. [Quality, Access]
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: - AzCH-CCP ACC-RBHA’s member experience rating for <i>Getting Needed Care</i> was below the 25th percentile for the general child population. [Quality, Access] - AzCH-CCP ACC-RBHA’s member experience ratings for <i>Rating of Personal Doctor</i>, <i>Getting Needed Care</i>, <i>Customer Service</i>, and <i>Coordination of Care</i> were below the 25th percentiles for the CCC population. [Quality, Access] - AzCH-CCP ACC-RBHA’s member experience ratings for <i>Rating of Personal Doctor</i>, <i>How Well Doctors Communicate</i>, and <i>Coordination of Care</i> were between the 25th and 49th percentiles for the general child population. [Quality]

Strengths, Opportunities for Improvement, and Recommendations

- AzCH-CCP ACC-RBHA's member experience ratings for *Rating of All Health Care* and *Rating of Specialist Seen Most Often* were between the 25th and 49th percentiles for the CCC population. **[Quality]**

Recommendation: HSAG recommends that AzCH-CCP ACC-RBHA explore what may be driving lower experience scores and develop initiatives designed to improve the quality of and access to care, including a focus on improving parents'/caretakers' overall experiences with the health plan, all health care, their child's personal doctor and his or her ability to communicate, coordination of care, customer service, and getting needed care.

BUFC ACC

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2025, HSAG evaluated BUFC ACC’s data system for processing of each data type used for reporting the Contractor’s CY 2024 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. While BUFC was successful in reporting valid rates for all AHCCCS-required performance measures for its ACC Medicaid Title XIX and KidsCare Title XXI combined populations, some hybrid measures were determined Do Not Report (DNR) due to not following AHCCCS sampling requirements for the separate Title XIX and Title XXI programs.

Table 5-20 displays HSAG’s PMV findings for each data type reviewed during CYE 2025 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 5-20—CYE 2025 PMV Findings

Data Type	HSAG Findings
Medical Services Data	<i>No identified concerns</i>
Enrollment Data	<i>No identified concerns</i>
Provider Data	<i>No identified concerns</i>
Medical Record Review Process	<i>No identified concerns</i>
Supplemental Data	<i>No identified concerns</i>
Data Integration	<i>Issues identified in rate review resulted in a DNR designation for hybrid measures that did not follow AHCCCS’ sampling methodology requirements. AHCCCS-required methodology was not followed for HPCMI-AD, which was reported as admin.</i>

Results for Performance Measures

Table 5-21 presents the CY 2023 and CY 2024 BUFC ACC performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and/or MY 2024. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 5-21—CY 2023 and CY 2024 BUFC ACC Performance Measure Results

Measure	MY 2023 Performance	MY 2024 Performance	2023-2024 Comparison ¹	2024 Performance Level ²
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	81.51%	84.18% ⁺	→	★★
Postpartum Care	70.80%	74.21% ⁺	→	★
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	53.01%	52.98%	→	★
Antidepressant Medication Management				
Effective Acute Phase Treatment	64.35% [^]	66.13% [^]	→	★★★★
Effective Continuation Phase Treatment	48.09% [^]	49.41% [^]	→	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.92% [^]	84.46% [^]	↑	★★★★
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—Total	43.59% [^]	37.06%	↓	★★
30-Day Follow-Up—Total	54.24% [^]	48.45%	→	★
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—Total	27.15% [^]	34.60% [^]	↑	★★★★★
30-Day Follow-Up—Total	37.61% [^]	42.87% [^]	↑	★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total	36.91%	39.02%	→	★★
30-Day Follow-Up—Total	54.55%	55.39%	→	★★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	—	57.46% [^]	—	★★★★★
Continuation and Maintenance Phase	—	64.60% [^]	—	★★★★★
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation of SUD Treatment—Total—Total	50.95% [^]	51.33% [^]	→	★★★★★
Engagement of SUD Treatment—Total—Total	21.31% [^]	21.63% [^]	→	★★★★★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Total	72.09% [^]	62.02% [^]	↓	★★

Measure	MY 2023 Performance	MY 2024 Performance	2023-2024 Comparison ¹	2024 Performance Level ²
Use of Opioids at High Dosage				
Use of Opioids at High Dosage*	10.92%	10.51%	→	★
Care of Acute and Chronic Conditions				
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status <8.0%	67.64%^	59.37% ⁺	↓	★★
Glycemic Status >9.0%*	32.36%^	27.74% ⁺	→	★★★
Pediatric Health				
Child and Adolescent Well-Care Visits				
Total	44.04%	46.37%	↑	★
Childhood Immunization Status				
Combination 3	59.61%	68.13% ⁺	↑	★★★★
Combination 7	51.82%	61.56% ⁺	↑	★★★★
Combination 10	22.87%	27.98% ⁺	→	★★★★
Childhood Immunization Status (ECDS)				
Combination 3	—	66.60%^	—	★★★★★
Combination 7	—	59.69%^	—	★★★★★
Combination 10	—	27.87%^	—	★★★★
Developmental Screening in the First Three Years of Life				
Total	NA	28.95%	—	NC
Immunizations for Adolescents				
Combination 1	84.67%^	87.59% ⁺	→	★★★★★
Combination 2	44.04%^	41.61% ⁺	→	★★★★
Immunizations for Adolescents (ECDS)				
Combination 1	—	86.15%^	—	★★★★★
Combination 2	—	42.29%^	—	★★★★★
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total	—	45.12%^	—	★★★★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	80.54%^	81.75% ⁺	→	★★
Counseling for Nutrition—Total	16.12%	70.32% ⁺	↑	★★
Counseling for Physical Activity—Total	13.74%	67.15% ⁺	↑	★★
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	63.60%^	67.57%^	↑	★★★★★

Measure	MY 2023 Performance	MY 2024 Performance	2023-2024 Comparison ¹	2024 Performance Level ²
<i>Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits</i>	59.86%	66.58%	↑	★
Preventive Screening				
Breast Cancer Screening				
<i>Total (50-74 Years)</i>	53.22%	55.10%	↑	NC
Breast Cancer Screening (ECDS)				
<i>Breast Cancer Screening</i>	—	55.10%	—	★★
Cervical Cancer Screening				
<i>Cervical Cancer Screening</i>	48.42%	53.04% ⁺	→	★★
Cervical Cancer Screening (ECDS)				
<i>Cervical Cancer Screening</i>	—	47.32%	—	★★
Colorectal Cancer Screening				
<i>Total</i>	—	39.35%	—	★★
Appropriate Utilization of Services				
Plan All-Cause Readmissions				
<i>O/E Ratio—18–64 Years*</i>	—	1.1602 [^]	—	★★
Oral Health				
Oral Evaluation, Dental Services				
<i>Total</i>	—	40.59%	—	★★

* A lower rate indicates better performance for this measure.

** Table A-2 in [Appendix A. Methodology](#) outlines which immunizations are included within each combination.

NC± indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

+ Indicates the measure was reported using hybrid methodology.

NA⁺⁺ indicates the denominator was too small to report a valid rate, based on the applicable measure specification.

█ and ^ indicates that the rate met or exceeded the MY 2023 and/or MY 2024 national Medicaid mean.

— Indicates a 2023–2024 comparison is not presented in the CYE 2025 Annual Technical Report because either the CY 2023 rate was not presented in the CYE 2024 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

¹Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.

²Performance Levels for CY 2024 were based on comparisons of the HEDIS MY 2024 measure rates to NCQA Quality Compass national Medicaid HEDIS MY 2024 benchmarks.

↑ Indicates statistically significant improvement of measure rates.

↓ Indicates statistically significant decline of measure rates.

→ Indicates no statistically significant change in measure rates.

Performance Levels for 2024 represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 5-22 presents strengths, opportunities for improvement, and recommendations for BUFC ACC related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-22—BUFC ACC Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations	
Strengths	
In the Behavioral Health measure group:	
- Ten of 16 BUFC ACC measure rates (62.50 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. [Quality, Timeliness, Access] <i>Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years) and Effective Continuation Phase Treatment—Total (18+ Years)</i> <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years</i> <i>Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years) and 30-Day Follow-Up—Total (13+ Years)</i> <i>Follow-Up Care for Children Prescribed ADHD Medication (ECDS)—Initiation Phase (6-12 Years) and Continuation and Maintenance Phase (6-12 Years)</i> <i>Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Total (13+ Years) and Engagement of SUD Treatment—Total—Total (13+ Years)</i> <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)</i> - BUFC ACC’s performance measure rates for <i>Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)</i> and <i>Engagement of SUD Treatment—Total—Total (13+ Years)</i> were at or between the 75th percentile and 89th percentile, indicating that most members diagnosed with SUD may have initiated SUD treatment and had two or more additional SUD services or MAT within 34 days of the initiation visit, which, in conjunction with counseling or other behavioral therapies, has been shown to reduce SUD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.⁷⁴ [Quality, Timeliness, Access] - BUFC ACC’s performance measure rate for <i>Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)</i> was at or between the 75th and 89th percentile. In 2022, 48.7 million Americans over 12 years of age (about 17.3 percent of the population) were classified as having an SUD within the	

⁷⁴ National Committee for Quality Assurance. Initiation and Engagement of Substance Use Disorder Treatment (IET). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/initiation-and-engagement-of-substance-use-disorder-treatment-iet/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

past year.⁷⁵ High ED use for individuals with substance use may signal a lack of access to care or issues with continuity of care. Timely follow-up care helps individuals with SUD stay connected with the health care system. **[Quality, Timeliness, Access]**

- BUFC ACC’s performance measure rate for *Follow-Up Care for Children Prescribed ADHD Medication (ECDS)—Initiation Phase (6–12 Years)* was at or above the 90th percentile, indicating that members newly prescribed ADHD medication had at least one follow-up care visits within 30 days of when the first ADHD medication was dispensed. BUFC ACC’s performance measure rate for *Follow-Up Care for Children Prescribed ADHD Medication (ECDS)—Continuation and Maintenance Phase* was at or between the 75th percentile and 89th percentile, indicating that members newly prescribed ADHD medication had at least three follow-up care visits within a 300-day (10 month) period, one of which was within 30 days of when the first ADHD medication was dispensed. Research indicates that ADHD is one of the more common chronic conditions of childhood. Children with ADHD may experience significant functional problems, such as school difficulties, academic underachievement, troublesome relationships with family members and peers, and behavioral problems. Given the high prevalence of ADHD among U.S. children (8.7 percent, or 5.3 million individuals), primary care clinicians will regularly encounter children with ADHD and should have a strategy for diagnosing and long-term management of this condition.⁷⁶ **[Quality, Timeliness, Access]**

In the Care of Acute and Chronic Conditions measure group:

- Both BUFC ACC indicator rates (100 percent) for the *Glycemic Status Assessment for Patients With Diabetes* measure met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. **[Quality, Timeliness, Access]**
 - *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status < 8.0%—Total (18–75 Years)*
 - *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status > 9.0%—Total (18–75 Years)*
- BUFC ACC’s performance measure indicator rate for *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status > 9.0%—Total (18–75 Years)* was at or between the 50th and 74th percentile and showed an improvement of approximately 5 percentage points when compared to MY 2023. This indicates that most members diagnosed with diabetes are controlling their HbA1c levels. Based on evidence-based guidelines, high performance on this measure rate may indicate that members with diabetes may be able to manage their condition through the appropriate use of medications, diet and nutrition, or physical activity. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.⁷⁷ **[Quality]**

⁷⁵ National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Substance Use (FUA). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/follow-up-after-emergency-department-visit-for-substance-use-fua/>. Accessed on: Feb 11, 2026.

⁷⁶ National Committee for Quality Assurance. Follow-Up Care for Children Prescribed ADHD Medication (ADD-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/follow-up-care-for-children-prescribed-adhd-medication-add-e/>. Accessed on: Feb 11, 2026.

⁷⁷ National Committee for Quality Assurance. Glycemic Status Assessment for Patients with Diabetes (GSD). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/glycemic-status-assessment-for-patients-with-diabetes-gsd/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

In the Pediatric Health measure group:

- Twelve of 18 BUFC ACC measure rates (66.67 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. **[Quality, Timeliness, Access]**
 - *Childhood Immunization Status—Combination 3 and Combination 7*
 - *Childhood Immunization Status (ECDS)—Combination 3, Combination 7, and Combination 10*
 - *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)*
 - *Immunizations for Adolescents (ECDS)—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)*
 - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)*
 - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total (3–17 Years)*
 - *Well-Child Visits in the First 30 Months of Life—First 15 Months—Six or More Well-Child Visits*
- BUFC ACC’s performance measure rate for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)* was at or between the 75th and 89th percentile, indicating that most children or adolescents with ongoing antipsychotic medication use had metabolic testing during the year. **[Quality]**
- BUFC ACC’s performance measure rates for *Immunizations for Adolescents (ECDS)—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)* and *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* were at or between the 75th and 89th percentile, indicating that most adolescents were receiving one dose of meningococcal vaccine, one Tdap [tetanus, diphtheria, pertussis] vaccine, and the complete HPV vaccine series by their 13th birthday. Receiving recommended vaccinations is the best defense against serious vaccine-preventable diseases, including meningococcal meningitis, tetanus, diphtheria, pertussis (whooping cough), and HPV.⁷⁸ **[Quality, Access]**

Opportunities for Improvement and Recommendations

While BUFC was successful in reporting valid rates for all AHCCCS-required performance measures for its ACC population, the audit identified some considerations and recommendations for future years’ reporting. **[Quality]**

Recommendation: HSAG recommends that BUFC work to collect and integrate more race data for future stratification reporting to improve data completeness. BUFC should ensure that it submits all Record of Administration, Data Management and Processes (Roadmap) and associated attachments as part of its ISCAT submission, including all data inventories and supplemental data documentation to allow for a more

⁷⁸ National Committee for Quality Assurance. Immunizations for Adolescents (IMA-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/immunizations-for-adolescents-ima-e/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

streamlined review of documentation, which will reduce the amount of follow-up requests. In addition, during the case management medical record review validation (CMMRRV) processes, two critical errors were identified, which required two measures with second samples and revisions to the final medical record compliant case counts. Therefore, HSAG recommends that BUFC incorporate the feedback provided during this year's validation process into its abstraction process to mitigate these issues in future years. Finally, HSAG recommends that BUFC follow AHCCCS' guidance on conducting separate samples for all hybrid measures and ensure that the reporting methodology used follows AHCCCS requirements.

In the Maternal and Perinatal Care measure group, BUFC ACC's performance measure rate for *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, and the performance measure rate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* was at or between the 25th and 49th percentile, indicating an opportunity to increase access to timely prenatal and postpartum care. **[Quality, Timeliness, Access]**

Recommendations: BUFC ACC has implemented multiple interventions in prior years to address the *Prenatal and Postpartum Care—Postpartum Care* rate, including a preventive care initiative for women, discharge outreach when a member delivers, and collaboration with behavioral health facilities. HSAG recommends that BUFC ACC monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Postpartum Care* measure indicator, measuring effectiveness of interventions when possible. HSAG recommends that BUFC ACC consider whether there are disparities/SDOH within BUFC ACC's population that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that BUFC ACC implement appropriate interventions to reduce barriers to care.

In the Behavioral Health measure group:

- BUFC ACC's performance measure rate for *Use of Opioids at High Dosage—18+ Years* was below the 25th percentile, indicating an opportunity to identify trends leading to higher opioid use. **[Quality]**

Recommendations: HSAG recommends that BUFC ACC follow the CDC guidelines on opioid prescribing for chronic, nonmalignant pain, which recommend the use of "additional precautions" when prescribing dosages ≥ 50 MED and that providers avoid or "carefully justify" increasing dosages ≥ 90 mg MED. In 2019, the authors of the 2016 guidelines published commentary that cautioned providers, systems, payers, and states from developing policies and practices that are "inconsistent with and go beyond" the guideline recommendations. The commentary included cautions regarding strict enforcement of dosage and duration thresholds, as well as abrupt tapering of opioids. The opioid dosage assessed in this measure is a reference point for health plans to identify members who may be at high risk for opioid overuse and misuse. HSAG recommends BUFC ACC outreach to members who fall within this category to assess and schedule interventions as necessary.⁷⁹ HSAG also recommends that BUFC ACC identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts.

⁷⁹ National Committee for Quality Assurance. Use of Opioids at High Dosage (HDO). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/use-of-opioids-at-high-dosage-hdo/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

- BUFC ACC's performance measure rate for *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years* fell below the 25th percentile for MY 2024 and fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024, indicating opportunities to improve psychotropic medication compliance for members. **[Quality]**

Recommendations: Schizophrenia is a chronic and disabling psychiatric disorder that requires ongoing treatment and monitoring. Symptoms include hallucinations, illogical thinking, memory impairment, and incoherent speech. Medication nonadherence is common and a major concern in the treatment of schizophrenia. Using antipsychotic medications as prescribed reduces the risk of relapse or hospitalization.⁸⁰ In a systematic review of medication adherence studies, several interventions that worked in studies were motivational interviewing, daily texts to individuals with schizophrenia, and other medication reminders. Other effective studies utilized Meds-Help, a pharmacy-based intervention, environmental support through home visits and reminders to adhere to medication, a psychoeducational program (FSPP), an intervention called STOPS that focuses on the importance of the supervisor's role for patients during treatment, and an IOT program.⁸¹ HSAG recommends that BUFC ACC consider or continue implementing one or more of these interventions that have been associated with increased medication adherence for members with schizophrenia. In addition, HSAG recommends that BUFC ACC consider or continue utilizing financial incentives offered to patients with severe mental illness to improve treatment adherence.

- BUFC ACC's performance measure rate for *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total (6+ Years)* fell below the 25th percentile and fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024, indicating that members were not receiving important timely follow-up visits for mental illness after an ED visit. Research suggests that follow-up care for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function, and increased compliance with follow-up instructions.⁸² **[Quality, Timeliness, Access]**

Recommendations: HSAG recommends that BUFC ACC educate members about the importance of follow-up visits in a timely manner and assist members with scheduling the follow-up visit. Additionally, BUFC ACC should train providers to allow the member to take ownership of the treatment process while conducting a comprehensive assessment of members to include social, mental, and physical health while engaging the member in the treatment plan. BUFC should ensure the ED visit documentation is submitted

⁸⁰ National Committee for Quality Assurance. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/adherence-to-antipsychotic-medications-for-individuals-with-schizophrenia-saa/>. Accessed on: Feb 11, 2026.

⁸¹ Cahaya N, Kristina SA, Widayanti AW, et al. Interventions to Improve Medication Adherence in People with Schizophrenia: A Systematic Review. Patient preference and adherence vol. 16 2431-2449. 1 Sep. 2022, doi:10.2147/PPA.S378951. Available at: <https://pubmed.ncbi.nlm.nih.gov/36072918/>. Accessed on: Feb 11, 2026.

⁸² National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Mental Illness (FUM). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/follow-up-after-emergency-department-visit-for-mental-illness-fum/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

to the appropriate outpatient provider within 24 hours of the ED visit to ensure appointment scheduling occurs immediately.

In the Pediatric Health measure group:

- BUFC ACC's performance measure rate for *Child and Adolescent Well-Care Visits—Total (3–21 Years)* was below the 25th percentile, indicating that children and adolescents were not always receiving well-care visits at the recommended intervals. Assessing physical, emotional, and social development is important at every stage of life, particularly for children and adolescents. Well-care visits give providers an opportunity to influence health and development, and they are a critical opportunity for screening and counseling.⁸³ **[Quality, Access]**
- BUFC ACC's performance measure rate for *Well-Child Visits in the First 30 Months of Life—15 Months–30 Months—Two or More Well-Child Visits* fell below the 25th percentile, indicating opportunities for children who turned 30 months old during the measurement year to have at least two well-child visits with a PCP in the prior 15 months.⁸⁴ **[Quality, Access]**

Recommendations: HSAG recommends that BUFC ACC identify performance improvement efforts to improve well-child visits, such as drawing from other states' performance improvement initiatives. For instance, as part of a federal performance initiative to improve well-child care, California and Virginia have focused on reducing delays in newborn enrollment data, and Missouri and Texas focused on beneficiary barriers and implemented interventions such as utilizing patient portals and phone outreach. HSAG recommends that BUFC ACC identify other barriers to care and conduct a focus group on identifying ways to address barriers.⁸⁵

In the Preventive Screening measure group, BUFC ACC's performance measure rates for *Breast Cancer Screening (ECDS)—Total (50–74 Years)*, *Cervical Cancer Screening—21–64 Years*, and *Cervical Cancer Screening (ECDS)—21–64 Years* were at or between the 25th and 49th percentile, indicating that women were not always receiving timely screening for breast cancer and cervical cancer. Early detection reduces the risk of dying from these types of cancer and can lead to a greater range of treatment options and lower health care costs. Prolonged delays in screening may lead to delayed diagnoses, poor health consequences, and an increase in cancer disparities among women already experiencing health inequities.⁸⁶ **[Quality]**

Recommendations: While BUFC ACC conducted a root cause analysis and implemented interventions specific to the MY 2023 *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—*

⁸³ National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (WCV). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/child-and-adolescent-well-care-visits-wcv/>. Accessed on: Feb 11, 2026.

⁸⁴ National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (WCV). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/child-and-adolescent-well-care-visits-wcv/>. Accessed on: Feb 11, 2026.

⁸⁵ Centers for Medicare & Medicaid Services. Well-Child Care. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html>. Accessed on: Feb 11, 2026.

⁸⁶ Centers for Disease Control and Prevention. Sharp Declines in Breast and Cervical Cancer Screening. Available at: [Sharp Declines in Breast and Cervical Cancer Screening | CDC Archive](#). Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

21–64 Years rates, these rates remained low for both CY 2023 and CY 2024. HSAG recommends that BUFC ACC consider utilizing one-on-one interactions with health care professionals, such as CHWs, which have been shown to improve screenings. Additionally, HSAG recommends that BUFC ACC monitor and expand on interventions currently in place to improve performance related to these measures.

In the Appropriate Utilization of Services measure group, BUFC ACC’s performance measure rate for *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total (18–64 Years)* fell at or between the 25th and 49th percentile, indicating that members who were admitted to an acute inpatient and observation stay might have followed that stay with an unplanned acute readmission for any diagnosis within 30 days.⁸⁷ **[Quality]**

Recommendations: HSAG recommends that BUFC ACC consider leveraging the RED, which has been shown to reduce readmissions and posthospital ED visits for implementing interventions.⁸⁸ Other interventions that might be effective include technology platforms, including AI or machine learning, that can assist the plan in identifying members more at risk of readmission. HSAG also recommends that BUFC ACC continue to utilize case management strategies that focus on person-centered techniques, addressing barriers and/or SDOH as needed.

Validation of Performance Improvement Projects

Back to Basics PIP

In CYE 2025, BUFC ACC continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 3, PIP validation activities focused on improvement from the baseline results. BUFC ACC submitted Remeasurement 3 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes to or discontinuation of the interventions.

HSAG conducted an annual validation of the third remeasurement year reflective of CY 2024 (January 1, 2024, through December 31, 2024) using AHCCCS-calculated and validated indicator rates. HSAG evaluated BUFC ACC’s performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of [Appendix A. Methodology](#).

⁸⁷ National Committee for Quality Assurance. Plan All-Cause Readmissions (PCR). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/plan-all-cause-readmissions-pcr/>. Accessed on: Feb 11, 2026.

⁸⁸ Agency for Healthcare Research and Quality. Re-Engineered Discharge (RED) Toolkit. Available at: <https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool1.html>. Accessed on: Feb 11, 2026.

Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG’s confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG’s confidence that the PIP’s performance indicator results demonstrated evidence of significant improvement. Table 5-23 displays the overall confidence levels for the BUFC ACC *Back to Basics* PIP.

Table 5-23—BUFC ACC *Back to Basics* PIP Overall Confidence Levels for Remeasurement 3

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
BUFC ACC	<i>High Confidence</i>	100%	100%	<i>Moderate Confidence</i>	33%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Measure Results

Table 5-24 and Table 5-25 provide the *Back to Basics* PIP baseline, Remeasurement Year 1, Remeasurement Year 2, and Remeasurement Year 3 rates for each indicator for BUFC ACC.

Table 5-24—BUFC ACC *Back to Basics* PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: <i>W30 Rate 1</i>			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
BUFC ACC	63.46%	58.11%	63.60%	67.57%

Table 5-25—BUFC ACC *Back to Basics* PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: WCV			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
BUFC ACC	46.65%	39.63%	44.04%	46.37%

Interventions

Table 5-26 presents PIP interventions for BUFC ACC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-26—BUFC ACC *Back to Basics* PIP Interventions

Contractor	Interventions
BUFC ACC	- Promoted the Quality of Medicine (PQM) reports sent quarterly to providers to identify BUFC eligible members due and/or past due for a well-child/well-care visit. - The member outreach team contacted BUFC-eligible guardians of members/members identified as due and/or past due for a well-child/well-care visit, within the measurement period and assist to schedule an appointment. - EPSDT reminder postcards reminded guardians of members/members identified as due for a well-child/well-care visit, within the measurement period. - Second EPSDT reminder postcards reminded guardians of members/members identified as due for a well-child/well-care visit, within the measurement period, six months after their birth month. - Member newsletter. - Member handbook. - Online provider manual. - Health plan social media page included educational materials on well-child/well-care visits. - Provider site visits—Provider education on requirements and training is a component of EPSDT-related services, detailed information regarding all mailings, expectations, and minimum performance standards. - Health plan pediatric webpage educated members on immunizations, importance of routine care, benefits, and assistance available. - Participation in the Summer Back to School Campaign offered eligible members an incentive for completing a well-child visit during the campaign period.

Contractor	Interventions
	- Implemented a fall campaign that offered eligible members an incentive for completing a well-child visit during the campaign period. - Targeted text message campaign designed and implemented to outreach those young adult members ages 18–21 years old who were provided education and scheduling information for routine well-care visits. - CRS Provider JOCs [Joint Operating Committees]—Education on requirements to include detailed information on clinic-specific performance and measure specifications. - Implementation of a Back-to-School Campaign incentive program offering targeted subpopulations with noted disparities a gift card for completing a well-child visit during the campaign period.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-27 presents strengths, opportunities for improvement, and recommendations for BUFC ACC related to the *Back to Basics* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-27—BUFC ACC Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: - BUFC ACC adhered to acceptable methodology through all phases of the PIP. [Quality, Access] - BUFC ACC developed and implemented interventions that led to statistically significant improvement in the <i>W30</i> performance indicator between the baseline and Remeasurement 3. [Quality, Access]
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: Indicator 2, <i>WCV</i>, remained below the baseline rate at Remeasurement 3. [Quality, Access] Recommendations: HSAG recommends that BUFC ACC apply lessons learned from conducting the <i>Back to Basics</i> PIP to future PIPs.

Prenatal and Postpartum Care PIP

In CYE 2025, BUFC ACC submitted Remeasurement 1 results for the *Prenatal and Postpartum Care* PIP, which was initiated in CY 2022. BUFC ACC submitted Remeasurement 1 performance indicator results and interventions implemented.

HSAG conducted an annual validation of Remeasurement Year 1 reflective of CY 2024 (January 1, 2024, through December 31, 2024) using AHCCCS-calculated and validated indicator rates. HSAG evaluated BUFC ACC’s performance indicator results based on an analysis of improvement strategies implemented as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection in [Appendix A. Methodology](#).

Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG’s confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG’s confidence that the PIP’s performance indicator results demonstrated evidence of significant improvement. Table 5-28 displays the overall confidence levels for the BUFC ACC *Prenatal and Postpartum Care* PIP.

Table 5-28—BUFC ACC *Prenatal and Postpartum Care* PIP Overall Confidence Levels for Remeasurement 1

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
BUFC ACC	<i>High Confidence</i>	100%	100%	<i>Moderate Confidence</i>	67%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Measure Results

Table 5-29 and Table 5-30 provide the *Prenatal and Postpartum Care* PIP baseline and Remeasurement Year 1 rates for each indicator for BUFC ACC.

Table 5-29—BUFC ACC Prenatal and Postpartum Care PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: <i>Timeliness of Prenatal Care</i>	
	Baseline Year	Remeasurement 1
	CY 2022*	CY 2024
BUFC ACC	81.51%	84.18%

*The CY 2022 indicator rate was provided by AHCCCS.

Table 5-30—BUFC ACC Prenatal and Postpartum Care PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: <i>Postpartum Care</i>	
	Baseline Year	Remeasurement 1
	CY 2022*	CY 2024
BUFC ACC	69.83%	74.21%

*The CY 2022 indicator rate was provided by AHCCCS.

Interventions

Table 5-31 presents PIP interventions for BUFC ACC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-31—BUFC ACC Prenatal and Postpartum Care PIP Interventions

Contractor	Interventions
BUFC ACC	- Prenatal packets will be distributed to all pregnant members following MCH notification of the member's pregnancy and will be distributed every two weeks. - Development and implementation of a pilot program with an outpatient behavioral health/substance abuse facility to engage women who may be pregnant or postpartum and struggling with mental health and/or substance abuse challenges. - Develop a PCP/practice-specific Value-Based Purchasing (VBP)/Pay-for-Performance program targeting timeliness of prenatal care within their assigned membership. - MCH to provide a minimum of two pregnancy submissions to each semiannual BUFC ACC member newsletter, providing key maternity and family planning information to the membership. - MCH review of all OB referrals originating outside of the NOP process, within one business day of receipt.

Contractor	Interventions
	- Review weekly pregnancy indicator data to identify potential pregnancies, research and confirm pregnancies, education, and assist with initiation of prenatal care. - Conduct provider education on the health plan's coverage, requirements and resources related to family planning, prenatal and postpartum coverage, services, and care. - Members called within 72 hours post-discharge and educated on the importance of a postpartum visit, offered resources and additional assistance. - A customer care alert system that identifies members who have delivered or should have delivered puts an alert on the file to help connect with the member. - Webpage and social media posts to educate members on the importance of establishing prenatal care early and often, as well as providing education on postpartum care and postpartum depression (PPD). - Expand all utilization of technology platforms to improve accessibility to early and regular prenatal education, care, and health plan support. - Postpartum care member satisfaction survey to further identify barriers members may be facing that prevented them from engaging in prenatal and/or postpartum care. - Well-women preventive care member outreach and text message campaign to include education and information on prenatal and postpartum care.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-32 presents strengths, opportunities for improvement, and recommendations for BUFC ACC related to the *Prenatal and Postpartum Care* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-32—BUFC ACC Strengths, Opportunities for Improvement, and Recommendations Related to the *Prenatal and Postpartum Care* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: BUFC ACC developed and implemented measurement systems for interventions that led to non-statistically significant improvement in both indicators at Remeasurement 1. [Quality, Access]
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: Neither indicator demonstrated statistically significant improvement at Remeasurement 1. [Quality, Access]

Strengths, Opportunities for Improvement, and Recommendations

Recommendations: As the PIP progresses, HSAG recommends that BUFC ACC:

- Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.
- Continue implementing identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.
- Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.

Compliance Reviews

In CYE 2025, HSAG conducted a review of 15 standard areas using monitoring tools to assess and document BUFC ACC’s compliance with federal and State requirements. The 15 standards for review were related to the federal Medicaid managed care regulations and associated State requirements. The compliance review included completing a desk review of documents, a review of the Contractor’s NCQA health plan accreditation reports and findings, file reviews, and an on-site review that included reviewing additional documents and conducting interviews with the Contractor.

Results

Table 5-33 presents the compliance review scores for BUFC ACC.

Table 5-33—Standards and Compliance Review Scores

Standard #	Standard Name*	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				D	M	NM	NA	
I	Disenrollment: Requirements and Limitations	9	9	0	6	3	0	67%
II	Member Rights and Member Information	22	22	6	15	1	0	95%
III	Emergency and Poststabilization Services	13	13	0	11	2	0	85%
IV	Availability of Services	12	12	7	5	0	0	100%
V	Assurances of Adequate Capacity and Services	3	3	0	3	0	0	100%
VI	Coordination and Continuity of Care	12	12	10	2	0	0	100%
VII	Coverage and Authorization of Services	30	30	7	20	3	0	90%
VIII	Provider Selection	7	7	2	4	1	0	86%
IX	Confidentiality	3	3	1	2	0	0	100%
X	Grievance and Appeal Systems	38	38	2	30	6	0	84%
XI	Subcontractual Relationships and Delegation	5	5	1	2	2	0	60%

Standard #	Standard Name*	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				D	M	NM	NA	
XII	Practice Guidelines	6	6	5	1	0	0	100%
XIII	Health Information Systems	9	9	0	8	1	0	89%
XIV	Quality Assessment and Performance Improvement Program	9	9	2	6	1	0	89%
XV	Program Integrity	15	14	0	14	0	1	100%
Totals		193	192	43	129	20	1	90%

* Table A-7 in [Appendix A. Methodology](#) outlines the compliance review standards and associated federal citations.

D=Deemed, **M**=Met, **NM**=Not Met, **NA**=Not Applicable

Total Elements: The total number of applicable elements in each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that received a score of **NA**.

Total Compliance Score: The compliance scores were calculated by adding the **Deemed** elements and the **Met** elements and then dividing by the total number of applicable elements.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-34 presents strengths, opportunities for improvement, and recommendations for BUFC ACC based on compliance activities conducted in CYE 2025, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-34—BUFC ACC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
BUFC ACC achieved full compliance in six of the 15 standards reviewed, demonstrating strengths and adherence to all requirements measured in the following areas: - Availability of Services [Timeliness, Access] - Assurances of Adequate Capacity and Services [Timeliness, Access] - Confidentiality [Quality] - Coordination and Continuity of Care [Quality, Timeliness, Access] - Practice Guidelines [Quality] - Program Integrity [Quality]
Opportunities for Improvement and Recommendations
The areas with the greatest opportunity for improvement were related to the following, as these areas received performance scores under 95 percent: Coverage and Authorization of Services [Quality, Timeliness, Access]

Strengths, Opportunities for Improvement, and Recommendations

- Disenrollment: Requirements and Limitations [Quality]
- Emergency and Poststabilization Services [Quality, Timeliness, Access]
- Grievance and Appeal Systems [Quality, Timeliness, Access]
- Health Information Systems [Quality]
- Provider Selection [Timeliness, Access]
- Quality Assessment and Performance Improvement Program [Quality, Timeliness]
- Subcontractual Relationships and Delegation [Quality]

Recommendation: HSAG recommends that BUFC ACC address the elements scored as *Not Met* through the CAP process during CYE 2026.

Network Adequacy Validation

ISCA Results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if BUFC ACC's interpretation of data was accurate.

Table 5-35 summarizes HSAG's validation ratings for BUFC ACC by indicator type.

Table 5-35—Summary of BUFC ACC's Validation Ratings by Indicator Type

Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Appointment Availability	100%	0%	0%	0%
Time/Distance	100%	0%	0%	0%

Of the network adequacy indicators assessed, BUFC ACC received *High Confidence* for both appointment availability and time/distance indicators. However, there were identified areas for improvement; please refer to the Contractor-specific Strengths, Opportunities for Improvement, and Recommendations section below for more details.

NAV Results

HSAG evaluated BUFC ACC's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents CYE 2024 S2 validation findings specific to the ACC Program, with one results table for each of the following GSAs:

- Central GSA: Gila, Maricopa, and Pinal counties

- South GSA: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma counties

Each Contractor-specific table summarizes validation results containing the percentage of members meeting each time/distance standard by county, with color coding to identify whether the time/distance standard was “Met” or “Not Met.”

Table 5-36—Time/Distance Validation Results for BUFC ACC Central GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^	99.2^Y	100.0^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0^	99.3^Y	100.0^
BHRF	NA	98.0 ^Y	NA
Cardiologist, Adult	100.0^	99.9^	100.0^
Cardiologist, Pediatric	100.0^	100.0^Y	100.0^
Dentist, Pediatric	99.7 ^Y	99.2 ^Y	100.0
Hospital	100.0	99.9	100.0
OB/GYN	100.0	100.0 ^Y	100.0
Pharmacy	100.0	99.2 ^Y	100.0
PCP, Adult	100.0^	99.8^Y	100.0^
PCP, Pediatric	100.0^	99.7^	100.0^

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

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

NA indicates results are not applicable to the county.

Table 5-37—Time/Distance Validation Results for BUFC ACC South GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Cochise	Graham	Greenlee	La Paz	Pima	Santa Cruz	Yuma
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^	100.0^	100.0^	100.0^Y	97.2^Y	100.0^	100.0^Y
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0^	100.0^	100.0^	100.0^	97.2^Y	100.0^	100.0^
BHRF	NA	NA	NA	NA	91.8 ^Y	NA	NA
Cardiologist, Adult	99.7^	100.0^	100.0^	100.0^	99.4^	100.0^	100.0^
Cardiologist, Pediatric	100.0^	100.0	100.0^	100.0^	99.7^Y	100.0^	100.0^

Provider Category	Cochise	Graham	Greenlee	La Paz	Pima	Santa Cruz	Yuma
Dentist, Pediatric	99.7 ^Y	96.7 ^Y	63.1 ^R	50.8 ^R	98.6	100.0	99.7 ^Y
Hospital	100.0	100.0	100.0	100.0	99.7 ^Y	100.0	100.0
OB/GYN	100.0	100.0	100.0	100.0	99.6 ^Y	100.0	100.0
Pharmacy	99.5	99.5 ^Y	99.6 ^Y	74.1 ^R	97.4 ^Y	100.0	99.6 ^Y
PCP, Adult	99.6 ^{^Y}	99.5 ^{^Y}	99.6 ^{^Y}	99.6 ^{^Y}	99.8 ^{^Y}	100.0 [^]	99.7 ^{^Y}
PCP, Pediatric	99.8 ^{^Y}	99.6 ^{^Y}	99.7 ^{^Y}	99.9 ^{^Y}	99.7 ^{^Y}	100.0 [^]	99.7 ^{^Y}

Y

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

R

represents time/distance standard results that do not meet the compliance standard based on HSAG's results.

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

NA indicates results are not applicable to the county.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-38 presents strengths, opportunities for improvement, and recommendations for BUFC ACC related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-38—BUFC ACC Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: - BUFC ACC used multiple methods to ensure provider data were complete and current, including daily data reports for each LOB, random audits on data entry, and maintaining clear expectations for providers to update changes. [Access] - BUFC ACC met all minimum network requirements for all assigned counties except in Greenlee and La Paz counties. [Access] - BUFC ACC met all minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; BHRF; Cardiologist, Adult and Pediatric; Hospital; OB/GYN; and PCP, Adult and Pediatric. [Access] Note: BUFC ACC provides coverage in the following counties: Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Santa Cruz, and Yuma.
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement:

Strengths, Opportunities for Improvement, and Recommendations

- HSAG identified an opportunity for BUFC ACC to strengthen its methods to calculate appointment availability indicator results. BUFC ACC’s appointment availability survey script incorporated leading questions directed toward providers, accompanied by a predetermined response format designed to align with AHCCCS compliance requirements. [Access]

Recommendation: HSAG recommends that BUFC ACC revise its appointment availability survey script to use open-ended questions that solicit the earliest available appointment dates from each provider. The collected responses should then be independently evaluated to determine compliance with AHCCCS standards.

- BUFC ACC did not meet the minimum network requirements for Dentist, Pediatric and Pharmacy. [Access]

Recommendation: HSAG recommends that BUFC ACC maintain current compliance with network standards and continue to address network gaps, as applicable.

Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)

Results

HSAG administered member experience surveys on AHCCCS’ behalf to members enrolled in BUFC ACC’s KidsCare program. Table 5-39 shows the 2025 scores including the overall member experience ratings, national average comparisons, and program comparisons for each CAHPS measure for both the BUFC ACC general child and CCC populations.

Table 5-39—BUFC ACC CAHPS Comparative Analyses

Measure	2025 General Child KidsCare	2025 CCC KidsCare
Global Ratings		
<i>Rating of Health Plan</i>	★★★★★ 76.9% H	★★★★ 68.3% ⁺
<i>Rating of All Health Care</i>	★★★★ 70.7%	★ 60.3% ⁺
<i>Rating of Personal Doctor</i>	★★★★ 79.1%	★★ 73.1% ⁺
<i>Rating of Specialist Seen Most Often</i>	★★★★ 77.0% ⁺	★★★★★ 79.4% ⁺

Measure	2025 General Child KidsCare	2025 CCC KidsCare
Composite Measures		
<i>Getting Needed Care</i>	★★★★ 84.1%	★★★★ 84.4% ⁺
<i>Getting Care Quickly</i>	★★★★★ 90.5%	★★★★ 91.6% ⁺
<i>How Well Doctors Communicate</i>	★★★★ 94.9%	★★★★★ 97.8% ⁺ H
<i>Customer Service</i>	★★★★ 90.6% ⁺	★★ 88.2% ⁺
Individual Item Measure		
<i>Coordination of Care</i>	★★ 83.8% ⁺	★ 75.0% ⁺
CCC Composite Measures and Items		
<i>Access to Specialized Services</i>	NA	★★ 69.2% ⁺
<i>FCC: Personal Doctor Who Knows Child</i>	NA	★★★★★ 95.0% ⁺
<i>Coordination of Care for Children with Chronic Conditions</i>	NA	★★★★★ 82.3% ⁺
<i>Access to Prescription Medicines</i>	NA	★★★★★ 94.3% ⁺
<i>FCC: Getting Needed Information</i>	NA	★ 88.1% ⁺

Star Assignments Based on Percentiles:

★★★★★ 90th or Above ★★★★★ 75th-89th ★★★★ 50th-74th ★★ 25th-49th ★ Below 25th

↑ Indicates the 2025 score is statistically significantly higher than the KidsCare MCO Aggregate.

↓ Indicates the 2025 score is statistically significantly lower than the KidsCare MCO Aggregate.

H Indicates the 2025 score is statistically significantly higher than the NCQA national average.

L Indicates the 2025 score is statistically significantly lower than the NCQA national average.

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

NA Indicates that this measure is not applicable for the population.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-40 presents strengths, opportunities for improvement, and recommendations for BUFC ACC related to CAHPS, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-40—BUFC ACC Strengths, Opportunities for Improvement, and Recommendations Related to CAHPS

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • BUFC ACC’s member experience ratings for <i>How Well Doctors Communicate</i>, <i>FCC: Personal Doctor Who Knows Child</i>, <i>Coordination of Care for Children with Chronic Conditions</i>, and <i>Access to Prescription Medicines</i> were at or above the 90th percentiles for the CCC population. [Quality, Access] • BUFC ACC’s member experience ratings for <i>Rating of Health Plan</i> and <i>Getting Care Quickly</i> were at or between the 75th and 89th percentiles for the general child population. [Quality, Timeliness] • BUFC ACC’s member experience rating for <i>Rating of Specialist Seen Most Often</i> was at or between the 75th and 89th percentiles for the CCC population. [Quality] • BUFC ACC’s 2025 score for <i>Rating of Health Plan</i> was statistically significantly higher than the NCQA national average for the general child population. [Quality] • BUFC ACC’s 2025 score for <i>How Well Doctors Communicate</i> was statistically significantly higher than the NCQA national average for the CCC population. [Quality]
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: • BUFC ACC’s member experience ratings for <i>Rating of All Health Care</i>, <i>Coordination of Care</i>, and <i>FCC: Getting Needed Information</i> were below the 25th percentiles for the CCC population. [Quality] • BUFC ACC’s member experience rating for <i>Coordination of Care</i> was between the 25th and 49th percentile for the general child population. [Quality] • BUFC ACC’s member experience ratings for <i>Rating of Personal Doctor</i>, <i>Customer Service</i>, and <i>Access to Specialized Services</i> were between the 25th and 49th percentiles for the CCC population. [Quality, Access] Recommendation: HSAG recommends that BUFC ACC explore what may be driving lower experience scores and develop initiatives designed to improve the quality of and access to care, including a focus on improving parents’/caretakers’ overall experiences with all health care, their child’s personal doctor, coordination of care, customer service, getting needed information, and getting access to specialized services.

Care1st ACC-RBHA

As of October 1, 2024, Care1st ACC-RBHA merged with AzCH-CCP ACC-RBHA. While Care1st ACC-RBHA no longer held a contract with AHCCCS during CYE 2025, it was required to participate in EQR activities related to CY 2024 performance measure data, PIP data, and network adequacy data. Results, strengths, and opportunities for improvement are presented below for PMV and PIP validation. Care1st ACC-RBHA was not subject to operational review or CAHPS activities.

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2025, HSAG evaluated Care1st ACC-RBHA's data system for processing of each data type used for reporting the Contractor's CY 2024 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that Care1st ACC-RBHA followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-41 displays HSAG's PMV findings for each data type reviewed during CYE 2025 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 5-41—CYE 2025 PMV Findings

Data Type	HSAG Findings
Medical Services Data	<i>No identified concerns</i>
Enrollment Data	<i>No identified concerns</i>
Provider Data	<i>No identified concerns</i>
Medical Record Review Process	<i>No identified concerns</i>
Supplemental Data	<i>No identified concerns</i>
Data Integration	<i>No identified concerns</i>

Results for Performance Measures

Since Care1st ACC-RBHA merged with AzCH-CCP ACC-RBHA, Care1st ACC-RBHA performance measure rates and the combined AzCH-CCP ACC-RBHA/Care1st ACC-RBHA performance measure rates are reflective of the following conditions:

- Continuous enrollment aligned with the measure technical specifications and AHCCCS guidance.
- Members who transferred to AzCH-CCP ACC-RBHA as of October 1, 2024, were considered continuously enrolled in Care1st ACC-RBHA for measure calculation (i.e., nine months in Care1st

ACC-RBHA and three months in AzCH-CCP ACC-RBHA for measures that require a full year of continuous enrollment).

The combined AzCH-CCP ACC-RBHA/Care1st ACC-RBHA performance measure rates are located in [Appendix B. CY 2024 Combined Performance Measure Results for AzCH-CCP ACC-RBHA and Care1st ACC-RBHA](#).

Table 5-42 presents the CY 2023 and CY 2024 Care1st ACC-RBHA performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and/or MY 2024. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 5-42—CY 2023 and CY 2024 Care1st ACC-RBHA Performance Measure Results

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
<i>Timeliness of Prenatal Care</i>	81.51% ⁺	82.97% ⁺	→	★★
<i>Postpartum Care</i>	62.04% ⁺	70.07% ⁺	↑	★
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
<i>18+ Years</i>	50.30%	57.05%	→	★
Antidepressant Medication Management				
<i>Effective Acute Phase Treatment—Total (18+ Years)</i>	61.60%	64.50% [^]	→	★★★★
<i>Effective Continuation Phase Treatment—Total (18+ Years)</i>	44.69%	47.75% [^]	→	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
<i>18–64 Years</i>	82.71% [^]	77.47%	↓	★
Follow-Up After ED Visit for Mental Illness				
<i>7-Day Follow-Up—Total (6+ Years)</i>	52.11% [^]	53.49% [^]	→	★★★★★
<i>30-Day Follow-Up—Total (6+ Years)</i>	61.97% [^]	63.95% [^]	→	★★★★
Follow-Up After ED Visit for Substance Use				
<i>7-Day Follow-Up—Total (13+ Years)</i>	30.27% [^]	35.78% [^]	→	★★★★★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
30-Day Follow-Up—Total (13+ Years)	41.97%^	45.78%^	→	★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	48.77%^	48.59%^	→	★★★
30-Day Follow-Up—Total (6+ Years)	67.90%^	66.22%^	→	★★★
Follow-Up Care for Children Prescribed ADHD Medication (ECDS)				
Initiation Phase (6–12 Years)	—	63.32%^	—	★★★★★
Continuation and Maintenance Phase (6–12 Years)	—	76.06%^	—	★★★★★
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	40.61%	42.27%	→	★★
Engagement of SUD Treatment—Total—Total (13+ Years)	15.38%^	15.17%	→	★★★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Total (1–17 Years)	77.78%^	74.42%^	→	★★★★★
Use of Opioids at High Dosage				
18+ Years*	5.91%^	5.28%^	→	★★
Care of Acute and Chronic Conditions				
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status <8.0%—Total (18–75 Years)	50.12% ⁺	46.80%	→	★
Glycemic Status >9.0%—Total (18–75 Years)*	40.88% ⁺	46.13%	↓	★
Pediatric Health				
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	41.83%	44.96%	↑	★
Childhood Immunization Status**				
Combination 3	48.91% ⁺	54.32%	→	★
Combination 7	42.34% ⁺	48.56%	↑	★
Combination 10	16.55% ⁺	17.03%	→	★
Childhood Immunization Status (ECDS)**				
Combination 3	—	54.32%	—	★
Combination 7	—	48.56%	—	★★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Combination 10	—	17.03%	—	★
Developmental Screening in the First Three Years of Life				
Total (0–3 Years)	18.25%	12.75%	↓	NC [±]
Immunizations for Adolescents**				
Combination 1 (Meningococcal, Tdap)	73.24% ⁺	70.43%	→	★
Combination 2 (Meningococcal, Tdap, HPV)	28.47% ⁺	29.34%	→	★
Immunizations for Adolescents (ECDS)**				
Combination 1 (Meningococcal, Tdap)	—	70.43%	—	★
Combination 2 (Meningococcal, Tdap, HPV)	—	29.34%	—	★
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	—	44.77% [^]	—	★★★★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total (3–17 Years)	62.53% ⁺	37.97%	↓	★
Counseling for Nutrition—Total (3–17 Years)	51.58% ⁺	37.46%	↓	★
Counseling for Physical Activity—Total (3–17 Years)	51.09% ⁺	36.97%	↓	★
Well-Child Visits in the First 30 Months of Life				
First 15 Months—Six or More Well-Child Visits	54.76%	58.66%	→	★★
15 Months–30 Months—Two or More Well-Child Visits	59.16%	61.46%	→	★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	36.41%	39.82%	↑	NC [±]
Breast Cancer Screening (ECDS)				
Total (50–74 Years)	—	39.77%	—	★
Cervical Cancer Screening				
21–64 Years	36.01% ⁺	37.69%	→	★
Cervical Cancer Screening (ECDS)				
21–64 Years	—	37.68%	—	★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Colorectal Cancer Screening (ECDS)				
Total (45–75 Years)	—	29.76%	—	★
Appropriate Utilization of Services				
Plan All-Cause Readmissions				
Observed/Expected (O/E) Ratio—Total (18–64 Years)*	—	1.0657 [^]	—	★★★
Oral Health				
Oral Evaluation, Dental Services				
Total (0–20 Years)	—	54.08% [^]	—	★★★★★

* A lower rate indicates better performance for this measure.

** Table A-2 in [Appendix A. Methodology](#) outlines which immunizations are included within each combination.

+ Indicates the measure was reported using hybrid methodology.

NC± indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

■ and ^ indicates that the rate met or exceeded the MY 2023 and/or MY 2024 national Medicaid mean.

— Indicates a 2023–2024 comparison is not presented in the CYE 2025 Annual Technical Report because either the CY 2023 rate was not presented in the CYE 2024 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

¹Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.

²Performance Levels for CY 2024 were based on comparisons of the HEDIS MY 2024 measure rates to NCQA Quality Compass national Medicaid HEDIS MY 2024 benchmarks.

↑ Indicates statistically significant improvement of measure rates.

↓ Indicates statistically significant decline of measure rates.

→ Indicates no statistically significant change in measure rates.

Performance Levels for 2024 represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Strengths and Opportunities for Improvement

Table 5-43 presents strengths and opportunities for improvement for Care1st ACC-RBHA related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement. As of October 1, 2024, Care1st ACC-RBHA no longer holds an AHCCCS contract; therefore, the information in this section does not include recommendations.

Table 5-43—Care1st ACC-RBHA Strengths and Opportunities for Improvement Related to Performance Measures

Strengths and Opportunities for Improvement
Strengths
In the Behavioral Health measure group: - Twelve of 16 Care1st ACC-RBHA measure rates (75.00 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. [Quality, Timeliness, Access] <i>Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years) and Effective Continuation Phase Treatment—Total (18+ Years)</i> <i>Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)</i> <i>Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years) and 30-Day Follow-Up—Total (13+ Years)</i> <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)</i> <i>Follow-Up Care for Children Prescribed ADHD Medication (ECDS)—Initiation Phase (6–12 Years) and Continuation and Maintenance Phase (6–12 Years)</i> <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)</i> <i>Use of Opioids at High Dosage—18+ Years</i> - Care1st ACC-RBHA’s performance measure rates for <i>Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)</i>, <i>Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)</i>, and <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)</i> were at or between the 75th and 89th percentile, indicating timely follow-up for members after going to the ED for a mental illness or for substance use and proper care for children and adolescents being prescribed antipsychotics. [Quality, Timeliness, Access] - Care1st ACC-RBHA’s performance measure rates for <i>Follow-Up Care for Children Prescribed ADHD Medication (ECDS)—Initiation Phase (6–12 Years) and Continuation and Maintenance Phase (6–12 Years)</i> were at or above the 90th percentile, indicating timely follow-up care visits for children being newly prescribed ADHD medication. Research indicates that ADHD is one of the more common chronic conditions of childhood. Children with ADHD may experience significant functional problems, such as school difficulties, academic underachievement, troublesome relationships with family members and peers, and behavioral problems. Given the high prevalence of ADHD among U.S. children (8.7 percent, or 5.3 million individuals), primary

Strengths and Opportunities for Improvement
care clinicians will regularly encounter children with ADHD and should have a strategy for diagnosing and long-term management of this condition. ⁸⁹ [Quality, Timeliness, Access]
Opportunities for Improvement
In the Maternal and Perinatal Care measure group, Care1st ACC-RBHA's performance measure rate for <i>Prenatal and Postpartum Care—Postpartum Care</i> fell below the 25th percentile, indicating an opportunity to increase access to timely postpartum care. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants. ⁹⁰ [Quality, Timeliness, Access]
In the Behavioral Health measure group, Care1st ACC-RBHA's performance measure rates for <i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years</i> and <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years</i> fell below the 25th percentile, indicating opportunities to improve psychotropic medication compliance for members and diabetes screenings for those members diagnosed appropriately and using antipsychotics. [Quality]
In the Preventive Screening measure group, Care1st ACC-RBHA's performance measure rates for <i>Breast Cancer Screening (ECDS)—50–74 Years</i> , <i>Cervical Cancer Screening—21–64 Years</i> , and <i>Cervical Cancer Screening (ECDS)—21–64 Years</i> fell below the 25th percentile, indicating that some women were not receiving timely screening for breast and cervical cancers. Early detection reduces the risk of dying from these types of cancers and can lead to a greater range of treatment options and lower health care costs. [Quality]
In the Care of Acute and Chronic Conditions measure group, Care1st ACC-RBHA's performance measure rates for <i>Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total (18–75 Years)</i> and <i>Glycemic Status >9.0%—Total (18–75 Years)</i> fell below the 25th percentile, indicating poor control over diabetes. [Quality]
In the Pediatric Health measure group: Care1st ACC-RBHA's performance for the following measures fell below the 25th percentile, indicating that children and adolescents were not always getting their recommended immunizations. Vaccination coverage must be maintained in order to prevent a resurgence of vaccine-preventable diseases.⁹¹ [Quality, Access]

⁸⁹ National Committee for Quality Assurance. Follow-Up Care for Children Prescribed ADHD Medication (ADD-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/follow-up-care-for-children-prescribed-adhd-medication-add-e/>. Accessed on: Feb 11, 2026.

⁹⁰ National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: <https://ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/prenatal-and-postpartum-care-ppc/>. Accessed on: Feb 11, 2026.

⁹¹ National Committee for Quality Assurance. Childhood Immunization Status (CIS-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/childhood-immunization-status-cis-e/>. Accessed on: Feb 11, 2026.

Strengths and Opportunities for Improvement

- *Childhood Immunization Status—Combination 3, Combination 7, and Combination 10*
- *Childhood Immunization Status (ECDS)—Combination 3 and Combination 10*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)*
- *Immunizations for Adolescents (ECDS)—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)*
- Care1st ACC-RBHA’s performance measure rates for *Well-Child Visits in the First 30 Months of Life—15 Months–30 Months—Two or More Well-Child Visits* fell below the 25th percentile, indicating opportunities for children who turned 30 months old during the measurement year to have at least two well-child visits with a PCP in the prior 15 months.⁹² **[Quality, Access]**
- Care1st ACC-RBHA’s performance measure rates for *Child and Adolescent Well-Care Visits—Total (3–21 Years)* fell below the 25th percentile, indicating that children and adolescents were not always receiving well-care visits at the recommended intervals. Assessing physical, emotional, and social development is important at every stage of life, particularly for children and adolescents. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.⁹³ **[Quality, Access]**

Validation of Performance Improvement Projects

Back to Basics PIP

In CYE 2025, Care1st ACC-RBHA continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 3, PIP validation activities focused on improvement from the baseline results. Care1st ACC-RBHA submitted Remeasurement 3 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes to or discontinuation of the interventions.

HSAG conducted an annual validation of the third remeasurement year reflective of CY 2024 (January 1, 2024, through December 31, 2024) using AHCCCS-calculated and validated indicator rates. HSAG evaluated Care1st ACC-RBHA’s performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of [Appendix A. Methodology](#).

⁹² National Committee for Quality Assurance. Well-Child Visits in the First 30 Months of Life (W30). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/well-child-visits-in-the-first-30-months-of-life-w30/>. Accessed on: Feb 11, 2026.

⁹³ National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (WCV). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/child-and-adolescent-well-care-visits-wcv/>. Accessed on: Feb 11, 2026.

Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG’s confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG’s confidence that the PIP’s performance indicator results demonstrated evidence of significant improvement. Table 5-44 displays the overall confidence levels for the Care1st ACC-RBHA *Back to Basics* PIP.

Table 5-44—Care1st ACC-RBHA *Back to Basics* PIP Overall Confidence Levels for Remeasurement 3

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements Met ²	Percentage Score of Critical Elements Met ³	Confidence Level ¹	Percentage Score of Evaluation Elements Met ²	Percentage Score of Critical Elements Met ³
Care1st ACC-RBHA	<i>High Confidence</i>	100%	100%	<i>No Confidence</i>	33%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements Met**—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements Met**—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Measure Results

Table 5-45 and Table 5-46 provide the *Back to Basics* PIP baseline, Remeasurement Year 1, Remeasurement Year 2, and Remeasurement Year 3 rates for each indicator for Care1st ACC-RBHA.

Table 5-45—Care1st ACC-RBHA *Back to Basics* PIP Rates for PIP Indicator 1

Contractor	PIP Measure Indicator 1: W30 Rate 1			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
Care1st ACC-RBHA	70.46%	53.53%	54.76%	58.66%

Table 5-46—Care1st ACC-RBHA *Back to Basics* PIP Rates for PIP Indicator 2

Contractor	PIP Measure Indicator 2: <i>WCV</i>			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
Care1st ACC-RBHA	51.43%	33.71%	41.83%	44.96%

Interventions

Table 5-47 presents PIP interventions for Care1st ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-47—Care1st ACC-RBHA *Back to Basics* PIP Interventions

Contractor	Interventions
Care1st ACC-RBHA	- Targeted outreach to members 18 to 20 years of age who were educated about the availability of health care and encouraged to use services before they age out of EPSDT coverage. This outreach took place via enhanced text messaging and mailers to members with messaging relevant to their unique needs and concerns. - Revamped Member Incentive Program with a new vendor. The new incentive program allowed members to receive their reward with completion of a visit based on claims and no longer required members to take additional action to complete an attestation. - Engaged providers through the Arizona Complete Health Provider Engagement team and deployed new “Path to 5 Stars” provider resource guide for improving quality measures, including <i>W30</i> and <i>WCV</i>. The guide provided practitioners with Medicaid percentile targets, coding advice and best practices for performance improvement. The PQL team engaged high-volume Medicaid providers with a variety of data and resources. As of June 2024, Care1st members were added to the team’s EPSDT Report for Non-compliance, a standardized template based on EPSDT form data received, that is shared quarterly with these providers. Additional reports and resources (care gap data, missed opportunities report, month-over-month and year-over-year performance and educational resources) were shared regularly. - Deployed new “Member Passport,” with customized messaging to educate members on the importance of well-child visits and childhood immunizations. - Expanded sources of updated member contact information to utilize HIE and pharmacy data; updates are stored in Quality Outreach Tracker (QOT) tool.

Contractor	Interventions
	- Utilized EPSDT clinical forms from providers in processing HEDIS measures to determine when gaps are closed, allowing the health plan to more effectively target member- and provider-facing outreach with more current and complete data. - Expanded Tribal Liaison Program with additional full-time employee who collaborated with tribal entities and CBOs to address barriers related to location, cultural factors, and SDOH that delayed screening among American Indian members.

Strengths and Opportunities for Improvement

Table 5-48 presents strengths and opportunities for improvement for Care1st ACC-RBHA related to the *Back to Basics* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement. As of October 1, 2024, Care1st ACC-RBHA no longer holds an AHCCCS contract; therefore, the information in this section does not include recommendations.

Table 5-48—Care1st ACC-RBHA Strengths and Opportunities for Improvement Related to the *Back to Basics* PIP

Strengths and Opportunities for Improvement
Strengths
HSAG identified the following strengths: Care1st ACC-RBHA performed accurate statistical testing between the baseline and Remeasurement 3 results. [Quality, Access]
Opportunities for Improvement
HSAG identified the following opportunities for improvement: For Indicator 1, Care1st ACC-RBHA had a decline of 11.80 percentage points in the indicator rate between the baseline year and Remeasurement Year 3. Care1st ACC-RBHA had a decline of 6.47 percentage points in the indicator rate between the baseline year and Remeasurement Year 3 for Indicator 2. [Quality, Access]

Prenatal and Postpartum Care PIP

In CYE 2025, Care1st ACC-RBHA submitted Remeasurement 1 results for the *Prenatal and Postpartum Care* PIP, which was initiated in CY 2022. Care1st ACC-RBHA submitted Remeasurement 1 performance indicator results and interventions implemented.

HSAG conducted an annual validation of Remeasurement Year 1 reflective of CY 2024 (January 1, 2024, through December 31, 2024) using AHCCCS-calculated and validated indicator rates. HSAG evaluated Care1st ACC-RBHA's performance indicator results based on an analysis of improvement strategies

implemented as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of [Appendix A. Methodology](#).

Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG’s confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG’s confidence that the PIP’s performance indicator results demonstrated evidence of significant improvement. Table 5-49 displays the overall confidence levels for the Care1st ACC-RBHA *Prenatal Care and Postpartum Care* PIP.

Table 5-49—Care1st ACC-RBHA *Prenatal and Postpartum Care* PIP Overall Confidence Levels for Remeasurement 1

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
Care1st ACC-RBHA	<i>High Confidence</i>	100%	100%	<i>Moderate Confidence</i>	67%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Measure Results

Table 5-50 and Table 5-51 provide the *Prenatal and Postpartum Care* PIP baseline year and Remeasurement Year 1 rates for each indicator for Care1st ACC-RBHA.

Table 5-50—Care1st ACC-RBHA Prenatal and Postpartum Care PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: <i>Timeliness of Prenatal Care</i>	
	Baseline Year	Remeasurement 1
	CY 2022	CY 2024
Care1st ACC-RBHA	75.43%	82.97%

Table 5-51 Care1st ACC-RBHA Prenatal and Postpartum Care PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: <i>Postpartum Care</i>	
	Baseline Year	Remeasurement 1
	CY 2022	CY 2024
Care1st ACC-RBHA	68.37%	70.07%

Interventions

Table 5-52 presents PIP interventions for Care1st ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-52—Care1st ACC-RBHA Prenatal and Postpartum Care PIP Interventions

Contractor	Interventions
Care1st ACC-RBHA	- Offer a provider portal, allows providers 24/7 on-demand access to view measure rates care gap lists for outreach, health plan tools including EPSDT forms, clinical practice guidelines, and one touch prior authorization request. - Offer a member portal, allowing a member to change PCP assignment, see personalized care gaps, search providers, complete mini-health screener with one interaction at the member’s convenience 24/7. - Revamp the Member Incentive Program with a new vendor. Allows members to receive an incentive with completion of a visit (based on claims); no longer requires members to take additional action after the visit to complete an attestation. - Enhance provider education on the <i>PPC</i> measures, including gaps in care among assigned members, best practices for improvement, and resources to address SDOH and the patient/member experience. Provider quality liaisons (PQLs) will actively engage providers through on-site or virtual visits and provide technical assistance on quality care gaps, accessing and utilizing available NOP reports and provider analytic tools, as well as member experience, risk, and incentive programs.

Contractor	Interventions
	- Implement SSFB, which consists of identifying pregnant members, stratifying them by risk level and impact ability, and providing care management, care coordination and disease management interventions as appropriate. The program also offers educational materials, advice, and resources for all enrolled pregnant members and new parents. Members can fill out a NOP form through the member portal, which helps to identify risk factors and is a tool for early identification of pregnancy by the assigned provider. - A mobile application provides a specialized care plan (based on certain tracks) for members with a specialized daily health checklist; provider alerts, care gaps, and progress tracking to CMs; allows for two-way video/text communication with Care Management.

Strengths and Opportunities for Improvement

Table 5-53 presents strengths and opportunities for improvement for Care1st ACC-RBHA related to the *Prenatal and Postpartum Care* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement. As of October 1, 2024, Care1st ACC-RBHA no longer holds an AHCCCS contract; therefore, the information in this section does not include recommendations.

Table 5-53—Care1st ACC-RBHA Strengths and Opportunities for Improvement Related to the *Prenatal and Postpartum Care* PIP

Strengths and Opportunities for Improvement
Strengths
HSAG identified the following strengths: Care1st ACC-RBHA developed and implemented measurement systems for interventions that led to improvement in both indicators and statistically significant improvement in Indicator 1 at Remeasurement 1. [Quality, Access]
Opportunities for Improvement
HSAG identified the following opportunities for improvement: Only Indicator 1 demonstrated statistically significant improvement between the baseline rate and the Remeasurement 1 rate. [Quality, Access]

Network Adequacy Validation

ISCA Results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Care1st ACC-RBHA’s interpretation of data was accurate.

Table 5-54 summarizes HSAG’s validation ratings for Care1st ACC-RBHA by indicator type.

Table 5-54—Summary of Care1st ACC-RBHA’s Validation Ratings by Indicator Type

Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Appointment Availability	100%	0%	0%	0%
Time/Distance	100%	0%	0%	0%

Of the network adequacy indicators assessed, Care1st ACC-RBHA received *High Confidence* for both appointment availability and time/distance indicators.

NAV Results

HSAG evaluated Care1st ACC-RBHA compliance results with AHCCCS’ time/distance standards by GSA and county. This section presents CYE 2024 S2 validation findings specific to the ACC Program, with one results table for the following GSA:

- North GSA: Apache, Coconino, Mohave, Navajo, and Yavapai counties

Each Contractor-specific table summarizes validation results containing the percentage of members meeting each time/distance standard by county, with color coding to identify whether the time/distance standard was “*Met*” or “*Not Met*.”

Table 5-55—Time/Distance Validation Results for Care1st ACC-RBHA North GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Apache	Coconino	Mohave	Navajo	Yavapai
Behavioral Health Outpatient and Integrated Clinic, Adult	79.8 ^{^R}	99.0 ^{^Y}	99.6 ^{^Y}	95.1 [^]	100.0 [^]
Behavioral Health Outpatient and Integrated Clinic, Pediatric	76.5 ^{^R}	98.1 ^{^Y}	99.7 ^{^Y}	92.8 ^{^Y}	100.0 [^]
BHRF	NA	NA	NA	NA	NA
Cardiologist, Adult	91.7 ^{^Y}	99.0 [^]	99.9 ^{^Y}	95.0 ^{^Y}	100.0 [^]
Cardiologist, Pediatric	99.2 ^{^Y}	100.0 [^]	100.0 [^]	100.0 [^]	100.0 [^]

Provider Category	Apache	Coconino	Mohave	Navajo	Yavapai
Dentist, Pediatric	82.0 ^R	88.2 ^R	98.9 ^Y	91.2	98.1
Hospital	96.7 ^Y	100.0	99.9	98.4 ^Y	100.0
OB/GYN	96.7 ^Y	100.0	100.0	99.9 ^Y	100.0
Pharmacy	97.4 ^Y	94.5 ^Y	99.1 ^Y	99.3 ^Y	99.0
PCP, Adult	92.9 ^{^Y}	99.1 [^]	98.9 [^]	99.8 ^{^Y}	100.0 [^]
PCP, Pediatric	90.5 ^{^Y}	97.7 ^{^Y}	99.2 ^{^Y}	96.9 ^{^Y}	100.0 [^]

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

Strengths, Opportunities for Improvement, and Recommendations

Table 5-56 presents strengths, opportunities for improvement, and recommendations for Care1st ACC-related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement. As of October 1, 2024, Care1st ACC-RBHA no longer holds an AHCCCS contract; therefore, the information in this section does not include recommendations.

Table 5-56—Care1st ACC-RBHA Strengths and Opportunities for Improvement Related to NAV

Strengths and Opportunities for Improvement
Strengths
HSAG identified the following strengths: - Care1st ACC-RBHA established robust processes to ensure provider data remain accurate and up to date. These processes include several key initiatives, such as ongoing collaboration with providers through on-site visits; use of business intelligence tools; the biannual Preferences and Trends report; and multiple internal quality reports used to monitor, identify errors, and assess the accuracy of provider data. Additionally, Care1st ACC-RBHA has partnered with an external vendor to conduct quarterly reviews of key demographic data, further supporting the integrity and accuracy of provider data elements. [Access] - Care1st ACC-RBHA met all minimum network requirements for all assigned counties except in Apache and Coconino counties. [Access] - Care1st ACC-RBHA met all minimum network requirements for Cardiologist, Adult and Pediatric; Hospital; OB/GYN; PCP, Adult and Pediatric; and Pharmacy. [Access] Note: Care1st ACC-RBHA provides coverage in the following counties: Apache, Coconino, Mohave, Navajo, and Yavapai.

Strengths and Opportunities for Improvement**Opportunities for Improvement**

HSAG identified the following opportunities for improvement:

- Care1st ACC-RBHA did not meet the minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric and Dentist, Pediatric. **[Access]**

HCA ACC

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2025, HSAG evaluated HCA ACC’s data system for processing of each data type used for reporting the Contractor’s CY 2024 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that HCA ACC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-57 displays HSAG’s PMV findings for each data type reviewed during CYE 2025 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 5-57—CYE 2025 PMV Findings

Data Type	HSAG Findings
Medical Services Data	<i>No identified concerns</i>
Enrollment Data	<i>No identified concerns</i>
Provider Data	<i>No identified concerns</i>
Medical Record Review Process	<i>No identified concerns</i>
Supplemental Data	<i>No identified concerns</i>
Data Integration	<i>No identified concerns</i>

Results for Performance Measures

Table 5-58 presents the CY 2023 and CY 2024 HCA ACC performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and/or MY 2024. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 5-58—CY 2023 and CY 2024 HCA ACC Performance Measure Results

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	87.37% ⁺ [^]	87.85% ⁺ [^]	→	★★★
Postpartum Care	79.21% ⁺ [^]	79.17% ⁺	→	★★
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	47.92%	52.15%	→	★
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	61.98%	64.52% [^]	↑	★★★
Effective Continuation Phase Treatment—Total (18+ Years)	43.68%	46.62%	↑	★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	80.74%	82.72% [^]	→	★★
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	35.47%	52.69% [^]	↑	★★★★
30-Day Follow-Up—Total (6+ Years)	49.90%	63.68% [^]	↑	★★★
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	33.00% [^]	33.63% [^]	→	★★★★
30-Day Follow-Up—Total (13+ Years)	48.30% [^]	49.36% [^]	→	★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	57.89% [^]	70.35% [^]	↑	★★★★★
30-Day Follow-Up—Total (6+ Years)	74.20% [^]	83.75% [^]	↑	★★★★★
Follow-Up Care for Children Prescribed ADHD Medication (ECDS)				
Initiation Phase (6–12 Years)	—	57.29% [^]	—	★★★★★
Continuation and Maintenance Phase (6–12 Years)	—	67.12% [^]	—	★★★★★
Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	48.74% [^]	47.84% [^]	→	★★★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
<i>Engagement of SUD Treatment—Total—Total (13+ Years)</i>	18.43% [^]	18.97% [^]	→	★★★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
<i>Total (1–17 Years)</i>	65.97% [^]	71.61% [^]	→	★★★★
Use of Opioids at High Dosage				
<i>18+ Years*</i>	4.86% [^]	5.34% [^]	→	★★
Care of Acute and Chronic Conditions				
Glycemic Status Assessment for Patients With Diabetes				
<i>Glycemic Status <8.0%—Total (18–75 Years)</i>	55.47% ^{+^}	58.39% ⁺	→	★★
<i>Glycemic Status >9.0%—Total (18–75 Years)*</i>	31.63% ^{+^}	30.41% ^{+^}	→	★★★
Pediatric Health				
Child and Adolescent Well-Care Visits				
<i>Total (3–21 Years)</i>	43.22%	46.53%	↑	★
Childhood Immunization Status**				
<i>Combination 3</i>	53.04% ⁺	58.39% ⁺	→	★
<i>Combination 7</i>	44.77% ⁺	52.55% ⁺	↑	★
<i>Combination 10</i>	17.76% ⁺	19.46% ⁺	→	★
Childhood Immunization Status (ECDS)**				
<i>Combination 3</i>	—	57.13%	—	★★
<i>Combination 7</i>	—	50.28%	—	★★
<i>Combination 10</i>	—	18.48%	—	★
Developmental Screening in the First Three Years of Life				
<i>Total (0–3 Years)</i>	0.00%	26.03% ⁺	↑	NC [±]
Immunizations for Adolescents**				
<i>Combination 1 (Meningococcal, Tdap)</i>	83.45% ^{+^}	79.08% ⁺	→	★★
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	35.52% ⁺	35.04% ⁺	→	★★
Immunizations for Adolescents (ECDS)**				
<i>Combination 1 (Meningococcal, Tdap)</i>	—	79.37% [^]	—	★★
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	—	33.76%	—	★★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	—	43.95%^	—	★★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total (3–17 Years)	67.15% ⁺	70.07% ⁺	→	★
Counseling for Nutrition—Total (3–17 Years)	60.34% ⁺	60.58% ⁺	→	★
Counseling for Physical Activity—Total (3–17 Years)	57.18% ⁺	55.23% ⁺	→	★
Well-Child Visits in the First 30 Months of Life				
First 15 Months—Six or More Well-Child Visits	63.32%^	68.53%^	↑	★★★★★
15 Months–30 Months—Two or More Well-Child Visits	59.41%	63.85%	↑	★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	45.77%	49.47%	↑	NC [±]
Breast Cancer Screening (ECDS)				
Total (50–74 Years)	—	50.12%	—	★
Cervical Cancer Screening				
21–64 Years	47.93% ⁺	45.50% ⁺	→	★
Cervical Cancer Screening (ECDS)				
21–64 Years	—	43.79%	—	★
Colorectal Cancer Screening (ECDS)				
Total (45–75 Years)	—	33.74%	—	★
Appropriate Utilization of Services				
Plan All-Cause Readmissions				
Observed/Expected (O/E) Ratio—Total (18–64 Years)*	—	1.1543 [^]	—	★★
Oral Health				
Oral Evaluation, Dental Services				
Total (0–20 Years)	—	52.90%^	—	★★★★★

* A lower rate indicates better performance for this measure.

** Table A-2 in [Appendix A. Methodology](#) outlines which immunizations are included within each combination.

NC[±] indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

+ Indicates the measure was reported using hybrid methodology.

■ and ^ indicates that the rate met or exceeded the MY 2023 and/or MY 2024 national Medicaid mean.

— Indicates a 2023–2024 comparison is not presented in the CYE 2025 Annual Technical Report because either the CY 2023 rate was not presented in the CYE 2024 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

¹ Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.

² Performance Levels for CY 2024 were based on comparisons of the HEDIS MY 2024 measure rates to NCQA Quality Compass national Medicaid HEDIS MY 2024 benchmarks.

↑ Indicates statistically significant improvement of measure rates.

↓ Indicates statistically significant decline of measure rates.

→ Indicates no statistically significant change in measure rates.

Performance Levels for 2024 represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 5-59 presents strengths, opportunities for improvement, and recommendations for HCA ACC related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-59—HCA ACC Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations	
Strengths	
In the Behavioral Health measure group:	
- Fourteen of 16 HCA ACC measure rates (87.50 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. [Quality, Timeliness, Access] <i>Antidepressant Medication Management—Effective Acute Phase Treatment—18+ Years</i> <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years</i> <i>Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)</i> <i>Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total (13+ Years) and 30-Day Follow-Up—Total (13+ Years)</i> <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)</i>	

Strengths, Opportunities for Improvement, and Recommendations

- *Follow-Up Care for Children Prescribed ADHD Medication (ECDS)—Initiation Phase (6–12 Years) and Continuation and Maintenance Phase (6–12 Years)*
- *Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total—Total (13+ Years) and Engagement of SUD Treatment—Total—Total (13+ Years)*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)*
- *Use of Opioids at High Dosage—18+ Years*
- HCA ACC’s performance measure rates for *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)* and *30-Day Follow-Up—Total (13+ Years)*, *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)*, and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)* were at or between the 75th and the 89th percentile. Additionally, HCA ACC’s performance measure rates for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)*, *Follow-Up Care for Children Prescribed ADHD Medication (ECDS)—Initiation Phase (6–12 Years) and Continuation and Maintenance Phase (6–12 Years)* were at above the 90th percentile, indicating good follow-up and/or coordinated care following ED, inpatient, SUD, and medication treatment. **[Quality, Timeliness, Access]**

In the Pediatric Health measure group:

- Three of 18 HCA ACC measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. **[Quality, Access]**
 - *Immunizations for Adolescents (ECDS)—Combination 1 (Meningococcal, Tdap)*
 - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)*
 - *Well-Child Visits in the First 30 Months of Life—First 15 Months—Six or More Well-Child Visits*
- HCA ACC’s performance measure rate for *Well-Child Visits in the First 30 Months of Life—First 15 Months—Six or More Well-Child Visits* was at or between the 75th and the 89th percentile, indicating children who turned 15 months old during the measurement year had at least six well-child visits with a PCP in the prior 15 months. **[Quality, Access]**

In the Oral Health measure group, HCA ACC’s performance measure rate for *Oral Evaluation, Dental Services—Total (0–20 Years)* met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024, indicating that members under 21 years of age are receiving a comprehensive or periodic oral evaluation with a dental provider during the measurement year.

Opportunities for Improvement and Recommendations

In the Preventive Screening measure group, all four of HCA ACC’s performance measure rates fell below the 25th percentile. **[Quality]**

- *Breast Cancer Screening (ECDS)—Total (50–74 Years)*

Strengths, Opportunities for Improvement, and Recommendations

- *Cervical Cancer Screening—21–64 Years*
- *Cervical Cancer Screening (ECDS)—21–64 Years*
- *Colorectal Cancer Screening (ECDS)—Total (45–75 Years)*

Recommendations: HSAG recommends that HCA ACC monitor performance trends and strengthen interventions aimed at improving timely completion of age and gender appropriate screenings. HSAG recommends enhancing member and provider outreach efforts, including reminder systems, patient education, and care gap notifications, to increase screening awareness and adherence to recommended guidelines. Additionally, HSAG recommends evaluating potential barriers to screening, such as access to providers, scheduling challenges, and data capture or documentation issues, and implementing targeted interventions to address identified gaps. Leveraging best practices from other states or plans, including use of patient portals, mailed reminders, and coordinated care management support, may further support improvements in preventive screening rates.

In the Pediatric Health measure group, 9 of HCA ACC's 18 performance measure rates fell below the 25th percentile, indicating that children and adolescents were not always receiving recommended immunizations and routine well-care visits at appropriate intervals. Assessing physical, emotional, and social development is important at every stage of life, particularly for children and adolescents, when growth and development are rapid and highly sensitive to early intervention. Well-care visits provide an opportunity for providers to influence health and development, ensure timely immunizations, identify developmental or behavioral concerns, and offer age-appropriate screening and counseling.⁹⁴

[Quality, Access]

- *Child and Adolescent Well-Care Visits—Total*
- *Childhood Immunization Status—Combination 3, Combination 7, and Combination 10*
- *Childhood Immunization Status (ECDS)—Combination 10*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total (3–17 Years), Counseling for Nutrition—Total (3–17 Years), and Counseling for Physical Activity—Total (3–17 Years)*
- *Well-Child Visits in the First 30 Months of Life—15 Months–30 Months—Two or More Well-Child Visits*

Recommendations: HSAG recommends that HCA ACC continue to monitor and expand existing interventions to improve performance across the continuum of preventive care, including timely immunizations, routine well-care visits, and required BMI assessment and nutrition and physical activity counseling for children and adolescents. Additionally, HSAG recommends that HCA

⁹⁴ National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (WCV). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/child-and-adolescent-well-care-visits-wcv/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

ACC review performance improvement strategies implemented by other states, such as addressing data and enrollment delays, improving documentation, and reducing beneficiary access barriers through outreach efforts, including patient portals and targeted phone outreach. Finally, HSAG recommends that HCA ACC continue to identify and assess additional barriers to care and consider stakeholder or beneficiary feedback, such as focus groups, to inform future interventions.

While HCA ACC was successful in reporting valid rates for all AHCCCS-required performance measures, the audit identified the following recommendations for future years' reporting: **[Quality]**

Recommendations: HSAG recommends that HCA ACC continue to explore the use of additional data sources for capturing race and ethnicity data from members. This could involve investigating supplemental data sources and implementing new collection strategies to ensure more complete member profiles. Additionally, HSAG recommends that HCA ACC continue to uphold its adherence to continuous enrollment criteria to maintain compliance with AHCCCS requirements for performance measure reporting. This includes accurately accounting for members who switch product lines, and those for whom HCA ACC is the secondary payer.

Validation of Performance Improvement Projects

Back to Basics PIP

In CYE 2025, HCA ACC continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 3, PIP validation activities focused on improvement from the baseline results. HCA ACC submitted Remeasurement 3 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes to or discontinuation of the interventions.

HSAG conducted an annual validation of the third remeasurement year reflective of CY 2024 (January 1, 2024, through December 31, 2024) using AHCCCS-calculated and validated indicator rates. HSAG evaluated HCA ACC's performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of [Appendix A. Methodology](#).

Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG's confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG's confidence that the PIP's performance indicator results

demonstrated evidence of significant improvement. Table 5-60 displays the overall confidence levels for the HCA ACC *Back to Basics* PIP.

Table 5-60—HCA ACC *Back to Basics* PIP Overall Confidence Levels for Remeasurement 3

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
HCA ACC	<i>Low Confidence</i>	87%	89%	<i>High Confidence</i>	100%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Measure Results

Table 5-61 and Table 5-62 provide the *Back to Basics* PIP baseline, Remeasurement Year 1, Remeasurement Year 2, and Remeasurement Year 3 rates for each indicator for HCA ACC.

Table 5-61—HCA ACC *Back to Basics* PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: <i>W30 Rate 1</i>			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
HCA ACC	59.39%	56.13%	63.32%	68.53%

Table 5-62—HCA ACC *Back to Basics* PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: <i>WCV</i>			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
HCA ACC	43.60%	39.79%	43.22%	46.53%

Interventions

Table 5-63 presents PIP interventions for HCA ACC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-63—HCA ACC *Back to Basics* PIP Interventions

Contractor	Interventions
HCA ACC	• EPSDT staff conducted outreach calls to members with gaps in care. During the calls, the staff educated members on the benefits of the well-child visit, questioned the parents to determine what barriers have hindered them from scheduling, assisted with scheduling appointments, and arranged transportation. • HCA ACC also conducted regular outreach via other methods to ensure providers and members were aware of the need for these services and that these measures remain a focus for pediatric providers. Health Choice Communications Team sent fax blasts, spoke about these measures at the provider forum, discussed value-based contracts with providers, and sent reminder letters to members. • Missed Appointment Logs—HCA ACC Care Management Team received missed appointment logs from a number of our larger providers. The Health Choice care managers then made follow-up calls to assist the member in rescheduling the missed appointment. This also provided an opportunity to assist the member in overcoming any barriers that prevented the member from being able to attend the appointment.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-64 presents strengths, opportunities for improvement, and recommendations for HCA ACC related to the *Back to Basics* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-64—HCA ACC Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • HCA ACC adhered to acceptable methodology through all phases of the PIP. [Quality, Access] • HCA ACC developed and implemented interventions that led to statistically significant improvement in both performance indicators between the baseline year and Remeasurement Year 3. [Quality, Access]

Strengths, Opportunities for Improvement, and Recommendations**Opportunities for Improvement and Recommendations**

HSAG identified the following opportunities for improvement:

- HCA ACC deleted CY 2022 Remeasurement 1 statistical testing results. **[Quality, Access]**
- HCA ACC did not document statistical testing between the baseline and Remeasurement 3 for Indicator 1. **[Quality, Access]**
- HCA ACC made errors in the narrative summary of results between the baseline and Remeasurement 3. **[Quality, Access]**

Recommendations: HSAG recommends that HCA ACC apply lessons learned from conducting the *Back to Basics* PIP to future PIPs.

Prenatal and Postpartum Care PIP

In CYE 2025, HCA ACC submitted Remeasurement 1 results for the *Prenatal and Postpartum Care* PIP, which was initiated in CY 2022. HCA ACC submitted baseline and Remeasurement 1 performance indicator results and interventions implemented.

HSAG conducted an annual validation of Remeasurement Year 1 reflective of CY 2024 (January 1, 2024, through December 31, 2024) using AHCCCS-calculated and validated indicator rates. HSAG evaluated HCA ACC's performance indicator results based on an analysis of improvement strategies implemented as described in Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of [Appendix A. Methodology](#).

Validation Results

Table 5-65 displays the overall confidence levels for the HCA ACC *Prenatal Care and Postpartum Care* PIP.

Table 5-65—HCA ACC *Prenatal and Postpartum Care* PIP Overall Confidence Levels for Remeasurement 1

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
HCA ACC	<i>Low Confidence</i>	81%	83%	<i>Moderate Confidence</i>	67%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Measure Results

Table 5-66 and Table 5-67 provide the *Prenatal and Postpartum Care* PIP baseline and Remeasurement Year 1 rates for each indicator for HCA ACC.

Table 5-66—HCA ACC *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: <i>Timeliness of Prenatal Care</i>	
	Baseline Year	Remeasurement 1
	CY 2022	CY 2024
HCA ACC	86.85%	87.85%

Table 5-67—HCA ACC Prenatal and Postpartum Care PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: Postpartum Care	
	Baseline Year	Remeasurement 1
	CY 2022*	CY 2024
HCA ACC	65.26%	79.17%

Interventions

Table 5-68 presents PIP interventions for HCA ACC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-68—HCA ACC Prenatal and Postpartum Care PIP Interventions

Contractor	Interventions
HCA ACC	- Direct Member Outreach – The HCA ACC Maternal Team completes telephonic outreach to newly identified pregnant women within their first trimester or within 42 days of enrollment. This outreach is to ensure that members have access to providers and to coordinate care as necessary. - Maternal Care Management – HCA ACC offers a care management program for pregnant women with high risk conditions. Maternity care managers are nurses who are available to provide condition specific education and help pregnant women obtain the medical, behavioral, social, and community resources they need during the pregnant and post-partum period. If pregnant and has a high risk condition, care management is available to help. This coordination for maternal members does not end at birth. HCA ACC’s Maternal Care Management Team continues to outreach members to eliminate barriers in attending postpartum care, complete postpartum depression screenings, and coordinate care for members with complex health needs. - Provider Outreach – The HCA ACC Quality Improvement Specialist (QIS) Team conducts regular outreach to provider practices both by phone and in person. They share with each provider the Provider Toolkit which contains information on proper billing for the PPC Measures. The QIS Team also discusses and troubleshoots individual issues with providers as needed. Larger meetings are held with larger practices to discuss barriers and solutions on which HCA ACC can collaborate. - HCA ACC has partnered with a vendor in order to improve health outcomes for maternal members. Loneliness and social isolation are risk factors for poor health outcomes and have increased during the COVID pandemic. Consequently, in 2021, HCA ACC contracted with the vendor to address loneliness and social isolation for members with an SMI designation, using the

Contractor	Interventions
	vendor’s smart phone-based technology and live compassionate support. In addition, members with health care or SDOH needs are connected directly to HCA ACC care management team, a member’s provider/Health Home, or appropriate community-based agencies. • Stork Newsletter – HCA ACC has determined the need for member outreach via many routes and platforms. HCA ACC designed and sent out the Stork Newsletter to inform members of common issues related to pregnancy and the importance of preventative care. • Prenatal and Postpartum Incentives – HCA ACC has identified an opportunity to incentivize members for receiving needed prenatal and postpartum care visits. HCA ACC is offering an incentive to members who attend their Prenatal or Postpartum care visit. Each member can receive both incentives if they attend both visits within the identified timeframe. • VBP Contracting – Value-Based Purchasing (VBP) contracting can significantly improve prenatal and postpartum care visit rates by incentivizing healthcare providers to focus on quality and outcomes. By aligning financial incentives with quality care and patient outcomes, VBP contracting can create a healthcare environment that prioritizes the health and well-being of pregnant and postpartum individuals, ultimately improving visit rates and overall care quality.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-69 presents strengths, opportunities for improvement, and recommendations for HCA ACC related to the *Prenatal and Postpartum Care* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-69—HCA ACC Strengths, Opportunities for Improvement, and Recommendations Related to the *Prenatal and Postpartum Care* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • HCA ACC developed and implemented interventions that led to improvement in both indicators and statistically significant improvement in the <i>Postpartum Care</i> indicator at Remeasurement 1. [Quality, Access]
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: • HCA ACC did not document intervention effectiveness data for each intervention. [Quality, Access]

Strengths, Opportunities for Improvement, and Recommendations

- HCA ACC made errors in the narrative summary of results between the baseline and Remeasurement 1. **[Quality, Access]**

Recommendations: As the PIP progresses, HSAG recommends that HCA ACC:

- Seek technical assistance from HSAG to understand the requirements for intervention effectiveness measurement and narrative summary of results, if needed.
- Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.
- Continue implementing identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.
- Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.

Compliance Reviews

In CYE 2025, HSAG conducted a review of 15 standard areas using monitoring tools to assess and document HCA ACC's compliance with federal and State requirements. The 15 standards for review were related to the federal Medicaid managed care regulations and associated State requirements. The compliance review included completing a desk review of documents, a review of the Contractor's NCQA health plan accreditation reports and findings, file reviews, and an on-site review that included reviewing additional documents and conducting interviews with the Contractor.

Results

Table 5-70 presents the compliance review scores for HCA ACC.

Table 5-70—Standards and Compliance Review Scores

Standard #	Standard Name*	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				D	M	NM	NA	
I	Disenrollment: Requirements and Limitations	9	9	0	8	1	0	89%
II	Member Rights and Member Information	22	22	0	21	1	0	95%
III	Emergency and Poststabilization Services	13	13	0	13	0	0	100%
IV	Availability of Services	12	12	0	12	0	0	100%
V	Assurances of Adequate Capacity and Services	3	3	0	3	0	0	100%
VI	Coordination and Continuity of Care	12	10	0	10	0	2	100%
VII	Coverage and Authorization of Services	30	29	0	26	3	1	90%

Standard #	Standard Name*	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				D	M	NM	NA	
VIII	Provider Selection	7	7	0	6	1	0	86%
IX	Confidentiality	3	3	0	3	0	0	100%
X	Grievance and Appeal Systems	38	38	0	36	2	0	95%
XI	Subcontractual Relationships and Delegation	5	5	0	5	0	0	100%
XII	Practice Guidelines	6	6	0	6	0	0	100%
XIII	Health Information Systems	9	9	0	8	1	0	89%
XIV	Quality Assessment and Performance Improvement Program	9	8	0	8	0	1	100%
XV	Program Integrity	15	14	0	14	0	1	100%
Totals		193	188	0	179	9	5	95%

* Table A-7 in [Appendix A. Methodology](#) outlines the compliance review standards and associated federal citations.

D=Deemed, **M**=Met, **NM**=Not Met, **NA**=Not Applicable

Total Elements: The total number of applicable elements in each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that received a score of **NA**.

Total Compliance Score: The compliance scores were calculated by adding the **Deemed** elements and the **Met** elements and then dividing by the total number of applicable elements.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-71 presents strengths, opportunities for improvement, and recommendations for HCA ACC based on compliance activities conducted in CYE 2025, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-71—HCA ACC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths HCA ACC achieved full compliance in nine of the 15 standards reviewed, demonstrating strengths and adherence to all requirements measured in the following areas: - Assurances of Adequate Capacity and Services [Timeliness, Access] - Availability of Services [Timeliness, Access] - Confidentiality [Quality] - Coordination and Continuity of Care [Quality, Timeliness, Access] - Emergency and Poststabilization Services [Quality, Timeliness, Access] - Practice Guidelines [Quality] - Program Integrity [Quality]

Strengths, Opportunities for Improvement, and Recommendations
- Quality Assessment and Performance Improvement Program [Quality, Timeliness] - Subcontractual Relationships and Delegation [Quality]
Opportunities for Improvement and Recommendations
The areas with the greatest opportunity for improvement were related to the following, as these areas received performance scores under 95 percent: - Coverage and Authorization of Services [Quality, Timeliness, Access] - Disenrollment: Requirements and Limitations [Quality] - Health Information Systems [Quality] - Provider Selection [Timeliness, Access] Recommendation: HSAG recommends that HCA ACC address the elements scored as <i>Not Met</i> through the CAP process during CYE 2026.

Network Adequacy Validation

ISCA Results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if HCA ACC’s interpretation of data was accurate.

Table 5-72 summarizes HSAG’s validation ratings for HCA ACC by indicator type.

Table 5-72—Summary of HCA ACC’s Validation Ratings by Indicator Type

Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Appointment Availability	100%	0%	0%	0%
Time/Distance	100%	0%	0%	0%

Of the network adequacy indicators assessed, HCA ACC received *High Confidence* for both appointment availability and time/distance indicators.

NAV Results

HSAG evaluated HCA ACC’s compliance results with AHCCCS’ time/distance standards by GSA and county. This section presents CYE 2024 S2 validation findings specific to the ACC Program, with one results table for each of the following GSAs:

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

Each Contractor-specific table summarizes validation results containing the percentage of members meeting each time/distance standard by county, with color coding to identify whether the time/distance standard was “Met” or “Not Met.”

Table 5-73—Time/Distance Validation Results for HCA ACC Central GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^	99.0^Y	100.0^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0^	99.2^Y	100.0^
BHRF	NA	98.6^Y	NA
Cardiologist, Adult	100.0^	99.9^	100.0^
Cardiologist, Pediatric	100.0^	100.0^	100.0^
Dentist, Pediatric	100.0	99.5^Y	100.0
Hospital	100.0	99.9	100.0
OB/GYN	100.0	100.0^Y	100.0
Pharmacy	100.0	99.1	100.0
PCP, Adult	100.0^	99.7^	100.0^
PCP, Pediatric	100.0^	99.7^	100.0^

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

Table 5-74—Time/Distance Validation Results for HCA ACC North GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Apache	Coconino	Mohave	Navajo	Yavapai
Behavioral Health Outpatient and Integrated Clinic, Adult	87.9^Y	97.6^Y	99.9^	96.0^	99.3^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	89.1^Y	96.7^Y	100.0^	94.8^Y	99.5^Y
BHRF	NA	NA	NA	NA	NA
Cardiologist, Adult	95.4^Y	98.9^Y	99.9^Y	96.9^Y	100.0^
Cardiologist, Pediatric	99.7^Y	100.0^	100.0^	100.0^	100.0^

Provider Category	Apache	Coconino	Mohave	Navajo	Yavapai
Dentist, Pediatric	88.0 ^R	97.1 ^Y	99.2 ^Y	97.2	99.1
Hospital	100.0	100.0	100.0	100.0	100.0
OB/GYN	92.1 ^Y	100.0	100.0	99.9	100.0 ^Y
Pharmacy	94.7 ^Y	94.0 ^Y	99.1 ^Y	99.7 ^Y	98.7 ^Y
PCP, Adult	89.8 ^{^Y}	98.2 ^{^Y}	98.8 ^{^Y}	98.0 ^{^Y}	99.6 [^]
PCP, Pediatric	92.1 ^{^Y}	97.2 ^{^Y}	99.3 ^{^Y}	97.2 [^]	99.1 [^]

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

R represents time/distance standard results that do not meet the compliance standard based on HSAG's results.

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

NA indicates results are not applicable to the county.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-75 presents strengths, opportunities for improvement, and recommendations for HCA ACC related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-75—HCA ACC Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: - HCA ACC ensured the completeness and accuracy of provider data through multiple strategies, including generating daily data reports for each LOB, conducting random audits of data entry, and setting clear expectations for providers to submit updates. [Access] - HCA ACC met all minimum network requirements for all assigned counties except Apache County. [Access] - HCA ACC met the minimum network requirements for BHRF; Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; Cardiologist, Adult and Pediatric; Hospital; OB/GYN; PCP, Adult and Pediatric; and Pharmacy. [Access] Note: HCA ACC provides coverage in the following counties: Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal, and Yavapai.
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: HCA ACC did not meet the minimum network requirements for Dentist, Pediatric. [Access]

Strengths, Opportunities for Improvement, and Recommendations

Recommendation: HSAG recommends that HCA ACC maintain current compliance with network standards and continue to address network gaps, as applicable.

Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)

Results

HSAG administered member experience surveys on AHCCCS' behalf to members enrolled in HCA ACC's KidsCare program. Table 5-76 shows the 2025 scores including the overall member experience ratings, national average comparisons, and program comparisons for each CAHPS measure for both the HCA ACC general child and CCC populations.

Table 5-76—HCA ACC CAHPS Comparative Analyses

Measure	2025 General Child KidsCare	2025 CCC KidsCare
Global Ratings		
<i>Rating of Health Plan</i>	★★★★ 71.7%	★★★ 64.3% ⁺
<i>Rating of All Health Care</i>	★★★★ 70.7%	★★★★ 67.5% ⁺
<i>Rating of Personal Doctor</i>	★★★★ 79.4%	★★★★★★ 89.5% ⁺ H
<i>Rating of Specialist Seen Most Often</i>	★★★★ 74.4% ⁺	★★★★ 72.7% ⁺
Composite Measures		
<i>Getting Needed Care</i>	★★★★★ 88.1% ⁺	★★★★ 86.3% ⁺
<i>Getting Care Quickly</i>	★★★★ 88.2% ⁺	★ 85.5% ⁺
<i>How Well Doctors Communicate</i>	★★★★★★ 97.5% H	★★★★★★ 99.3% ⁺ H
<i>Customer Service</i>	★★★★ 90.5% ⁺	★★★★★ 92.9% ⁺

Measure	2025 General Child KidsCare	2025 CCC KidsCare
Individual Item Measure		
<i>Coordination of Care</i>	★★ 83.0% ⁺	★★★★★ 88.9% ⁺
CCC Composite Measures and Items		
<i>Access to Specialized Services</i>	NA	★★★★★ 87.1%
<i>FCC: Personal Doctor Who Knows Child</i>	NA	★★★ 92.2% ⁺
<i>Coordination of Care for Children with Chronic Conditions</i>	NA	★★★★★ 87.0% ⁺ H
<i>Access to Prescription Medicines</i>	NA	★★★ 90.3% ⁺
<i>FCC: Getting Needed Information</i>	NA	★★★★★ 95.0% ⁺

Star Assignments Based on Percentiles:

★★★★★ 90th or Above ★★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

↑ Indicates the 2025 score is statistically significantly higher than the KidsCare MCO Aggregate.

↓ Indicates the 2025 score is statistically significantly lower than the KidsCare MCO Aggregate.

H Indicates the 2025 score is statistically significantly higher than the NCQA national average.

L Indicates the 2025 score is statistically significantly lower than the NCQA national average.

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

NA Indicates that this measure is not applicable for the population.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-77 presents strengths, opportunities for improvement, and recommendations for HCA ACC related to CAHPS, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-77—HCA ACC Strengths, Opportunities for Improvement, and Recommendations Related to CAHPS

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: - HCA ACC’s member experience rating for <i>How Well Doctors Communicate</i> was at or above the 90th percentile for the general child population. [Quality] - HCA ACC’s member experience ratings for Rating of Personal Doctor, How Well Doctors Communicate, Coordination of Care, Access to Specialized Services, Coordination of Care for

Strengths, Opportunities for Improvement, and Recommendations

Children with Chronic Conditions, and FCC: Getting Needed Information were at or above the 90th percentiles for the CCC population. **[Quality, Access]**

- HCA ACC's member experience rating for *Getting Needed Care* was at or between the 75th and 89th percentiles for the general child population. **[Quality, Access]**
- HCA ACC's member experience rating for *Customer Service* was at or between the 75th and 89th percentiles for the CCC population. **[Quality]**
- HCA ACC's 2025 score for *How Well Doctors Communicate* was statistically significantly higher than the NCQA national average for the general child population. **[Quality]**
- HCA ACC's 2025 scores for *Rating of Personal Doctor*, *How Well Doctors Communicate*, and *Coordination of Care for Children with Chronic Conditions* were statistically significantly higher than the NCQA national averages for the CCC population. **[Quality]**

Opportunities for Improvement and Recommendations

HSAG identified the following opportunities for improvement:

- HCA ACC's member experience rating for *Getting Care Quickly* was below the 25th percentile for the CCC population. **[Quality, Access]**
- HCA ACC's member experience rating for *Coordination of Care* was between the 25th and 49th percentiles for the general child population. **[Quality]**
- HCA ACC's member experience rating for *Rating of Health Plan* was between the 25th and 49th percentiles for the CCC population. **[Quality]**

Recommendation: HSAG recommends that HCA ACC explore what may be driving lower experience scores and develop initiatives designed to improve the quality of and access to care, including a focus on improving parents'/caretakers' overall experiences with the health plan, coordination of care, and getting needed care.

Mercy Care ACC-RBHA

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2025, HSAG evaluated Mercy Care ACC-RBHA’s data system for processing of each data type used for reporting the Contractor’s CY 2024 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that Mercy Care ACC-RBHA followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-78 displays HSAG’s PMV findings for each data type reviewed during CYE 2025 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 5-78—CYE 2025 PMV Findings

Data Type	HSAG Findings
Medical Services Data	<i>No identified concerns</i>
Enrollment Data	<i>No identified concerns</i>
Provider Data	<i>No identified concerns</i>
Medical Record Review Process	<i>No identified concerns</i>
Supplemental Data	<i>No identified concerns</i>
Data Integration	<i>No identified concerns</i>

Results for Performance Measures

Table 5-79 presents the CY 2023 and CY 2024 Mercy Care ACC-RBHA performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and/or MY 2024. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 5-79—CY 2023 and CY 2024 Mercy Care ACC-RBHA Performance Measure Results

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
<i>Maternal and Perinatal Care</i>				
<i>Prenatal and Postpartum Care</i>				

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
<i>Timeliness of Prenatal Care</i>	NA ⁺⁺	86.37% ⁺⁺	—	★★★
<i>Postpartum Care</i>	NA ⁺⁺	73.24% ⁺	—	★
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
<i>18+ Years</i>	41.57%	52.72%	↑	★
Antidepressant Medication Management				
<i>Effective Acute Phase Treatment—Total (18+ Years)</i>	51.28%	53.52%	↑	★
<i>Effective Continuation Phase Treatment—Total (18+ Years)</i>	35.70%	38.43%	↑	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
<i>18–64 Years</i>	83.22% [^]	82.91% [^]	→	★★★★
Follow-Up After ED Visit for Mental Illness				
<i>7-Day Follow-Up—Total (6+ Years)</i>	51.05% [^]	48.87% [^]	→	★★★★
<i>30-Day Follow-Up—Total (6+ Years)</i>	60.23% [^]	60.96% [^]	→	★★★★
Follow-Up After ED Visit for Substance Use				
<i>7-Day Follow-Up—Total (13+ Years)</i>	31.31% [^]	32.82% [^]	→	★★★★★
<i>30-Day Follow-Up—Total (13+ Years)</i>	41.31% [^]	44.02% [^]	→	★★★★
Follow-Up After Hospitalization for Mental Illness				
<i>7-Day Follow-Up—Total (6+ Years)</i>	52.34% [^]	47.32% [^]	↓	★★★★
<i>30-Day Follow-Up—Total (6+ Years)</i>	69.56% [^]	67.10% [^]	↓	★★★★
Follow-Up Care for Children Prescribed ADHD Medication (ECDS)				
<i>Initiation Phase (6–12 Years)</i>	—	56.43% [^]	—	★★★★★
<i>Continuation and Maintenance Phase (6–12 Years)</i>	—	63.98% [^]	—	★★★★★
Initiation and Engagement of SUD Treatment				
<i>Initiation of SUD Treatment—Total—Total (13+ Years)</i>	52.37% [^]	49.41% [^]	↓	★★★★
<i>Engagement of SUD Treatment—Total—Total (13+ Years)</i>	19.97% [^]	20.72% [^]	→	★★★★★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Total (1–17 Years)	71.68% [^]	65.34% [^]	↓	★★★
Use of Opioids at High Dosage				
18+ Years*	8.64%	8.68%	→	★
Care of Acute and Chronic Conditions				
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status <8.0%—Total (18–75 Years)	63.99% ^{+^}	64.23% ^{+^}	→	★★★
Glycemic Status >9.0%—Total (18–75 Years)*	28.22% ^{+^}	27.25% ^{+^}	→	★★★
Pediatric Health				
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	53.58% [^]	56.00% [^]	↑	★★★
Childhood Immunization Status**				
Combination 3	62.53% ⁺	66.42% ^{+^}	→	★★★
Combination 7	51.34% ⁺	59.85% ^{+^}	↑	★★★
Combination 10	24.33% ⁺	24.82% ⁺	→	★★★
Childhood Immunization Status (ECDS)**				
Combination 3	—	65.91% [^]	—	★★★★★
Combination 7	—	57.16% [^]	—	★★★
Combination 10	—	22.18%	—	★★★
Developmental Screening in the First Three Years of Life				
Total (0–3 Years)	27.98%	36.25% ⁺	↑	NC [±]
Immunizations for Adolescents**				
Combination 1 (Meningococcal, Tdap)	87.10% ^{+^}	89.29% ^{+^}	→	★★★★★
Combination 2 (Meningococcal, Tdap, HPV)	41.36% ^{+^}	42.58% ^{+^}	→	★★★
Immunizations for Adolescents (ECDS**)				
Combination 1 (Meningococcal, Tdap)	—	86.94% [^]	—	★★★★★
Combination 2 (Meningococcal, Tdap, HPV)	—	40.61% [^]	—	★★★★★
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	—	43.97% [^]	—	★★★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total (3–17 Years)	81.51% ⁺⁺	82.00% ⁺⁺	→	★★
Counseling for Nutrition—Total (3–17 Years)	74.45% ⁺⁺	73.24% ⁺⁺	→	★★
Counseling for Physical Activity—Total (3–17 Years)	71.29% ⁺⁺	72.02% ⁺⁺	→	★★★
Well-Child Visits in the First 30 Months of Life				
First 15 Months—Six or More Well-Child Visits	67.87% [^]	72.26% [^]	↑	★★★★★
15 Months–30 Months—Two or More Well-Child Visits	66.26%	73.41% [^]	↑	★★★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	55.33% [^]	57.90%	↑	NC [±]
Breast Cancer Screening (ECDS)				
Total (50–74 Years)	—	57.90% [^]	—	★★★
Cervical Cancer Screening				
21–64 Years	60.83% ⁺⁺	54.74% ⁺	→	★★
Cervical Cancer Screening (ECDS)				
21–64 Years	—	53.06% [^]	—	★★★
Colorectal Cancer Screening (ECDS)				
Total (45–75 Years)	—	45.12% [^]	—	★★★
Appropriate Utilization of Services				
Plan All-Cause Readmissions				
Observed/Expected (O/E) Ratio—Total (18–64 Years)*	—	1.1283 [^]	—	★★★
Oral Health				
Oral Evaluation, Dental Services				
Total (0–20 Years)	—	56.94% [^]	—	★★★★★

* A lower rate indicates better performance for this measure.

** Table A-2 in [Appendix A. Methodology](#) outlines which immunizations are included within each combination.

NA⁺⁺ indicates the denominator was too small to report a valid rate, based on the applicable measure specification.

NC[±] indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

+ Indicates the measure was reported using hybrid methodology.

 and [^] indicates that the rate met or exceeded the MY 2023 and/or MY 2024 national Medicaid mean.

— Indicates a 2023–2024 comparison is not presented in the CYE 2025 Annual Technical Report because either the CY 2023 rate was not presented in the CYE 2024 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

¹ Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a p value of <0.01 due to large denominators.

² Performance Levels for CY 2024 were based on comparisons of the HEDIS MY 2024 measure rates to NCQA Quality Compass national Medicaid HEDIS MY 2024 benchmarks.

↑ Indicates statistically significant improvement of measure rates.

↓ Indicates statistically significant decline of measure rates.

→ Indicates no statistically significant change in measure rates.

Performance Levels for 2024 represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 5-80 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-80—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group, 12 of 16 Mercy Care ACC-RBHA measure rates (75.00 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. [Quality, Timeliness, Access] <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years</i> <i>Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)</i> <i>Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years) and 30-Day Follow-Up—Total (13+ Years)</i> <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)</i> <i>Follow-Up Care for Children Prescribed ADHD Medication (ECDS)—Initiation Phase (6–12 Years) and Continuation and Maintenance Phase (6–12 Years)</i> <i>Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Total (13+ Years) and Engagement of SUD Treatment—Total—Total (13+ Years)</i> <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)</i>

Strengths, Opportunities for Improvement, and Recommendations

In the Pediatric Health measure group, 15 of 18 Mercy Care ACC-RBHA measure rates (83.33 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. **[Quality, Timeliness, Access]**

- *Child and Adolescent Well-Care Visits—Total (3–21 Years)*
- *Childhood Immunization Status—Combination 3 and Combination 7*
- *Childhood Immunization Status (ECDS)—Combination 3 and Combination 7*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)*
- *Immunizations for Adolescents (ECDS)—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total (3–17 Years), Counseling for Nutrition—Total (3–17 Years), and Counseling for Physical Activity—Total (3–17 Years)*
- *Well-Child Visits in the First 30 Months of Life—First 15 Months—Six or More Well-Child Visits and 15 Months–30 Months—Two or More Well-Child Visits*

Opportunities for Improvement and Recommendations

While Mercy Care ACC-RBHA was successful in reporting valid rates for all AHCCCS-required performance measures, the audit identified the following recommendations for future years' reporting: **[Quality]**

Recommendations: HSAG recommends that Mercy Care ACC-RBHA continue to work with AHCCCS to explore the use of additional data sources for capturing member race and ethnicity information from members to support performance measure reporting. This could involve investigating supplemental data sources and implementing new collection strategies to ensure more complete member profiles. Additionally, HSAG recommends that Mercy Care ACC-RBHA continue to uphold its adherence to continuous enrollment criteria to maintain compliance with AHCCCS requirements for performance measure reporting. This includes accurately accounting for members who switch product lines, and those for whom Mercy Care ACC-RBHA is the secondary payer.

In the Maternal and Perinatal Care measure group, Mercy Care ACC-RBHA's performance measure rate for *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, indicating many pregnant women did not receive timely postpartum follow-up. **[Quality]**

Recommendations: HSAG recommends that Mercy Care ACC-RBHA continue to implement and enhance targeted interventions to improve timely postpartum follow-up. These efforts should focus on strengthening care coordination after delivery, addressing potential access and scheduling

Strengths, Opportunities for Improvement, and Recommendations

barriers, and improving member outreach and education regarding the importance of postpartum care. In addition, Mercy Care ACC-RBHA should monitor performance regularly and assess documentation and coding practices to ensure that all qualifying postpartum services are accurately captured.

In the Behavioral Health measure group:

- Mercy Care ACC-RBHA's performance measure rates for *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total (18+ Years)* fell below both the 25th percentile in MY 2024 and the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024, indicating an opportunity to identify trends leading to antidepressant medication mismanagement.

[Quality]

Recommendation: Suicide is the 10th leading cause of death in the United States. Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy and self-esteem, and can lead to suicide. Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness, and identifying and managing side effects.⁹⁵ HSAG recommends that Mercy Care ACC-RBHA consider clinical recommendations shown to improve adherence to antidepressants, such as assessing depressive symptoms at baseline and at each follow-up, as well as providing psychoeducation to the member and family.⁹⁶

- Mercy Care ACC-RBHA's performance measure rates for *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years* fell below both the 25th percentile in MY 2024 and the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024, indicating opportunities to improve psychotropic medication compliance for members. [Quality]

Recommendations: Schizophrenia is a chronic and disabling psychiatric disorder that requires ongoing treatment and monitoring. Symptoms include hallucinations, illogical thinking, memory impairment, and incoherent speech. Medication nonadherence is common and a major concern in the treatment of schizophrenia. Using antipsychotic medications as prescribed reduces the risk of relapses or hospitalization.⁹⁷ In a systematic review of medication adherence studies, several

⁹⁵ National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/antidepressant-medication-management-amm/>. Accessed on: Feb 11, 2026.

⁹⁶ Solmi M, Miola A, Croatto G, et al. How can we improve antidepressant adherence in the management of depression? A targeted review and 10 clinical recommendations. *Brazilian Journal of Psychiatry*. 2021;43(2):189–202.

⁹⁷ National Committee for Quality Assurance. Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/adherence-to-antipsychotic-medications-for-individuals-with-schizophrenia-saa/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

interventions that worked were motivational interviewing, daily texts to individuals with schizophrenia, and other medication reminders. Other effective studies utilized Meds-Help, a pharmacy-based intervention, environmental support through home visits and reminders to adhere to medication, a psychoeducational program (FSPP), an intervention called STOPS that focuses on the importance of the supervisor's role for patients during treatment, and an IOT program.⁹⁸

HSAG recommends that Mercy Care ACC-RBHA consider implementing one or more of these interventions that have been associated with increased medication adherence for members with schizophrenia. In addition, HSAG recommends that Mercy Care ACC-RBHA consider utilizing financial incentives offered to patients with severe mental illness to improve treatment adherence.

- Mercy Care ACC-RBHA's performance measure rate for *Use of Opioids at High Dosage—18+ Years* fell below both the 25th percentile in MY 2024 and the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024. **[Quality]**

Recommendations: HSAG recommends that Mercy Care ACC-RBHA continue to evaluate its opioid prescription monitoring efforts to identify opportunities to enhance oversight of prescription opioids at a high dosage. Through this process, Mercy Care ACC-RBHA should determine if it is necessary to deploy additional mechanisms to identify members who may be at high risk for opioid overuse and misuse, as literature suggests there is a correlation between high dosages of prescription opioids and the risk of both fatal and nonfatal overdoses.⁹⁹ Mercy Care ACC-RBHA should continue to report any completed prescription opioid monitoring effort enhancements to AHCCCS. HSAG also recommends that Mercy Care ACC-RBHA identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts.

Validation of Performance Improvement Projects

Back to Basics PIP

In CYE 2025, Mercy Care ACC-RBHA continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 3, PIP validation activities focused on improvement from the baseline results. Mercy Care ACC-RBHA submitted Remeasurement 3

⁹⁸ Cahaya N, Kristina SA, Widayanti AW, et al. Interventions to Improve Medication Adherence in People with Schizophrenia: A Systematic Review. Patient preference and adherence vol. 16 2431-2449. 1 Sep. 2022, doi:10.2147/PPA.S378951. Available at: <https://pubmed.ncbi.nlm.nih.gov/36072918/>. Accessed on: Feb 11, 2026.

⁹⁹ National Committee for Quality Assurance. Use of Opioids at High Dosage (HDO). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/use-of-opioids-at-high-dosage-hdo/>. Accessed on: Feb 11, 2026.

performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes to or discontinuation of the interventions.

HSAG conducted an annual validation of the third remeasurement year reflective of CY 2024 (January 1, 2024, through December 31, 2024) using AHCCCS-calculated and validated indicator rates. HSAG evaluated Mercy Care ACC-RBHA’s performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of [Appendix A. Methodology](#).

Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG’s confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG’s confidence that the PIP’s performance indicator results demonstrated evidence of significant improvement. Table 5-81 displays the overall confidence levels for the Mercy Care ACC-RBHA *Back to Basics* PIP.

Table 5-81—Mercy Care ACC-RBHA *Back to Basics* PIP Overall Confidence Levels for Remeasurement 3

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
Mercy Care ACC-RBHA	<i>Low Confidence</i>	73%	78%	<i>High Confidence</i>	100%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Measure Results

Table 5-82 and Table 5-83 provide the *Back to Basics* PIP baseline, Remeasurement Year 1, Remeasurement Year 2, and Remeasurement Year 3 rates for each indicator for Mercy Care ACC-RBHA.

Table 5-82—Mercy Care ACC-RBHA *Back to Basics* PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: W30 Rate 1			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
Mercy Care ACC-RBHA	64.96%	65.12%	67.87%	72.26%

Table 5-83—Mercy Care ACC-RBHA *Back to Basics* PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: WCV			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
Mercy Care ACC-RBHA	52.92%	49.57%	53.58%	56.00%

Interventions

Table 5-84 presents PIP interventions for Mercy Care ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-84—Mercy Care ACC-RBHA *Back to Basics* PIP Interventions

Contractor	Interventions
Mercy Care ACC-RBHA	- Enhanced provider education on the AHCCCS periodicity schedule which requires six well-visits by age 15 months, two additional visits between 15 and 30 months, and annual well-visits after 30 months of age. - Enhanced provider education on well-child visit codes. - Enhanced provider awareness of sick and well-visit combination and coding (modifier 25). - Enhanced provider awareness of Mercy Care ACC-RBHA’s “unlimited” well-child visit policy. - Partnership and collaboration with pediatric providers to promote EPSDT “awareness.” - Referred new members to pediatric providers for comprehensive EPSDT services and care.

Contractor	Interventions
	- Revised member outreach schedule for members ages 3–6 from a “summer schedule” with calls beginning in April and ending in August, to a monthly schedule to increase well-child visit rates for this age group. - Multi-modal member outreach to members who had gaps in care with well-child visits and/or immunizations. Mercy Care Health Assistant member portal, text messaging, emails, and incentives. - Leveraged faith-based organizations to disseminate information on the identified disparities.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-85 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA related to the *Back to Basics* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-85—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: Mercy Care ACC-RBHA developed and implemented interventions that led to statistically significant improvement in both indicator outcomes between baseline and Remeasurement 3. [Quality, Access]
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: Mercy Care ACC-RBHA did not update its resubmission narrative summary to address issues identified with statistical testing and did not provide CY 2024 intervention effectiveness data for the targeted interventions. [Quality, Access] Recommendation: HSAG recommends that Mercy Care ACC-RBHA apply lessons learned from conducting the <i>Back to Basics</i> PIP to future PIPs.

Prenatal and Postpartum Care PIP

In CYE 2025, Mercy Care ACC-RBHA submitted Remeasurement 1 results for the *Prenatal and Postpartum Care* PIP, which was initiated in CY 2022. Mercy Care ACC-RBHA submitted baseline performance indicator results and interventions implemented.

HSAG conducted an annual validation of Remeasurement Year 1 reflective of CY 2024 (January 1, 2024, through December 31, 2024) using AHCCCS-calculated and validated indicator rates. HSAG evaluated Mercy Care ACC-RBHA’s performance indicator results based on an analysis of improvement strategies implemented as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of [Appendix A. Methodology](#).

Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG’s confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG’s confidence that the PIP’s performance indicator results demonstrated evidence of significant improvement. Table 5-86 displays the overall confidence levels for the Mercy Care ACC-RBHA *Prenatal and Postpartum Care* PIP.

Table 5-86—Mercy Care ACC-RBHA *Prenatal and Postpartum Care* PIP Overall Confidence Levels for Remeasurement 1

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
Mercy Care ACC-RBHA	<i>High Confidence</i>	100%	100%	<i>Low Confidence</i>	33%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Measure Results

Table 5-87 and Table 5-88 provide the *Prenatal and Postpartum Care* PIP baseline and Remeasurement 1 rates for each indicator for Mercy Care ACC-RBHA.

Table 5-87—Mercy Care ACC-RBHA Prenatal and Postpartum Care PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: <i>Timeliness of Prenatal Care</i>	
	Baseline Year	Remeasurement 1
	CY 2022	CY 2024
Mercy Care ACC-RBHA	84.91%	86.37%

Table 5-88—Mercy Care ACC-RBHA Prenatal and Postpartum Care PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: <i>Postpartum Care</i>	
	Baseline Year	Remeasurement 1
	CY 2022	CY 2024
Mercy Care ACC-RBHA	78.10%	73.24%

Interventions

Table 5-89 presents PIP interventions for Mercy Care ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-89—Mercy Care ACC-RBHA Prenatal and Postpartum Care PIP Interventions

Contractor	Interventions
Mercy Care ACC-RBHA	- Leveraging the ACOG data submitted to the perinatal Integrated Care Management (ICM) team for low-risk pregnancy identification, in addition to use by perinatal CM team. - Leveraging newborn notifications for identification of postpartum members. - Implementing a process to identify pregnant members through positive pregnancy tests in the HIE. - Revising the outreach process so that the postpartum mailing is sent to the member regardless of whether or not the member’s PCP or baby’s PCP information is available (revised letter template and process). - Expanding education to OB/GYNs by MCH coordinators. - Improving medical record retrieval processes to ensure requested records for all sample members are received. - Prenatal and postpartum member incentives for all LOBs. - Health Assistant App—member Web portal. - Add the prenatal care measure to Mercy Care ACC-RBHA’s Vendor Business Services (VBS) contracts.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-90 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA related to the *Prenatal and Postpartum Care* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-90—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to the *Prenatal and Postpartum Care* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: Mercy Care ACC-RBHA developed and implemented measurement systems for interventions that led to improvement in Indicator 1 at Remeasurement 1. [Quality, Access]
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: - The improvement reported at Remeasurement 1 for Indicator 1 was not statistically significant, while the Indicator 2 rate declined. [Quality, Access] Recommendations: As the PIP progresses, HSAG recommends that Mercy Care ACC-RBHA: - Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. - Continue implementing identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. - Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.

Compliance Reviews

Results

AHCCCS conducted a compliance review of Mercy Care ACC-RBHA from February 12, 2024, through February 15, 2024. On May 2, 2024, AHCCCS finalized the report findings, provided Mercy Care ACC-RBHA with a CAP submission matrix, and required a CAP for any standard with a total score of less than 95 percent. On June 7, 2024, AHCCCS accepted Mercy Care ACC-RBHA's proposed CAPs and required the Contractor to submit updated policies, manuals, desktop procedures, and other vital documents to provide evidence of CAP completion. On May 19, 2025, AHCCCS reviewed Mercy Care ACC-RBHA's CAP status and determined that all CAPs had been completed and approved for closure.

Table 5-91—Mercy Care ACC-RBHA Compliance Review Results

AHCCCS Compliance Focus Areas	CYE 2024 Mercy Care ACC-RBHA Scores	CYE 2025 Mercy Care ACC-RBHA CAP Update
Corporate Compliance	100%	NA
Claims and Information Standards	99%	NA
Delivery Systems	97%	NA
General Administration	96%	NA
Grants Management	100%	NA
Grievance Systems	100%	NA
Adult; EPSDT; and Maternal Child Health	96%	NA
Medical Management	97%	NA
Member Information	90%	Met
Quality Management	95%	NA
Quality Improvement	100%	NA
Reinsurance	100%	NA
Third-Party Liability	100%	NA
Integrated Systems of Care	99%	NA

NA = Not applicable. A CAP was not required as the CYE 2024 score was 95% or above.
Met = AHCCCS accepted and closed the Contractor's CAP.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-92 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA based on compliance activities conducted in CYE 2025, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-92—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
Mercy Care ACC-RBHA successfully closed CAPs in the following focus area: Member Information (MI) [Quality]
Opportunities for Improvement and Recommendations
As a result of its CAP interventions implemented in CYE 2025, Mercy Care ACC-RBHA was found to be fully compliant within all focus areas and had no continuing corrective actions or recommendations.

Network Adequacy Validation

ISCA Results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Mercy Care ACC-RBHA’s interpretation of data was accurate.

Table 5-93 summarizes HSAG’s validation ratings for Mercy Care ACC-RBHA by indicator type.

Table 5-93—Summary of Mercy Care ACC-RBHA’s Validation Ratings by Indicator Type

Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Appointment Availability	100%	0%	0%	0%
Time/Distance	100%	0%	0%	0%

Of the network adequacy indicators assessed, Mercy Care ACC-RBHA received *High Confidence* for both appointment availability and time/distance indicators.

NAV Results

HSAG evaluated Mercy Care ACC-RBHA’s compliance results with AHCCCS’ time/distance standards by GSA and county. This section presents CYE 2024 S2 validation findings specific to the ACC Program, with one results table for the following GSA:

- Central GSA: Gila, Maricopa, and Pinal counties

Each Contractor-specific table summarizes validation results containing the percentage of members meeting each time/distance standard by county, with color coding to identify whether the time/distance standard was “*Met*” or “*Not Met*.”

Table 5-94—Time/Distance Validation Results for Mercy Care ACC-RBHA Central GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^	99.0^	100.0^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0^	99.1^	100.0^
BHRF	NA	99.6	NA
Cardiologist, Adult	100.0^	100.0^Y	100.0^
Cardiologist, Pediatric	100.0^	100.0^	100.0^
Dentist, Pediatric	99.5	99.4Y	100.0

Provider Category	Gila	Maricopa	Pinal
Hospital	100.0	99.9	100.0
OB/GYN	100.0	99.9	100.0
Pharmacy	100.0 ^Y	99.1 ^Y	100.0
PCP, Adult	100.0 [^]	99.7 ^{^Y}	100.0 [^]
PCP, Pediatric	100.0 [^]	99.7 [^]	100.0 [^]

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

Strengths, Opportunities for Improvement, and Recommendations

Table 5-95 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-95—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: - Mercy Care ACC-RBHA maintained a robust internal provider data management process supported by multiple data management platforms and applications. This system included weekly reconciliation between credentialing and operational systems, the application of United States Postal Service (USPS) address standardization, and annual validations of the provider directory through direct provider attestations. These activities demonstrated a strong process for maintaining accurate and up-to-date provider information. [Access] - Mercy Care ACC-RBHA met all minimum network requirements for all assigned counties. [Access] Note: Mercy Care ACC-RBHA provides coverage in the following counties: Gila, Maricopa, and Pinal.
Opportunities for Improvement and Recommendations
HSAG identified no opportunities for improvement for Mercy Care ACC-RBHA.

Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)

Results

HSAG administered member experience surveys on AHCCCS' behalf to members enrolled in Mercy Care ACC-RBHA's KidsCare program.

Table 5-96 shows the 2025 scores including the overall member experience ratings, national average comparisons, and program comparisons for each CAHPS measure for both the Mercy Care ACC-RBHA general child and CCC populations.

Table 5-96—Mercy Care ACC-RBHA CAHPS Comparative Analyses

Measure	2025 General Child KidsCare	2025 CCC KidsCare
Global Ratings		
<i>Rating of Health Plan</i>	★★★★★ 77.4% H	★★★★★ 75.3% ⁺
<i>Rating of All Health Care</i>	★★★★★ 77.9% H	★★★★★ 77.0% ⁺ H
<i>Rating of Personal Doctor</i>	★★★★★ 83.2% H	★★★★★ 79.4% ⁺
<i>Rating of Specialist Seen Most Often</i>	★★ 69.4% ⁺	★ 61.0% ⁺
Composite Measures		
<i>Getting Needed Care</i>	★★★★★ 87.5% ⁺	★★★★ 86.2% ⁺
<i>Getting Care Quickly</i>	★★★★★ 91.1% ⁺	★★★★ 91.2% ⁺
<i>How Well Doctors Communicate</i>	★★★★★ 96.8% H	★★★★★ 97.1% ⁺
<i>Customer Service</i>	★ 85.5% ⁺	★★★★ 92.0% ⁺
Individual Item Measure		
<i>Coordination of Care</i>	★★ 82.0% ⁺	★★ 82.9% ⁺

Measure	2025 General Child KidsCare	2025 CCC KidsCare
CCC Composite Measures and Items		
<i>Access to Specialized Services</i>	NA	★★★★ 74.0% ⁺
<i>FCC: Personal Doctor Who Knows Child</i>	NA	★★★★ 92.1% ⁺
<i>Coordination of Care for Children with Chronic Conditions</i>	NA	★★★★★ 84.8% ⁺ H
<i>Access to Prescription Medicines</i>	NA	★★★★★ 92.5% ⁺
<i>FCC: Getting Needed Information</i>	NA	★★★★★ 93.4% ⁺

Star Assignments Based on Percentiles:

★★★★★ 90th or Above ★★★★★ 75th-89th ★★★★ 50th-74th ★★★ 25th-49th ★ Below 25th

↑ Indicates the 2025 score is statistically significantly higher than the KidsCare MCO Aggregate.

↓ Indicates the 2025 score is statistically significantly lower than the KidsCare MCO Aggregate.

H Indicates the 2025 score is statistically significantly higher than the NCQA national average.

L Indicates the 2025 score is statistically significantly lower than the NCQA national average.

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

NA Indicates that this measure is not applicable for the population.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-97 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA related to CAHPS, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-97—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to CAHPS

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: - Mercy Care ACC-RBHA’s member experience ratings for <i>Rating of All Health Care</i>, <i>Rating of Personal Doctor</i>, and <i>How Well Doctors Communicate</i> were at or above the 90th percentile for the general child population. [Quality] - Mercy Care ACC-RBHA’s member experience ratings for <i>Rating of Health Plan</i>, <i>Rating of All Health Care</i>, <i>How Well Doctors Communicate</i>, and <i>Coordination of Care for Children with Chronic Conditions</i> were at or above the 90th percentile for the CCC population. [Quality]

Strengths, Opportunities for Improvement, and Recommendations

- Mercy Care ACC-RBHA's member experience ratings for *Rating of Health Plan*, *Getting Needed Care*, and *Getting Care Quickly* were at or between the 75th and 89th percentiles for the general child population. **[Quality, Timeliness, Access]**
- Mercy Care ACC-RBHA's member experience ratings for *Rating of Personal Doctor*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information* were at or between the 75th and 89th percentiles for the CCC population. **[Quality, Access]**
- Mercy Care ACC-RBHA's 2025 scores for *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *How Well Doctors Communicate* were statistically significantly higher than the NCQA national averages for the general child population. **[Quality]**
- Mercy Care ACC-RBHA's 2025 scores for *Rating of All Health Care* and *Coordination of Care for Children with Chronic Conditions* were statistically significantly higher than the NCQA national averages for the CCC population. **[Quality]**

Opportunities for Improvement and Recommendations

HSAG identified the following opportunities for improvement:

- Mercy Care ACC-RBHA's member experience rating for *Customer Service* was below the 25th percentile for the general child population. **[Quality]**
- Mercy Care ACC-RBHA's member experience rating for *Rating of Specialist Seen Most Often* was below the 25th percentile for the CCC population. **[Quality]**
- Mercy Care ACC-RBHA's member experience ratings for *Rating of Specialist Seen Most Often* and *Coordination of Care* were between the 25th and 49th percentiles for the general child population. **[Quality]**
- Mercy Care ACC-RBHA's member experience rating for *Coordination of Care* was between the 25th and 49th percentiles for the CCC population. **[Quality]**

Recommendation: HSAG recommends that Mercy Care ACC-RBHA explore what may be driving lower experience scores and develop initiatives designed to improve the quality of care, including a focus on improving parents'/caretakers' overall experiences with the specialist their child sees most often, coordination of care, and customer service.

Molina ACC

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2025, HSAG evaluated Molina ACC’s data system for processing of each data type used for reporting the Contractor’s CY 2024 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that Molina ACC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-98 displays HSAG’s PMV findings for each data type reviewed during CYE 2025 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 5-98—CYE 2025 PMV Findings

Data Type	HSAG Findings
Medical Services Data	<i>No identified concerns</i>
Enrollment Data	<i>No identified concerns</i>
Provider Data	<i>No identified concerns</i>
Medical Record Review Process	<i>No identified concerns</i>
Supplemental Data	<i>No identified concerns</i>
Data Integration	<i>The Prenatal and Postpartum care (PPC) measure was not calculated using the AHCCCS-required methodology and was reported as admin for Title XXI.</i>

Results for Performance Measures

Table 5-99 presents the CY 2023 and CY 2024 Molina ACC performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and/or MY 2024. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 5-99—CY 2023 and CY 2024 Molina ACC Performance Measure Results

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	85.40% ⁺ [^]	84.91% ⁺ [^]	→	★★
Postpartum Care	66.42% ⁺	70.07% ⁺	→	★
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	41.67%	50.00%	→	★
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	57.28%	61.34%	→	★★
Effective Continuation Phase Treatment—Total (18+ Years)	37.46%	43.72%	↑	★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	76.74%	82.23%	→	★★
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	42.00% [^]	63.16% [^]	↑	★★★★★
30-Day Follow-Up—Total (6+ Years)	64.00% [^]	65.79% [^]	→	★★★★★
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	30.29% [^]	27.41% [^]	→	★★★★
30-Day Follow-Up—Total (13+ Years)	37.59% [^]	41.62% [^]	→	★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	46.28% [^]	46.80% [^]	→	★★★★
30-Day Follow-Up—Total (6+ Years)	63.27% [^]	65.46% [^]	→	★★★★
Follow-Up Care for Children Prescribed ADHD Medication (ECDS)				
Initiation Phase (6–12 Years)	—	67.39% [^]	—	★★★★★
Continuation and Maintenance Phase (6–12 Years)	—	73.53% [^]	—	★★★★★
Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	56.68% [^]	54.47% [^]	→	★★★★★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
<i>Engagement of SUD Treatment—Total—Total (13+ Years)</i>	24.06% [^]	22.56% [^]	→	★★★★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
<i>Total (1–17 Years)</i>	55.38%	64.10% [^]	→	★★★
Use of Opioids at High Dosage				
<i>18+ Years*</i>	2.24% [^]	5.39% [^]	→	★★
Care of Acute and Chronic Conditions				
Glycemic Status Assessment for Patients With Diabetes				
<i>Glycemic Status <8.0%—Total (18–75 Years)</i>	46.23% ⁺	52.55% ⁺	→	★
<i>Glycemic Status >9.0%—Total (18–75 Years)*</i>	44.04% ⁺	34.55% ⁺	↑	★★
Pediatric Health				
Child and Adolescent Well-Care Visits				
<i>Total (3–21 Years)</i>	43.53%	49.54%	↑	★
Childhood Immunization Status**				
<i>Combination 3</i>	58.88% ⁺	64.48% ⁺	→	★★
<i>Combination 7</i>	50.12% ⁺	55.47% ⁺	→	★★
<i>Combination 10</i>	18.25% ⁺	22.87% ⁺	→	★★
Childhood Immunization Status (ECDS)**				
<i>Combination 3</i>	—	63.57% [^]	—	★★★★
<i>Combination 7</i>	—	55.31% [^]	—	★★★★
<i>Combination 10</i>	—	22.57%	—	★★
Developmental Screening in the First Three Years of Life				
<i>Total (0–3 Years)</i>	NA ⁺⁺	28.22% ⁺	—	NC [±]
Immunizations for Adolescents**				
<i>Combination 1 (Meningococcal, Tdap)</i>	80.54% ⁺⁺	76.16% ⁺	→	★★
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	27.74% ⁺	29.68% ⁺	→	★
Immunizations for Adolescents (ECDS)**				
<i>Combination 1 (Meningococcal, Tdap)</i>	—	76.64%	—	★★
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	—	30.09%	—	★★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	—	32.74%	—	★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total (3–17 Years)	79.32% ⁺	80.05% ⁺	→	★★
Counseling for Nutrition—Total (3–17 Years)	69.59% ⁺⁺	72.99% ⁺⁺	→	★★
Counseling for Physical Activity—Total (3–17 Years)	67.40% ⁺⁺	68.37% ⁺⁺	→	★★
Well-Child Visits in the First 30 Months of Life				
First 15 Months—Six or More Well-Child Visits	63.07% [^]	68.68% [^]	↑	★★★★
15 Months–30 Months—Two or More Well-Child Visits	67.27%	69.80%	→	★★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	49.10%	51.39%	→	NC [±]
Breast Cancer Screening (ECDS)				
Total (50–74 Years)	—	52.15%	—	★★
Cervical Cancer Screening				
21–64 Years	43.55% ⁺	45.99% ⁺	→	★
Cervical Cancer Screening (ECDS)				
21–64 Years	—	42.38%	—	★
Colorectal Cancer Screening (ECDS)				
Total (45–75 Years)	—	29.38%	—	★
Appropriate Utilization of Services				
Plan All-Cause Readmissions				
Observed/Expected (O/E) Ratio—Total (18–64 Years)*	—	NA ⁺⁺	—	NC [±]
Oral Health				
Oral Evaluation, Dental Services				
Total (0–20 Years)	—	44.07% [^]	—	★★

* A lower rate indicates better performance for this measure.

** Table A-2 in [Appendix A. Methodology](#) outlines which immunizations are included within each combination.

NC[±] indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

+ Indicates the measure was reported using hybrid methodology.

NA⁺⁺ indicates the denominator was too small to report a valid rate, based on the applicable measure specification.

 and ^ indicates that the rate met or exceeded the MY 2023 and/or MY 2024 national Medicaid mean.

— Indicates a 2023–2024 comparison is not presented in the CYE 2025 Annual Technical Report because either the CY 2023 rate was not presented in the CYE 2024 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

¹ Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.

² Performance Levels for CY 2024 were based on comparisons of the HEDIS MY 2024 measure rates to NCQA Quality Compass national Medicaid HEDIS MY 2024 benchmarks.

↑ Indicates statistically significant improvement of measure rates.

↓ Indicates statistically significant decline of measure rates.

→ Indicates no statistically significant change in measure rates.

Performance Levels for 2024 represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 5-100 presents strengths, opportunities for improvement, and recommendations for Molina ACC related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-100—Molina ACC Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations	
Strengths	
In the Behavioral Health measure group:	
- Twelve of 16 Molina ACC performance measure rates (75.00 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024: [Quality, Timeliness, Access] <i>Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)</i> <i>Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years) and 30-Day Follow-Up—Total (13+ Years)</i> <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)</i> <i>Follow-Up Care for Children Prescribed ADHD Medication (ECDS)—Initiation Phase (6–12 Years) and Continuation and Maintenance Phase (6–12 Years)</i> <i>Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years) and Engagement of SUD Treatment—Total—Total (13+ Years)</i>	

Strengths, Opportunities for Improvement, and Recommendations

- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)*
- *Use of Opioids at High Dosage—18+ Years*
- Molina ACC’s performance measure rates for *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total (6+ Years)*, and *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* and *Engagement of SUD Treatment—Total—Total (13+ Years)* were at or between the 75th and 89th percentile, indicating that most members received follow-up or coordinated care after an ED visit for substance use or mental illness. Additionally, the result suggests that most members diagnosed with SUD initiated treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization treatment, or MAT within 14 days of diagnosis and had two or more additional SUD services or medications within 34 days of the initiation visit.¹⁰⁰ **[Quality, Timeliness, Access]**
- Molina ACC’s performance measure rates for *Follow-Up Care for Children Prescribed ADHD Medication (ECDS)—Initiation Phase (6–12 Years)* and *Continuation and Maintenance Phase (6–12 Years)*, and *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* were at or above the 90th percentile, indicating that most members received follow-up or coordinated care after an ED visit for mental illness or medication prescription. **[Quality, Timeliness, Access]**

In the Pediatric Health measure group, the following performance measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024: **[Quality, Access]**

- *Childhood Immunization Status (ECDS)—Combination 3 and Combination 7*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total (3–17 Years)* and *Counseling for Physical Activity—Total (3–17 Years)*
- *Well-Child Visits in the First 30 Months of Life—First 15 Months—Six or More Well-Child Visits*

Opportunities for Improvement and Recommendations

While Molina ACC was successful in reporting valid rates for all AHCCCS-required performance measures, the audit identified the following recommendations for future years’ reporting: **[Quality]**

Recommendations: HSAG recommends that Molina ACC continue to explore the use of additional data sources for capturing race and ethnicity information from members. This could involve investigating supplemental data sources and implementing new collection strategies to ensure more complete member profiles. In addition, HSAG recommends that Molina ACC continue to uphold its adherence to continuous enrollment criteria to maintain compliance with

¹⁰⁰ National Committee for Quality Assurance. Initiation and Engagement of Substance Use Disorder Treatment (IET). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/initiation-and-engagement-of-substance-use-disorder-treatment-iet/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

AHCCCS requirements for performance measure reporting. This includes accurately accounting for members who switch product lines, and those for whom Molina ACC is the second payer.

In the Maternal and Perinatal Care measure group, Molina ACC's performance measure rate for *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, and its *Prenatal and Postpartum Care—Timeliness of Prenatal Care* rate fell at or between the 25th and 49th percentile, indicating an opportunity to increase access to timely postpartum care. Timely and adequate postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.¹⁰¹ **[Quality, Timeliness, Access]**

Recommendations: While Molina ACC conducted a root cause analysis and implemented interventions specific to the *Prenatal and Postpartum Care—Postpartum Care* measure indicator, this rate remained low in MY 2024; therefore, HSAG recommends that Molina ACC continue to implement appropriate interventions to improve performance related to postpartum care. HSAG also recommends that Molina ACC monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care* measure, submitting the results of interventions as required by AHCCCS. HSAG recommends that Molina ACC consider whether there are disparities/SDOH within the Molina ACC population that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that Molina ACC implement appropriate interventions to reduce barriers to care. A few strategies could include providing expanded access appointments outside of business hours to accommodate work schedules or childcare needs. Further, HSAG recommends that Molina ACC identify payment structure types that will incentivize quality care. Bundling payments may cause disincentives for postpartum care, as providers might receive the same payment regardless of whether the member attends the postpartum visit.¹⁰²

In the Behavioral Health measure group, Molina ACC's performance measure rate for *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* fell below the 25th percentile, indicating an opportunity for members to increase adherence to antipsychotics for members with schizophrenia. Schizophrenia is a chronic and disabling psychiatric disorder that requires ongoing treatment and monitoring. Symptoms include hallucinations, illogical thinking, memory impairment, and incoherent speech. Medication nonadherence is common and a major concern in the treatment of schizophrenia. Using antipsychotic medications as prescribed reduces the risk of relapse or hospitalization.¹⁰³ **[Quality]**

¹⁰¹ National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/prenatal-and-postpartum-care-ppc/>. Accessed on: Feb 11, 2026.

¹⁰² Centers for Medicare & Medicaid Services. Lessons Learned about Payment Strategies to Improve Postpartum Care in Medicaid and CHIP. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/postpartum-payment-strategies.pdf>. Accessed on: Feb 11, 2026.

¹⁰³ National Committee for Quality Assurance. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/adherence-to-antipsychotic-medications-for-individuals-with-schizophrenia-saa/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

Recommendation: While Molina ACC conducted a root cause analysis and implemented interventions specific to the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure, this rate remained low in MY 2024. HSAG recommends that Molina ACC continue to monitor and expand on interventions currently in place to improve performance related to the continuous medication treatment for members with a diagnosis of schizophrenia.

In the Care of Acute and Chronic Conditions measure group, Molina ACC's *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total (18–75 Years)* measure rate fell below the 25th percentile, and the *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0%—Total (18–75 Years)* measure rate fell at or between the 25th and 49th percentile, indicating poor control over diabetes. **[Quality]**

Recommendations: Diabetes is a complex group of diseases marked by high blood glucose (blood sugar) due to the body's inability to make or use insulin. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life. With support from healthcare providers, patients can manage their diabetes with self-care, taking medications as instructed, eating a healthy diet, being physically active, and quitting smoking.¹⁰⁴ While Molina ACC conducted a root cause analysis and implemented interventions specific to the *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total (18–75 Years)* measure rate, it remained low in MY 2024; therefore, HSAG recommends that Molina ACC continue to improve performance related to members' control over diabetes. HSAG also recommends that Molina ACC monitor and expand on interventions currently in place to improve performance related to members' HbA1c control. HSAG recommends that Molina ACC consider providing coverage for personal CGMs for Type 1 and Type 2 diabetes. Offering coverage for CGMs coupled with educating providers and patients about this coverage might improve diabetes control. HSAG also recommends that Molina ACC identify whether self-monitoring interventions might be effective, such as EpxDiabetes, which has bidirectional text and call capabilities.¹⁰⁵

In the Pediatric Health measure group, the following Molina ACC performance measure rates fell below the 25th percentile: **[Quality, Access]**

- *Child and Adolescent Well-Care Visits—Total (3–21 Years)*

¹⁰⁴ National Committee for Quality Assurance. Glycemic Status Assessment for Patients with Diabetes (GSD). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/glycemic-status-assessment-for-patients-with-diabetes-gsd/>. Accessed on: Feb 11, 2026.

¹⁰⁵ Xu R, Xing M, Javaherian K, et al. Improving HbA1c with Glucose Self-Monitoring in Diabetic Patients with EpxDiabetes, a Phone Call and Text Message-Based Telemedicine Platform: A Randomized Controlled Trial. *Telemedicine journal and e-health : the official journal of the American Telemedicine Association* vol. 26,6 (2020): 784-793. Available at: <https://read.qxmd.com/read/31621523/improving-hba1c-with-glucose-self-monitoring-in-diabetic-patients-with-epxd diabetes-a-phone-call-and-text-message-based-telemedicine-platform-a-randomized-controlled-trial>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

- Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)*

Recommendations: HSAG recommends that Molina ACC continue to monitor and expand existing interventions to improve performance across the continuum of preventive care, including timely immunizations and routine well-care visits. Additionally, HSAG recommends that Molina ACC review performance improvement strategies implemented by other states, such as addressing data and enrollment delays, improving documentation, and reducing beneficiary access barriers through outreach efforts, including patient portals and targeted phone outreach. Finally, HSAG recommends that Molina ACC continue to identify and assess additional barriers to care and consider stakeholder or beneficiary feedback, such as focus groups, to inform future interventions.

In the Preventive Screening measure group, Molina ACC's performance measure rates for *Cervical Cancer Screening*, *Cervical Cancer Screening (ECDS)*, and *Colorectal Cancer Screening (ECDS)—Total* fell below the 25th percentile, indicating that members were not always receiving timely screening for cervical and colorectal cancer. Early detection reduces the risk of dying from these types of cancer and can lead to a greater range of treatment options and lower healthcare costs. Prolonged delays in screening may lead to delayed diagnoses, poor health consequences, and an increase in cancer disparities among women already experiencing health inequities.¹⁰⁶ **[Quality]**

Recommendations: HSAG recommends that Molina ACC identify disparities or SDOH within the plan's populations that contributed to the preventive screening rates. Upon identification of a root cause, HSAG recommends that Molina ACC implement appropriate interventions to reduce barriers to care. Further, HSAG recommends that Molina ACC provide scheduled reminders, direct providers to send messages to members, and utilize personalized outreach for overdue patients. Communication should be clear and concise and include information on the procedure time. Some of these interventions might include a mobile clinic to conduct the screening, transportation assistance, and adjusting hours for visits to accommodate those with job/childcare concerns.

Validation of Performance Improvement Projects

Back to Basics PIP

In CYE 2025, Molina ACC continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 3, PIP validation activities focused on improvement from the baseline results. Molina ACC submitted Remeasurement 3 performance indicator results and

¹⁰⁶ Centers for Disease Control and Prevention. Sharp Declines in Breast and Cervical Cancer Screening. Available at: <https://archive.cdc.gov/#/details?q=Sharp%20Declines%20in%20Breast%20and%20Cervical%20Cancer%20Screening&start=0&rows=10&url=https://www.cdc.gov/media/releases/2021/p0630-cancer-screenings.html>. Accessed on: Feb 11, 2026.

interventions implemented along with the status of interventions, focus, and rationale for changes to or discontinuation of the interventions.

HSAG conducted an annual validation of the third remeasurement year reflective of CY 2024 (January 1, 2024, through December 31, 2024) using AHCCCS-calculated and validated indicator rates. HSAG evaluated Molina ACC’s performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of [Appendix A. Methodology](#).

Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG’s confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG’s confidence that the PIP’s performance indicator results demonstrated evidence of significant improvement. Table 5-101 displays the overall confidence levels for the Molina ACC *Back to Basics* PIP.

Table 5-101—Molina ACC *Back to Basics* PIP Overall Confidence Levels for Remeasurement 3

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
Molina ACC	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>	100%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Measure Results

Table 5-102 and Table 5-103 provide the *Back to Basics* PIP baseline, Remeasurement Year 1, Remeasurement Year 2, and Remeasurement Year 3 rates for each indicator for Molina ACC.

Table 5-102—Molina ACC *Back to Basics* PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: <i>W30 Rate 1</i>			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2020*	CY 2022	CY 2023	CY 2024
Molina ACC	49.06%	56.04%	63.07%	68.68%

* In CYE 2019, the Molina ACC performance measure rate for indicator 1 had a small denominator, which did not allow for reporting of the measure. CY 2020 served as baseline for indicator 1 for Molina ACC.

Table 5-103—Molina ACC *Back to Basics* PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: <i>WCV</i>			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
Molina ACC	33.85%	39.56%	43.53%	49.54%

Interventions

Table 5-104 presents PIP interventions for Molina ACC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-104—Molina ACC *Back to Basics* PIP Interventions

Contractor	Interventions
Molina ACC	- Contact Center member outreach: Used live call agents to outreach to members and assisted with connection to preventive care services and programs which included scheduling appointments, member check-in calls, and inbound support for program referrals. - Supplemental data sources: Remote access to provider electronic medical records (EMRs), EMR data feeds, and medical record requests for visits completed but not reported. - HEDIS 101: A course designed to equip all Molina employees with the knowledge and skills necessary to understand and effectively implement the HEDIS measures. By training all employees, from frontline staff to management, to support consistent adherence to HEDIS standards, these activities will improve the quality of services, the continuum of care, and health care outcomes. Training included the following objectives: - Understand HEDIS Measures: Introduced employees to the purpose and significance of HEDIS measures in evaluating healthcare quality and performance.

Contractor	Interventions
	• Familiarize with HEDIS Domains: Provided an overview of the various domains covered by HEDIS, such as preventive care, chronic conditions management, and member experience. • Interpret Measure Requirements: Enabled employees to comprehend the high-level technical details of each HEDIS measure, including the numerator, denominator, and exclusions. • Compliance and Best Practices: Emphasized the importance of compliance with HEDIS guidelines and promote best practices for achieving high-quality delivery of care and services. • Quality Improvement Initiatives: Encouraged employees to identify opportunities for QI based on HEDIS results. • Web-based portal for providers in a VBP contract or the Pay for Quality (P4Q) program to access their HEDIS performance scores and gaps in care. • The success of all VBP arrangements rely on data sharing and QI support. Providers need timely and easy-to-understand reporting. VBP partners are provided scorecards outlining the contractual benchmarks and their current performance relative to the established targets. Moving forward, Molina will have this dedicated system to ensure providers have the tools, information, and transparency needed to be successful in a VBP arrangement. • Providers have received individualized 1:1 training to help them become familiar with the platform. During Q4 2024, providers were informed that the system was still in beta as we worked through technical issues and finalized operational functionality. • To ensure continuity and accuracy, we have continued offering manual reports while performance scores and provider-based claim information is integrated. • Website updates: Annually reevaluate and update provider- and member-facing Molina website quality content to ensure appropriateness, accuracy, and relevance of information. Over time, some content on the website may become outdated or irrelevant. Regular evaluations give the opportunity to review and update content, ensuring it remains accurate, valuable, and aligned with current recommendations and guidance. • Provide a WCV Member Incentive for ages 3–7, 8–10, 11–21; with gaps in care will receive a gift card for completing their well-care visits. • Newborn member outreach: Highly collaborative and coordinated approach with real-time provider feedback and follow-up, supportive scheduling, claims verifications, exclusions, and handling of member issues. These activities improved the quality of services, the continuum of care, and health care outcomes by improving member awareness about the importance of timely access to care through strength-based health promotion, supportive scheduling, and appointment reminders.

Contractor	Interventions
	- Provider clinic days: Scheduled days with PCPs for Molina members to access services. During a clinic day, providers see a scheduled roster of Molina members, address their medical concerns, provide diagnoses, prescribe medications, perform procedures, and offer medical advice. Clinic days are an essential part of healthcare delivery, allowing for efficient and focused patient care in a more relaxed and less intense environment compared to when Molina members access care outside the clinic day period. - CLAS: Language access services (oral interpreting by trained and qualified interpreters, American Sign Language, access to telephonic interpreter services, member materials translated into alternative languages and made available in alternate formats); member materials written using Plain Language guidelines and content at a sixth-grade reading level or lower; ongoing cultural competency staff and provider trainings. Members who have access to culturally competent healthcare providers and staff are more likely to attend their appointments and comply with the providers' orders. These interventions helped members understand the conversations happening between them and their providers in the clinical setting, improving health literacy, clinical outcomes, member satisfaction, and member compliance. - WCV “Ride-to-Health” Bicycle Incentive in collaboration with a grocery delivery service: Members ages 8, 9, and 10 with gaps in care will receive a credit for use on the grocery delivery service app to purchase a bicycle and helmet for completing their well-care visits. Additionally, if members would prefer a gift card, members can select a gift card in lieu of a bicycle.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-105 presents strengths, opportunities for improvement, and recommendations for Molina ACC related to the *Back to Basics* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-105—Molina ACC Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: - Molina ACC adhered to acceptable methodology through all phases of the PIP. [Quality, Access] - Molina ACC developed and implemented interventions that led to statistically significant improvement in both indicator outcomes between the baseline and Remeasurement 2, and sustained the statistically significant improvement at Remeasurement 3. [Quality, Access]

Strengths, Opportunities for Improvement, and Recommendations**Opportunities for Improvement and Recommendations**

HSAG identified no opportunities for improvement related to the *Back to Basics* PIP.

Recommendations: Although there were no opportunities for improvement identified, HSAG recommends that Molina ACC apply lessons learned from conducting the *Back to Basics* PIP to future PIPs.

Prenatal and Postpartum Care PIP

In CYE 2025, Molina ACC submitted Remeasurement 1 results for the *Prenatal and Postpartum Care* PIP, which was initiated in CY 2022. Molina ACC submitted Remeasurement 1 performance indicator results and interventions implemented.

HSAG conducted an annual validation of the Remeasurement Year 1 reflective of CY 2024 (January 1, 2024, through December 31, 2024) using AHCCCS-calculated and validated indicator rates. HSAG evaluated Molina ACC's performance indicator results based on an analysis of improvement strategies implemented as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of [Appendix A. Methodology](#).

Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG's confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. Table 5-106 displays the overall confidence levels for the Molina ACC *Prenatal and Postpartum Care* PIP.

Table 5-106—Molina ACC *Prenatal and Postpartum Care* PIP Overall Confidence Levels for Remeasurement 1

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
Molina ACC	<i>High Confidence</i>	100%	100%	<i>Moderate Confidence</i>	67%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Measure Results

Table 5-107 and Table 5-108 provide the *Prenatal and Postpartum Care* PIP baseline and Remeasurement 1 rates for each indicator for Molina ACC.

Table 5-107—Molina ACC *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: <i>Timeliness of Prenatal Care</i>	
	Baseline Year	Remeasurement 1
	CY 2022	CY 2024
Molina ACC	83.70%	84.91%

Table 5-108—Molina ACC *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: <i>Postpartum Care</i>	
	Baseline Year	Remeasurement 1
	CY 2022	CY 2024
Molina ACC	64.23%	70.07%

Interventions

Table 5-109 presents PIP interventions for Molina ACC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-109—Molina ACC Prenatal and Postpartum Care PIP Interventions

Contractor	Interventions
Molina ACC	- Increased engagement with providers with the support of additional Molina staffing. Molina supplied performance measure reporting tip sheets, medical record review and feedback, one-on-one medical record documentation coaching and guidance, provider newsletters and webinars, improved coordination and communication, in-office provider visits, improved coordination and communication, engaging providers in QI meetings to discuss scorecards, gap closure rates, HEDIS measures education, and best practice facilitation. - Comprehensive HEDIS Measures Training Program: Designed to equip all Molina employees with the knowledge and skills necessary to understand and effectively implement HEDIS measures. By training all employees, from Molina health plan staff to management, to support consistent adherence to HEDIS standards, these activities will improve the quality of services, the continuum of care, and health care outcomes. Training will include the following objectives: - Understand HEDIS Measures: Introduce health plan associates to the purpose and significance of HEDIS measures in evaluating health care quality and performance. After training, employees should be able to provide both member and provider HEDIS measure education as needed. - Familiarize with HEDIS Domains: Provide an overview of the various domains covered by HEDIS, such as preventive care, chronic conditions management, and member experience. - Interpret Measure Requirements: Enable employees to comprehend the high-level technical details of each HEDIS measure, including the numerator, denominator, and exclusions. - Compliance and Best Practices: Emphasize the importance of compliance with HEDIS guidelines and promote best practices for achieving high-quality delivery of care and services. - QI Initiatives: Encourage employees to identify opportunities for QI based on HEDIS results. - A portal for providers in a VBP contract or P4Q program to quickly and efficiently access the HEDIS performance scores and gaps in care. - The success of all VBP arrangements relies on data sharing and QI support. Providers need timely and easy-to-understand reporting. VBP partners are

Contractor	Interventions
	provided scorecards outlining the contractual benchmarks and their current performance relative to the established targets. Moving forward, Molina will have this dedicated system to ensure providers have the tools, information, and transparency needed to be successful in a VBP arrangement. – Providers have received individualized 1:1 training to help them become familiar with the platform. During Q4 2024, providers were informed that the system was still in beta as we worked through technical issues and finalized operational functionality. – To ensure continuity and accuracy, we have continued offering manual reports while performance scores and provider-based claim information is integrated. • Website updates: Annually re-evaluate and update provider-facing and member-facing Molina website quality and member incentive to ensure appropriateness, accuracy, and relevance of information. Over time, some content on the website may become outdated or irrelevant. Regular evaluations give the opportunity to review and update content, ensuring it remains accurate, valuable, and aligned with current recommendations and guidance. • Supplemental Data Submission (SDS): Sources include remote access to provider electronic medical records (EMRs), EMR data feeds, and medical record requests for visits completed but not reported. Since medical records and supplemental data sources can be used to augment the completeness of administrative claims data alone, provider education is ongoing during QI meetings and as needed regarding the need to be aligned with the CMS data submission timeline. – SDS is an efficient and effective way to glean member and provider claims/encounter information and data. • Cultural Competency Plan: Delivery of culturally competent services and the provision of language and disability-related access to all enrollees, including limited English proficiency (LEP) persons. Enhancement of current patient focused QI activities and development of educational materials to address specific cultural competencies, ongoing monitoring of access and utilization of services, development of enhanced evidence-based approaches, and strategies to reduce disparities. • Cultural Competency Workgroup: Comprised of representatives of all health plans and LOBs from various departments, such as Quality Improvement, Provider Services, Member Services, Healthcare Services, and Human Resources. – The workgroup meets quarterly to assess Culturally and Linguistically Appropriate Services (CLAS) needs, such as trainings and employee communication. Cultural competency training provided to staff and

Contractor	Interventions
	clinicians in the form of written materials, health plan resources, and integration of cultural competency concepts into provider communications. • A Telehealth (Web and mobile based) prenatal and postpartum program aimed at improving maternal outcomes in the overall population, with a significant focus on minority women. The program leverages technology for member access to physical and behavioral health. – This program allows maternal members to receive telehealth care for follow-up visits, consultations, prescriptions, and diagnostics as needed. Postpartum maternal members benefit from postpartum visit and lactation supports as needed. – Once implemented, the program will be discussed in member outreach attempts; additionally, extensive provider education will be conducted on the telehealth opportunity for gap closure. • Postpartum Incentive—Fresh Funds in collaboration with a grocery delivery service: This program will be based on enrollment in the first trimester and include a Fresh Funds code that will allow members to purchase healthy approved groceries on the grocery delivery app. The program, once the member is enrolled, will include seven months of the benefit in addition to a grocery delivery membership. • High Risk OB (HROB) Program—Outreach calls attempted to all pregnant members; Care management sends a maternity packet to members upon notification of pregnancy. At delivery, any member being followed by care management is provided individualized outreach/encouragement/assistance in accessing timely care, thus increasing member support and compliance with pre- and postnatal care. Post-delivery members are followed up by care management and receive a postpartum letter directing members to their PCP/OBGYN. • Implementation of CLAS Evaluation: Delivery of culturally competent services and the provision of language and disability-related access to all enrollees, including LEP persons and ongoing evaluation of the CLAS Program.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-110 presents strengths, opportunities for improvement, and recommendations for Molina ACC related to the *Prenatal and Postpartum Care* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-110—Molina ACC Strengths, Opportunities for Improvement, and Recommendations Related to the Prenatal and Postpartum Care PIP

Strengths, Opportunities for Improvement, and Recommendations	
Strengths	
HSAG identified the following strengths: Molina ACC developed and implemented measurement systems for interventions that led to improvement in indicator outcomes at Remeasurement 1. [Quality, Access]	
Opportunities for Improvement and Recommendations	
HSAG identified the following opportunities for improvement: - The improvement reported at Remeasurement 1 for both indicators was not statistically significant improvement. [Quality, Access] Recommendations: As the PIP progresses, HSAG recommends that Molina ACC: - Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. - Continue implementing identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. - Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.	

Compliance Reviews

In CYE 2025, HSAG conducted a review of 15 standard areas using monitoring tools to assess and document Molina ACC’s compliance with federal and State requirements. The 15 standards for review were related to the federal Medicaid managed care regulations and associated State requirements. The compliance review included completing a desk review of documents, a review of the Contractor’s NCQA health plan accreditation reports and findings, file reviews, and an on-site review that included reviewing additional documents and conducting interviews with the Contractor.

Results

Table 5-111 presents the compliance review scores for Molina ACC.

Table 5-111—Standards and Compliance Review Scores

Standard #	Standard Name*	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				D	M	NM	NA	
I	Disenrollment: Requirements and Limitations	9	9	0	8	1	0	89%

Standard #	Standard Name*	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				D	M	NM	NA	
II	Member Rights and Member Information	22	22	7	13	2	0	91%
III	Emergency and Poststabilization Services	13	13	0	13	0	0	100%
IV	Availability of Services	12	12	7	4	1	0	92%
V	Assurances of Adequate Capacity and Services	3	3	0	3	0	0	100%
VI	Coordination and Continuity of Care	12	10	7	3	0	2	100%
VII	Coverage and Authorization of Services	30	29	5	20	4	1	86%
VIII	Provider Selection	7	7	2	4	1	0	86%
IX	Confidentiality	3	3	1	2	0	0	100%
X	Grievance and Appeal Systems	38	38	2	33	3	0	92%
XI	Subcontractual Relationships and Delegation	5	5	0	4	1	0	80%
XII	Practice Guidelines	6	6	5	1	0	0	100%
XIII	Health Information Systems	9	9	0	9	0	0	100%
XIV	Quality Assessment and Performance Improvement Program	9	8	2	6	0	1	100%
XV	Program Integrity	15	14	0	14	0	1	100%
Totals		193	188	38	137	13	5	93%

* Table A-7 in [Appendix A. Methodology](#) outlines the compliance review standards and associated federal citations.

D=Deemed, M=Met, NM=Not Met, NA=Not Applicable

Total Elements: The total number of applicable elements in each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that received a score of NA.

Total Compliance Score: The compliance scores were calculated by adding the **Deemed** elements and the **Met** elements and then dividing by the total number of applicable elements.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-112 presents strengths, opportunities for improvement, and recommendations for Molina ACC based on compliance activities conducted in CYE 2025, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-112—Molina ACC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
Molina ACC achieved full compliance in eight of the 15 standards reviewed, demonstrating strengths and adherence to all requirements measured in the following areas:

Strengths, Opportunities for Improvement, and Recommendations
- Assurances of Adequate Capacity and Services [Timeliness, Access] - Confidentiality [Quality] - Coordination and Continuity of Care [Quality, Timeliness, Access] - Emergency and Poststabilization Services [Quality, Timeliness, Access] - Health Information Systems [Quality] - Practice Guidelines [Quality] - Program Integrity [Quality] - Quality Assessment and Performance Improvement Program [Quality, Timeliness]
Opportunities for Improvement and Recommendations
The areas with the greatest opportunity for improvement were related to the following, as these areas received performance scores under 95 percent: - Availability of Services [Timeliness, Access] - Coverage and Authorization of Services [Quality, Timeliness, Access] - Disenrollment: Requirements and Limitations [Quality] - Grievance and Appeal Systems [Quality, Timeliness, Access] - Member Rights and Member Information [Quality, Timeliness, Access] - Provider Selection [Timeliness, Access] - Subcontractual Relationships and Delegation [Quality] Recommendation: HSAG recommends that Molina ACC address the elements scored as <i>Not Met</i> through the CAP process during CYE 2026.

Network Adequacy Validation

ISCA Results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Molina ACC's interpretation of data was accurate.

Table 5-113 summarizes HSAG's validation ratings for Molina ACC by indicator type.

Table 5-113—Summary of Molina ACC’s Validation Ratings by Indicator Type

Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Appointment Availability	100%	0%	0%	0%
Time/Distance	100%	0%	0%	0%

Of the network adequacy indicators assessed, Molina ACC received *High Confidence* for both appointment availability and time/distance indicators. However, there were identified areas for improvement; please refer to the Contractor-specific Strengths, Opportunities for Improvement, and Recommendations section below for more details.

NAV Results

HSAG evaluated Molina ACC’s compliance results with AHCCCS’ time/distance standards by GSA and county. This section presents CYE 2024 S2 validation findings specific to the ACC Program, with one results table for the following:

- GSA: Central GSA: Gila, Maricopa, and Pinal counties

Each Contractor-specific table summarizes validation results containing the percentage of members meeting each time/distance standard by county, with color coding to identify whether the time/distance standard was “*Met*” or “*Not Met*.”

Table 5-114—Time/Distance Validation Results for Molina ACC Central GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^	98.9^Y	100.0^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0^	98.8^Y	100.0^
BHRF	NA	98.5^Y	NA
Cardiologist, Adult	100.0^	100.0^Y	100.0^
Cardiologist, Pediatric	100.0^	100.0^	100.0^
Dentist, Pediatric	100.0	99.1^Y	100.0
Hospital	100.0	99.8^Y	100.0
OB/GYN	100.0	100.0	100.0
Pharmacy	100.0	99.0^Y	100.0
PCP, Adult	100.0^	99.8^Y	100.0^
PCP, Pediatric	100.0^	99.6^	100.0^

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

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

NA indicates results are not applicable to the county.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-115 presents strengths, opportunities for improvement, and recommendations for Molina ACC related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-115—Molina ACC Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: - Molina ACC efficiently maintained the accuracy and completeness of provider information through its quarterly attestation process and contracting with an AI vendor to perform monthly provider data validation. [Access] - Molina ACC met all minimum network requirements for all assigned counties. [Access] Note: Molina ACC provides coverage in the following counties: Gila, Maricopa, and Pinal.
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: Molina ACC should strengthen its methods used to calculate appointment availability indicator results. Molina ACC’s appointment availability methodology did not incorporate a standardized survey script for all callers to consistently and accurately collect responses to align with AHCCCS compliance requirements. [Access] Recommendation: HSAG recommends that Molina ACC revise its appointment availability methodology by developing a standardized survey script that aligns more closely with AHCCCS compliance requirements. HSAG recommends a survey script that uses open-ended questions that solicit the earliest available appointment dates from each provider. The collected responses should then be independently evaluated to determine compliance with AHCCCS standards.

Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)

Results

HSAG administered member experience surveys on AHCCCS’ behalf to members enrolled in Molina ACC’s KidsCare program. Table 5-116 shows the 2025 scores including the overall member experience

ratings, national average comparisons, and program comparisons for each CAHPS measure for both the Molina ACC general child and CCC populations.

Table 5-116—Molina ACC CAHPS Comparative Analyses

Measure	2025 General Child KidsCare	2025 CCC KidsCare
Global Ratings		
<i>Rating of Health Plan</i>	★ 65.0% ⁺	★★★★ 66.7% ⁺
<i>Rating of All Health Care</i>	★★★★★ 80.0% ⁺	★★★★★ 83.3% ⁺
<i>Rating of Personal Doctor</i>	★★★★★ 82.8% ⁺	★★★★★ 100.0% ⁺
<i>Rating of Specialist Seen Most Often</i>	★★★★★ 87.5%	★★★★★ 100.0% ⁺
Composite Measures		
<i>Getting Needed Care</i>	★★ 83.5% ⁺	★★★★★ 91.7% ⁺
<i>Getting Care Quickly</i>	★★ 87.0% ⁺	★★★★★ 100.0% ⁺
<i>How Well Doctors Communicate</i>	★★★★★ 98.9% ⁺ H↑	★★★★★ 100.0% ⁺
<i>Customer Service</i>	★★★★★ 92.9% ⁺	★★★★★ 100.0% ⁺
Individual Item Measure		
<i>Coordination of Care</i>	★★★★★ 90.0%	★★★★★ 100.0% ⁺
CCC Composite Measures and Items		
<i>Access to Specialized Services</i>	NA	★★★★ 80.6% ⁺
<i>FCC: Personal Doctor Who Knows Child</i>	NA	★★★★★ 100.0% ⁺
<i>Coordination of Care for Children with Chronic Conditions</i>	NA	★★★★★ 81.6% ⁺
<i>Access to Prescription Medicines</i>	NA	★★★★★ 100.0% ⁺

Measure	2025 General Child KidsCare	2025 CCC KidsCare
<i>FCC: Getting Needed Information</i>	NA	★★★★★ 100.0% ⁺

Star Assignments Based on Percentiles:

★★★★★ 90th or Above ★★★★★ 75th-89th ★★★★ 50th-74th ★★ 25th-49th ★ Below 25th

↑ Indicates the 2025 score is statistically significantly higher than the KidsCare MCO Aggregate.

↓ Indicates the 2025 score is statistically significantly lower than the KidsCare MCO Aggregate.

H Indicates the 2025 score is statistically significantly higher than the NCQA national average.

L Indicates the 2025 score is statistically significantly lower than the NCQA national average.

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

NA Indicates that this measure is not applicable for the population.

— Indicates that results for this measure are not displayed because too few members responded to the question.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-117 presents strengths, opportunities for improvement, and recommendations for Molina ACC related to CAHPS, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-117—Molina ACC Strengths, Opportunities for Improvement, and Recommendations Related to CAHPS

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: - Molina ACC’s member experience ratings for Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, How Well Doctors Communicate, Customer Service, and Coordination of Care were at or above the 90th percentiles for the general child population. [Quality] - Molina ACC’s member experience ratings for Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, Coordination of Care, FCC: Personal Doctor Who Knows Child, Coordination of Care for Children with Chronic Conditions, Access to Prescription Medicines, and FCC: Getting Needed Information were at or above the 90th percentiles for the CCC population. [Quality, Timeliness, Access] - Molina ACC’s member experience rating for <i>Access to Specialized Services</i> was at or between the 75th and 89th percentiles for the CCC population. [Quality, Access] - Molina ACC’s 2025 score for <i>How Well Doctors Communicate</i> was statistically significantly higher than the NCQA national average and the KidsCare MCO Aggregate for the general child population. [Quality]
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement:

Strengths, Opportunities for Improvement, and Recommendations

- Molina ACC's member experience rating for *Rating of Health Plan* was below the 25th percentile for the general child population. **[Quality]**
- Molina ACC's member experience ratings for *Getting Needed Care* and *Getting Care Quickly* were between the 25th and 49th percentiles for the general child population. **[Quality, Timeliness, Access]**

Recommendation: HSAG recommends that Molina ACC explore what may be driving lower experience scores and develop initiatives designed to improve the quality of, access to, and timeliness of care, including a focus on improving parents'/caretakers' overall experiences with the health plan and getting needed care in a timely manner.

UHCCP ACC

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2025, HSAG evaluated UHCCP ACC’s data system for processing of each data type used for reporting the Contractor’s CY 2024 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that UHCCP ACC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-118 displays HSAG’s PMV findings for each data type reviewed during CYE 2025 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 5-118—CYE 2025 PMV Findings

Data Type	HSAG Findings
Medical Services Data	<i>No identified concerns</i>
Enrollment Data	<i>No identified concerns</i>
Provider Data	<i>No identified concerns</i>
Medical Record Review Process	<i>No identified concerns</i>
Supplemental Data	<i>No identified concerns</i>
Data Integration	<i>CCS, CIS, DEV-CH, HPCMI-AD, IMA, LSC, PPC, and PPC2 measures were not calculated using the AHCCCS-required hybrid methodology and were reported as admin for Title XXI.</i>

Results for Performance Measures

Table 5-119 presents the CY 2023 and CY 2024 UHCCP ACC performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and/or MY 2024. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 5-119—CY 2023 and CY 2024 UHCCP ACC Performance Measure Results

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	82.73% ⁺	85.89% ⁺ [^]	→	★★
Postpartum Care	71.78% ⁺	71.05% ⁺	→	★
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	47.70%	49.66%	→	★
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	63.03% [^]	64.47% [^]	→	★★★★
Effective Continuation Phase Treatment—Total (18+ Years)	44.50%	46.32%	↑	★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	79.81%	82.92% [^]	↑	★★★★
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	42.73% [^]	42.86% [^]	→	★★★★
30-Day Follow-Up—Total (6+ Years)	54.65% [^]	53.65%	→	★★
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	28.49% [^]	31.52% [^]	↑	★★★★
30-Day Follow-Up—Total (13+ Years)	39.47% [^]	41.12% [^]	→	★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	49.48% [^]	46.34% [^]	↓	★★★★
30-Day Follow-Up—Total (6+ Years)	67.02% [^]	63.74% [^]	↓	★★★★
Follow-Up Care for Children Prescribed ADHD Medication (ECDS)				
Initiation Phase (6–12 Years)	—	57.21% [^]	—	★★★★★
Continuation and Maintenance Phase (6–12 Years)	—	65.57% [^]	—	★★★★★
Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	50.31% [^]	48.44% [^]	↓	★★★★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
<i>Engagement of SUD Treatment—Total—Total (13+ Years)</i>	18.63% [^]	18.78% [^]	→	★★★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
<i>Total (1–17 Years)</i>	68.20% [^]	68.74% [^]	→	★★★★★
Use of Opioids at High Dosage				
<i>18+ Years*</i>	10.54%	11.23%	→	★
Care of Acute and Chronic Conditions				
Glycemic Status Assessment for Patients With Diabetes				
<i>Glycemic Status <8.0%—Total (18–75 Years)</i>	58.64% ^{+^}	58.39% ⁺	→	★★
<i>Glycemic Status >9.0%—Total (18–75 Years)*</i>	30.41% ^{+^}	29.44% ^{+^}	→	★★★★
Pediatric Health				
Child and Adolescent Well-Care Visits				
<i>Total (3–21 Years)</i>	50.73%	53.70%	↑	★★
Childhood Immunization Status**				
<i>Combination 3</i>	67.15% ^{+^}	68.13% ^{+^}	→	★★★★
<i>Combination 7</i>	61.31% ^{+^}	62.29% ^{+^}	→	★★★★
<i>Combination 10</i>	29.93% ^{+^}	23.60% ⁺	↓	★★
Childhood Immunization Status (ECDS)**				
<i>Combination 3</i>	—	65.52% [^]	—	★★★★
<i>Combination 7</i>	—	57.85% [^]	—	★★★★★
<i>Combination 10</i>	—	23.45%	—	★★
Developmental Screening in the First Three Years of Life				
<i>Total (0–3 Years)</i>	11.92%	33.09% ⁺	↑	NC [±]
Immunizations for Adolescents**				
<i>Combination 1 (Meningococcal, Tdap)</i>	82.73% ^{+^}	86.13% ^{+^}	→	★★★★
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	40.39% ^{+^}	43.07% ^{+^}	→	★★★★
Immunizations for Adolescents (ECDS)**				
<i>Combination 1 (Meningococcal, Tdap)</i>	—	85.56% [^]	—	★★★★★
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	—	41.94% [^]	—	★★★★★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	—	47.58% [^]	—	★★★★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total (3–17 Years)	78.83% ⁺	86.86% ⁺⁺	↑	★★★★
Counseling for Nutrition—Total (3–17 Years)	48.66% ⁺	74.45% ⁺⁺	↑	★★★★
Counseling for Physical Activity—Total (3–17 Years)	41.12% ⁺	71.78% ⁺⁺	↑	★★★★
Well-Child Visits in the First 30 Months of Life				
First 15 Months—Six or More Well-Child Visits	65.19% [^]	69.20% [^]	↑	★★★★★
15 Months–30 Months—Two or More Well-Child Visits	66.82%	71.37%	↑	★★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	57.41%	61.08%	↑	NC [±]
Breast Cancer Screening (ECDS)				
Total (50–74 Years)	—	60.91% [^]	—	★★★★
Cervical Cancer Screening				
21–64 Years	51.58% ⁺	56.69% ⁺	→	★★
Cervical Cancer Screening (ECDS)				
21–64 Years	—	51.84% [^]	—	★★
Colorectal Cancer Screening (ECDS)				
Total (45–75 Years)	—	48.50% [^]	—	★★★★★
Appropriate Utilization of Services				
Plan All-Cause Readmissions				
Observed/Expected (O/E) Ratio—Total (18–64 Years)*	—	1.0772 [^]	—	★★★★
Oral Health				
Oral Evaluation, Dental Services				
Total (0–20 Years)	—	52.70% [^]	—	★★★★★

* A lower rate indicates better performance for this measure.

** Table A-2 in [Appendix A. Methodology](#) outlines which immunizations are included within each combination.

NC[±] indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

+ Indicates the measure was reported using hybrid methodology.

■ and ^ indicates that the rate met or exceeded the MY 2023 and/or MY 2024 national Medicaid mean.

— Indicates a 2023–2024 comparison is not presented in the CYE 2025 Annual Technical Report because either the CY 2023 rate was not presented in the CYE 2024 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

¹ Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.

² Performance Levels for CY 2024 were based on comparisons of the HEDIS MY 2024 measure rates to NCQA Quality Compass national Medicaid HEDIS MY 2024 benchmarks.

↑ Indicates statistically significant improvement of measure rates.

↓ Indicates statistically significant decline of measure rates.

→ Indicates no statistically significant change in measure rates.

Performance Levels for 2024 represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 5-120 presents strengths, opportunities for improvement, and recommendations for UHCCP ACC related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-120—UHCCP ACC Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Maternal and Perinatal Care measure group, the <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i> UHCCP ACC measure rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. [Quality, Timeliness, Access]
In the Behavioral Health measure group:
- Twelve of 16 UHCCP ACC measure rates (75.00 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. [Quality, Timeliness, Access] <i>Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)</i> <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years</i> <i>Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)</i> <i>Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total (13+ Years) and 30-Day Follow-Up—Total (13+ Years)</i> <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up (6+ Years)</i>

Strengths, Opportunities for Improvement, and Recommendations

- *Follow-Up Care for Children Prescribed ADHD Medication (ECDS)—Initiation Phase (6–12 Years) and Continuation and Maintenance Phase (6–12 Years)*
- *Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total—Total (13+ Years) and Engagement of SUD Treatment—Total—Total (13+ Years)*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)*
- UHCCP ACC’s performance measure rates for *Follow-Up Care for Children Prescribed ADHD Medication (ECDS)—Initiation Phase (6–12 Years)* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)* were at or between the 75th and 89th percentile. Additionally, UHCCP ACC’s performance measure rate for *Follow-Up Care for Children Prescribed ADHD Medication (ECDS)—Continuation and Maintenance Phase (6–12 Years)* was at or above the 90th percentile. **[Quality, Timeliness, Access]**

In the Pediatric Health measure group, 13 of 18 UHCCP ACC performance measure rates (72.22 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. **[Quality, Timeliness, Access]**

- *Childhood Immunization Status—Combination 3 and Combination 7*
- *Childhood Immunization Status (ECDS)—Combination 3 and Combination 7*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)*
- *Immunizations for Adolescents (ECDS)—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total (3–17 Years), Counseling for Nutrition—Total (3–17 Years), and Counseling for Physical Activity—Total (3–17 Years)*
- *Well-Child Visits in the First 30 Months of Life—First 15 Months—Six or More Well-Child Visits*

In the Preventive Screening measure group, UHCCP ACC’s performance measure rates for *Breast Cancer Screening (ECDS)—Total (50–74 Years)*, *Cervical Cancer Screening (ECDS)—21–64 Years*, and *Colorectal Cancer Screening (ECDS)—Total (45–75 Years)* met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. **[Quality]**

In the Oral Health measure group, UHCCP ACC’s performance measure rate for *Oral Evaluation, Dental Services—Total* was at or between the 75th and 89th percentile and met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. **[Access]**

Strengths, Opportunities for Improvement, and Recommendations
Opportunities for Improvement and Recommendations
In the Maternal and Perinatal Health measure group, UHCCP ACC’s performance measure rate for <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i> was between the 25th and 49th percentile; the <i>Prenatal and Postpartum Care—Postpartum Care</i> rate fell below the 25th percentile, indicating an opportunity to increase access to timely postpartum care. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.¹⁰⁷ [Quality, Timeliness, Access] Recommendations: While UHCCP ACC conducted a root cause analysis and implemented interventions specific to the MY 2023 <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i> and <i>Prenatal and Postpartum Care—Postpartum Care</i> rates, these rates remained low in MY 2024; therefore, HSAG recommends that UHCCP ACC continue to monitor and expand existing interventions to improve performance for both measure indicators.
While UHCCP ACC was successful in reporting valid rates for all AHCCCS-required performance measures, the audit identified the following recommendations for future years’ reporting: [Quality] Recommendations: HSAG recommends that UHCCP continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES. Additionally, HSAG recommends that UHCCP continue to uphold its adherence to continuous enrollment criteria to maintain compliance with AHCCCS’ requirements for performance measure reporting. This includes accurately accounting for members who switch product lines, and those for whom UHCCP is the second payer.

Validation of Performance Improvement Projects

Back to Basics PIP

In CYE 2025, UHCCP ACC continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 3, PIP validation activities focused on improvement from the baseline results. UHCCP ACC submitted Remeasurement 3 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes to or discontinuation of the interventions.

HSAG conducted an annual validation of the second remeasurement year reflective of CY 2024 (January 1, 2024, through December 31, 2024) using AHCCCS-calculated and validated indicator rates. HSAG

¹⁰⁷ National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/prenatal-and-postpartum-care-ppc/>. Accessed on: Feb 11, 2026.

evaluated UHCCP ACC’s performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of [Appendix A. Methodology](#).

Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG’s confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG’s confidence that the PIP’s performance indicator results demonstrated evidence of significant improvement. Table 5-121 displays the overall confidence levels for the UHCCP ACC *Back to Basics* PIP.

Table 5-121—UHCCP ACC *Back to Basics* PIP Overall Confidence Levels for Remeasurement 3

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
UHCCP ACC	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>	100%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Measure Results

Table 5-122 and Table 5-123 provide the *Back to Basics* PIP baseline, Remeasurement Year 1, Remeasurement Year 2, and Remeasurement Year 3 rates for each indicator for UHCCP ACC.

Table 5-122—UHCCP ACC *Back to Basics* PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: <i>W30 Rate 1</i>			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
UHCCP ACC	65.62%	61.85%	65.19%	69.20%

Table 5-123—UHCCP ACC *Back to Basics* PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: <i>WCV</i>			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
UHCCP ACC	52.70%	47.44%	50.73%	53.70%

Interventions

Table 5-124 presents PIP interventions for UHCCP ACC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-124—UHCCP ACC *Back to Basics* PIP Interventions

Contractor	Interventions
UHCCP ACC	- The Provider Tip Sheet provided best practices for improving well-care visit rates. Tips included information on how providers can make practice changes to incorporate well-care visits with sick visits. The clinical practice consultants (CPCs) shared the document with providers, along with the Missed Opportunities report, and provided one-to-one education. - Myth vs Fact member letter was mailed to guardians of children in the <i>WCV</i> measure. - CPC Monthly Talking Points: Coordination of Benefits (COB) and secondary claims submissions. - Member Rewards and QM Member Outreach

Strengths, Opportunities for Improvement, and Recommendations

Table 5-125 presents strengths, opportunities for improvement, and recommendations for UHCCP ACC related to the *Back to Basics* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-125—UHCCP ACC Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strength: UHCCP ACC developed and implemented measurement systems for interventions that led to statistically significant improvement in indicator outcomes at Remeasurement 3. [Quality, Access]
Opportunities for Improvement and Recommendations
HSAG identified no opportunities for improvement related to the <i>Back to Basics</i> PIP. Recommendations: Although there were no opportunities for improvement identified, HSAG recommends that UHCCP ACC apply lessons learned from conducting the <i>Back to Basics</i> PIP to future PIPs.

Prenatal and Postpartum Care PIP

In CYE 2025, UHCCP ACC submitted Remeasurement 1 results for the *Prenatal and Postpartum Care* PIP, which was initiated in CY 2022. UHCCP ACC submitted Remeasurement 1 performance indicator results and interventions implemented.

HSAG conducted an annual validation of Remeasurement Year 1 reflective of CY 2024 (January 1, 2024, through December 31, 2024) using AHCCCS-calculated and validated indicator rates. HSAG evaluated UHCCP ACC's performance indicator results based on an analysis of improvement strategies implemented as described in the Validation of Performance Improvement Project section, How Conclusions Were Drawn subsection of [Appendix A. Methodology](#).

Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG's confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. Table 5-126 displays the overall confidence levels for the UHCCP ACC Prenatal and Postpartum Care PIP.

Table 5-126—UHCCP ACC *Prenatal and Postpartum Care* PIP Overall Confidence Levels for Remeasurement 1

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
UHCCP ACC	<i>High Confidence</i>	100%	100%	<i>Moderate Confidence</i>	67%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Measure Results

Table 5-127 and Table 5-128 provide the *Prenatal and Postpartum Care* PIP baseline rates for each indicator for UHCCP ACC.

Table 5-127—UHCCP ACC *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: <i>Timeliness of Prenatal Care</i>	
	Baseline Year	Remeasurement 1
	CY 2022	CY 2024
UHCCP ACC	82.48%	85.89%

Table 5-128—UHCCP ACC *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: <i>Postpartum Care</i>	
	Baseline Year	Remeasurement 1
	CY 2022	CY 2024
UHCCP ACC	67.64%	71.05%

Interventions

Table 5-129 presents PIP interventions for UHCCP ACC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-129—UHCCP ACC Prenatal and Postpartum Care PIP Interventions

Contractor	Interventions
UHCCP ACC	- CPC Monthly Talking Points (Provider Education): Current Procedural Terminology (CPT) II Codes & Healthy First Steps (HFS) and/or member referrals/enrollment in a pregnancy application. UHCCP developed an educational document for providers: Increasing postpartum care visits. - CPT II Code National Report. Tools provide UHCCP insight into provider utilization of CPT II codes by HEDIS measure. CPCs identify providers with low utilization of CPT II codes and use this information to educate and encourage providers to improve their use of CPT II codes to obtain quality measure gap closures. - Maternity Peer Navigation—High-risk pregnant members who are referred by the care management team receive support with identified navigation areas of specialty: Chronically Ill with Comorbidities, Friendly Faces to the ED/Hospital, Mental and Behavioral Health, High Risk Pregnancy, Substance Use, Pre-Term Labor, Insufficient Antenatal Care, Pre-Eclampsia, Homeless, and Postpartum Depression. - Doula Program—According to ACOG, “Published data indicate that one of the most effective tools to improve labor and delivery outcomes is the continuous presence of support personnel, such as a doula.”¹⁰⁸ - Members are rewarded with a gift card for participation in HFS and/or enrollment in a pregnancy application and prenatal and postpartum care visits. - Live Member Outreach Prenatal Calls—UHCCP and the UHC National Team will use a modified/improved version of the HFS Pregnancy Report to identify members with prenatal gaps in care in a timely manner (weekly), and a call center performs outreach to members via live calls and assistance in scheduling their prenatal care appointment.

¹⁰⁸ American College of Obstetricians & Gynecologists. Approaches to Limit Intervention During Labor and Birth. Feb 2019. Available at: [Approaches to Limit Intervention During Labor and Birth | ACOG](#). Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-130 presents strengths, opportunities for improvement, and recommendations for UHCCP ACC related to the *Prenatal and Postpartum Care* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-130—UHCCP ACC Strengths, Opportunities for Improvement, and Recommendations Related to the *Prenatal and Postpartum Care* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: UHCCP ACC developed and implemented measurement systems for interventions that led to improvement in indicator outcomes at Remeasurement 1. [Quality, Access]
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: - The improvement reported at Remeasurement 1 for both indicators was not statistically significant improvement. [Quality, Access] Recommendations: As the PIP progresses, HSAG recommends that UHCCP ACC: - Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. - Continue implementing identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. - Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.

Compliance Reviews

In CYE 2025, HSAG conducted a review of 15 standard areas using monitoring tools to assess and document UHCCP ACC’s compliance with federal and State requirements. The 15 standards for review were related to the federal Medicaid managed care regulations and associated State requirements. The compliance review included completing a desk review of documents, a review of the Contractor’s NCQA health plan accreditation reports and findings, file reviews, and an on-site review that included reviewing additional documents and conducting interviews with the Contractor.

Results

Table 5-131 presents the compliance review scores for UHCCP ACC.

Table 5-131—Standards and Compliance Review Scores

Standard #	Standard Name*	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				D	M	NM	NA	
I	Disenrollment: Requirements and Limitations	9	9	0	8	1	0	89%
II	Member Rights and Member Information	22	22	5	15	2	0	91%
III	Emergency and Poststabilization Services	13	13	0	12	1	0	92%
IV	Availability of Services	12	12	7	5	0	0	100%
V	Assurances of Adequate Capacity and Services	3	3	0	3	0	0	100%
VI	Coordination and Continuity of Care	12	12	10	2	0	0	100%
VII	Coverage and Authorization of Services	30	30	7	19	4	0	87%
VIII	Provider Selection	7	7	2	5	0	0	100%
IX	Confidentiality	3	3	1	2	0	0	100%
X	Grievance and Appeal Systems	38	38	0	32	6	0	84%
XI	Subcontractual Relationships and Delegation	5	5	0	4	1	0	80%
XII	Practice Guidelines	6	6	5	1	0	0	100%
XIII	Health Information Systems	9	9	0	9	0	0	100%
XIV	Quality Assessment and Performance Improvement Program	9	9	2	6	1	0	89%
XV	Program Integrity	15	14	0	14	0	1	100%
Totals		193	192	39	137	16	1	92%

* Table A-7 in [Appendix A. Methodology](#) outlines the compliance review standards and associated federal citations.

D=Deemed, **M**=Met, **NM**=Not Met, **NA**=Not Applicable

Total Elements: The total number of applicable elements in each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that received a score of **NA**.

Total Compliance Score: The compliance scores were calculated by adding the **Deemed** elements and the **Met** elements and then dividing by the total number of applicable elements.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-132 presents strengths, opportunities for improvement, and recommendations for UHCCP ACC based on compliance activities conducted in CYE 2025, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-132—UHCCP ACC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
UHCCP ACC achieved full compliance in eight of the 15 standards reviewed, demonstrating strengths and adherence to all requirements measured in the following areas: - Assurances of Adequate Capacity and Services [Timeliness, Access] - Availability of Services [Timeliness, Access] - Confidentiality [Quality] - Coordination and Continuity of Care [Quality, Timeliness, Access] - Health Information Systems [Quality] - Practice Guidelines [Quality] - Program Integrity [Quality] - Provider Selection [Timeliness, Access]
Opportunities for Improvement and Recommendations
The areas with the greatest opportunity for improvement were related to the following, as these areas received performance scores under 95 percent: - Coverage and Authorization of Services [Quality, Timeliness, Access] - Disenrollment: Requirements and Limitations [Quality] - Emergency and Poststabilization Services [Quality, Timeliness, Access] - Grievance and Appeal Systems [Quality, Timeliness, Access] - Member Rights and Member Information [Quality, Timeliness, Access] - Quality Assessment and Performance Improvement Program [Quality, Timeliness] - Subcontractual Relationships and Delegation [Quality] Recommendation: HSAG recommends that UHCCP ACC address the elements scored as <i>Not Met</i> through the CAP process during CYE 2026.

Network Adequacy Validation

ISCA Results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if UHCCP ACC’s interpretation of data was accurate.

Table 5-133 summarizes HSAG’s validation ratings for UHCCP ACC by indicator type.

Table 5-133—Summary of UHCCP ACC’s Validation Ratings by Indicator Type

Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Appointment Availability	100%	0%	0%	0%
Time/Distance	100%	0%	0%	0%

Of the network adequacy indicators assessed, UHCCP ACC received *High Confidence* for both appointment availability and time/distance indicators. However, there were identified areas for improvement; please refer to the Contractor-specific Strengths, Opportunities for Improvement, and Recommendations section below for more details.

NAV Results

HSAG evaluated UHCCP ACC’s compliance results with AHCCCS’ time/distance standards by GSA and county. This section presents CYE 2024 S2 validation findings specific to the ACC Program, with one results table for each of the following GSAs:

- Central GSA: Gila, Maricopa, and Pinal counties
- South GSA: Pima County

Each Contractor-specific table summarizes validation results containing the percentage of members meeting each time/distance standard by county, with color coding to identify whether the time/distance standard was “*Met*” or “*Not Met*.”

Table 5-134—Time/Distance Validation Results for UHCCP ACC Central GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0 [^]	99.3 [^]	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0 [^]	99.3 [^]	100.0
BHRF	NA	97.1 ^Y	NA
Cardiologist, Adult	100.0 [^]	100.0 ^{^Y}	100.0
Cardiologist, Pediatric	100.0 [^]	100.0 [^]	100.0
Dentist, Pediatric	56.9 ^R	99.2 ^Y	100.0
Hospital	100.0	99.9	100.0
OB/GYN	100.0	100.0	100.0
Pharmacy	100.0	99.0	100.0

Provider Category	Gila	Maricopa	Pinal
PCP, Adult	100.0^	99.7^	100.0
PCP, Pediatric	100.0^	99.7^	100.0

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

Table 5-135—Time/Distance Validation Results for UHCCP ACC South GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Pima
Behavioral Health Outpatient and Integrated Clinic, Adult	97.0^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	97.2^Y
BHRF	90.5Y
Cardiologist, Adult	99.7^
Cardiologist, Pediatric	100.0^Y
Dentist, Pediatric	98.8Y
Hospital	99.5
OB/GYN	99.8Y
Pharmacy	98.5
PCP, Adult	99.8^Y
PCP, Pediatric	99.8^

Y represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-136 presents strengths, opportunities for improvement, and recommendations for UHCCP ACC related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-136—UHCCP ACC Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: - UHCCP ACC performed proactive outreach to maintain provider data accuracy. When providers did not attest or when business rules triggered a demographic verification request, outreach was completed via email or telephone, with up to three attempts. [Access] - UHCCP ACC met all minimum network requirements for all assigned counties except in Gila County. [Access] - UHCCP ACC met all minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; BHRF; Cardiologist, Adult and Pediatric; Hospital; OB/GYN; PCP, Adult and Pediatric; and Pharmacy. [Access] Note: UHCCP ACC provides coverage in the following counties: Gila, Maricopa, Pima, and Pinal.
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: - While UHCCP ACC had a strong outreach process in place, there is an opportunity to strengthen oversight by tracking and trending provider nonresponses to outreach and incorporate this into ongoing monitoring, which would help identify gaps and ensure timely resolution of provider data discrepancies. [Access] Recommendation: HSAG recommends that UHCCP ACC consider tracking and trending provider nonresponses to outreach attempts as part of its oversight process. Monitoring response rates and outcomes would allow UHCCP ACC to identify patterns (e.g., providers or groups with repeated nonresponses) and strengthen timeliness in updating provider records. - HSAG identified an opportunity for UHCCP ACC to strengthen its methods to calculate appointment availability indicator results. UHCCP ACC’s appointment availability survey script incorporated leading questions directed toward providers, accompanied by a predetermined response format designed to align with AHCCCS compliance requirements. [Access] Recommendation: HSAG recommends that UHCCP ACC revise its appointment availability survey script to use open-ended questions that solicit the earliest available appointment dates from each provider. The collected responses should then be independently evaluated to determine compliance with AHCCCS standards. - UHCCP ACC did not meet the minimum network requirements for Dentist, Pediatric. [Access]

Strengths, Opportunities for Improvement, and Recommendations

Recommendation: HSAG recommends that UHCCP ACC maintain current compliance with network standards and continue to address network gaps, as applicable.

Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)

Results

HSAG administered member experience surveys on AHCCCS' behalf to members enrolled in UHCCP ACC's KidsCare program. Table 5-137 shows the 2025 scores including the overall member experience ratings, national average comparisons, and program comparisons for each CAHPS measure for both the UHCCP ACC general child and CCC populations.

Table 5-137—UHCCP ACC CAHPS Comparative Analyses

Measure	2025 General Child KidsCare	2025 CCC KidsCare
Global Ratings		
<i>Rating of Health Plan</i>	★★★★★ 77.3%	★★★★★ 72.9% ⁺
<i>Rating of All Health Care</i>	★★★★ 72.3%	★★★ 61.9% ⁺
<i>Rating of Personal Doctor</i>	★★★★ 76.9%	★★★ 71.6% ⁺
<i>Rating of Specialist Seen Most Often</i>	★★★ 72.3% ⁺	★★★ 71.4% ⁺
Composite Measures		
<i>Getting Needed Care</i>	★★★★★★ 90.3% ⁺ H	★★★★★★ 90.1% ⁺ H
<i>Getting Care Quickly</i>	★★★★ 87.9% ⁺	★★★ 84.0% ⁺
<i>How Well Doctors Communicate</i>	★★★ 93.0%	★★★ 91.8% ⁺
<i>Customer Service</i>	★★★★★ 90.7% ⁺	★★★ 89.1% ⁺
Individual Item Measure		
<i>Coordination of Care</i>	★★★ 79.6% ⁺	★★★ 79.5% ⁺

Measure	2025 General Child KidsCare	2025 CCC KidsCare
CCC Composite Measures and Items		
<i>Access to Specialized Services</i>	NA	★ 59.5% ⁺
<i>FCC: Personal Doctor Who Knows Child</i>	NA	★ 88.4% ⁺
<i>Coordination of Care for Children with Chronic Conditions</i>	NA	★★★★ 78.8% ⁺
<i>Access to Prescription Medicines</i>	NA	★★★★ 92.9% ⁺
<i>FCC: Getting Needed Information</i>	NA	★★ 90.5% ⁺

Star Assignments Based on Percentiles:

★★★★★ 90th or Above ★★★★★ 75th-89th ★★★★ 50th-74th ★★ 25th-49th ★ Below 25th

↑ Indicates the 2025 score is statistically significantly higher than the KidsCare MCO Aggregate.

↓ Indicates the 2025 score is statistically significantly lower than the KidsCare MCO Aggregate.

H Indicates the 2025 score is statistically significantly higher than the NCQA national average.

L Indicates the 2025 score is statistically significantly lower than the NCQA national average.

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

NA Indicates that this measure is not applicable for the population.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-138 presents strengths, opportunities for improvement, and recommendations for UHCCP ACC related to CAHPS, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-138—UHCCP ACC Strengths, Opportunities for Improvement, and Recommendations Related to CAHPS

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: - UHCCP ACC's member experience rating for <i>Getting Needed Care</i> was at or above the 90th percentiles for both the general child and CCC populations. [Quality, Access] - UHCCP ACC's member experience ratings for <i>Rating of Health Plan</i> and <i>Customer Service</i> were at or between the 75th and 89th percentiles for the general child population. [Quality] - UHCCP ACC's member experience ratings for <i>Rating of Health Plan</i>, <i>Coordination of Care for Children with Chronic Conditions</i>, and <i>Access to Prescription Medicines</i> were at or between the 75th and 89th percentiles for the CCC population. [Quality, Access]

Strengths, Opportunities for Improvement, and Recommendations

- UHCCP ACC's 2025 score for *Getting Needed Care* was statistically significantly higher than the NCQA national averages for both the general child and CCC populations. **[Quality, Access]**

Opportunities for Improvement and Recommendations

HSAG identified the following opportunities for improvement:

- UHCCP ACC's member experience rating for *Coordination of Care* was below the 25th percentile for the general child population. **[Quality]**
- UHCCP ACC's member experience ratings for *Getting Care Quickly*, *How Well Doctors Communicate*, *Coordination of Care*, *Access to Specialized Services*, and *FCC: Personal Doctor Who Knows Child* were below the 25th percentiles for the CCC population. **[Quality, Timeliness, Access]**
- UHCCP ACC's member experience ratings for *Rating of Specialist Seen Most Often* and *How Well Doctors Communicate* were between the 25th and 49th percentiles for the general child population. **[Quality]**
- UHCCP ACC's member experience ratings for *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Customer Service*, and *FCC: Getting Needed Information* were between the 25th and 49th percentiles for the CCC population. **[Quality]**

Recommendation: HSAG recommends that UHCCP ACC explore what may be driving lower experience scores and develop initiatives designed to improve the quality of, access to, and timeliness of care, including a focus on improving parents'/caretakers' overall experiences with all health care, their child's personal doctor, how well the personal doctor knows their child, the specialist their child sees most often, the ability of their child's doctor to communicate, coordination of care, customer service, getting care in a timely manner, access to specialized services, and getting all information needed.

6. ACC-RBHA SMI-Designated Program-Level Comparative Results

The ACC-RBHA SMI-Designated Program provides integrated physical and behavioral health services to eligible Medicaid (Title XIX) and KidsCare (Title XXI) CHIP covered members determined to have a serious mental illness (SMI) designation. ACC-RBHA Contractors are also responsible for the provision of crisis services to all individuals, including but not limited to crisis telephone services, community-based mobile crisis teams, and facility-based crisis stabilization services.

This section includes ACC-RBHA SMI-Designated Program-level comparative results for the SMI-Designated population, organized by EQR-related activity, which includes strengths, opportunities for improvement, and HSAG’s recommendations for program-level performance improvement. This section also includes information about the extent to which each Contractor was able to address the prior year’s recommendations for each activity.

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2025, HSAG evaluated each ACC-RBHA SMI-Designated Program Contractor’s data system for processing of each data type used for reporting the Contractor’s CY 2024 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. A summary of these findings by ACC-RBHA Program Contractor is provided in Table 6-1. Table 6-1 also displays whether or not each ACC-RBHA Program Contractor met the assessed IS standards, which demonstrates whether or not the Contractor has effective IS practices and control procedures for data reporting. Additional information about each ACC-RBHA Program Contractor’s general findings for each data type reviewed can be found in [Section 7. ACC-RBHA SMI-Designated Program Contractor-Specific Results](#).

Additional information regarding the CMS EQR Protocol 2 audit requirements, including more information about the levels of scoring, can be found in the Validation of Performance Measures section in [Appendix A. Methodology](#).

Table 6-1—Performance Measure Validation Contractor Comparison:
CMS EQR Protocol 2 Validation Results for ACC-RBHA SMI-Designated Program Contractors

Data Type	AzCH-CCP ACC-RBHA	Care1st ACC-RBHA	Mercy Care ACC-RBHA
Medical Services Data	<i>Met</i>	<i>Met</i>	<i>Met</i>
Enrollment Data	<i>Met</i>	<i>Met</i>	<i>Met</i>
Provider Data	<i>Met</i>	<i>Met</i>	<i>Met</i>

Data Type	AzCH-CCP ACC-RBHA	Care1st ACC-RBHA	Mercy Care ACC-RBHA
Medical Record Review Processes	<i>Met</i>	<i>Met</i>	<i>Met</i>
Supplemental Data	<i>Met</i>	<i>Met</i>	<i>Met</i>
Data Preproduction Processing	<i>Met</i>	<i>Met</i>	<i>Met</i>
Data Integration and Reporting	<i>Met</i>	<i>Met</i>	<i>Met</i>

Results for Performance Measures

Table 6-2 presents the CY 2024 aggregate performance measure results for the ACC-RBHA SMI-Designated Program Contractors. Performance measure rate cells shaded green indicate that aggregate performance met or exceeded NCQA's Quality Compass national Medicaid HMO mean for HEDIS MY 2024. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the national Medicaid mean are shaded green. Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 6-2—CY 2024 Aggregate Performance Measure Results for the ACC-RBHA SMI-Designated Program Contractors

Performance Measure	AzCH-CCP ACC-RBHA	Care1st ACC-RBHA	Mercy Care ACC-RBHA	Aggregate
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
<i>Timeliness of Prenatal Care</i>	74.55% ⁺	NA ⁺⁺	82.51% ⁺	79.41%
<i>Postpartum Care</i>	58.18% ⁺	NA ⁺⁺	77.60% ⁺	71.56%
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
<i>18+ Years</i>	63.42%	68.50% [^]	66.05% [^]	65.65% [^]
Antidepressant Medication Management				
<i>Effective Acute Phase Treatment—Total (18+ Years)</i>	52.68%	64.14% [^]	50.77%	52.74%
<i>Effective Continuation Phase Treatment—Total (18+ Years)</i>	38.00%	47.81% [^]	38.56%	39.44%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
<i>18–64 Years</i>	85.98% [^]	83.52% [^]	86.23% [^]	85.93% [^]

Performance Measure	AzCH–CCP ACC-RBHA	Care1st ACC-RBHA	Mercy Care ACC-RBHA	Aggregate
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	57.21% [^]	70.25% [^]	56.36% [^]	59.09% [^]
30-Day Follow-Up—Total (6+ Years)	72.52% [^]	86.08% [^]	73.54% [^]	75.54% [^]
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	56.83% [^]	47.79% [^]	58.00% [^]	56.40% [^]
30-Day Follow-Up—Total (13+ Years)	71.81% [^]	66.37% [^]	73.27% [^]	72.02% [^]
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	62.11% [^]	60.86% [^]	70.85% [^]	68.38% [^]
30-Day Follow-Up—Total (6+ Years)	79.10% [^]	81.09% [^]	86.38% [^]	84.51% [^]
Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	56.46% [^]	34.06%	54.04% [^]	52.54% [^]
Engagement of SUD Treatment—Total—Total (13+ years)	18.90% [^]	8.07%	17.52% [^]	16.87% [^]
Use of Opioids at High Dosage				
18+ Years*	9.84%	5.11% [^]	8.59%	8.25%
Care of Acute and Chronic Conditions				
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status <8.0%—Total (18–75 Years)	56.21%	44.75%	69.10% ^{+^}	62.94% [^]
Glycemic Status >9.0%—Total (18–75 Years)*	38.12%	49.80%	26.03% ^{+^}	31.91% [^]
Pediatric Health				
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	32.47%	33.82%	35.46%	34.80%
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years) ^N	49.82%	36.10%	44.78%	45.09%
Breast Cancer Screening (ECDS)				
Total (50–74 Years)	49.78%	35.85%	44.78%	45.05%
Cervical Cancer Screening				
21–64 Years	46.04%	32.60%	45.26% ⁺	43.95%

Performance Measure	AzCH–CCP ACC-RBHA	Care1st ACC-RBHA	Mercy Care ACC-RBHA	Aggregate
Cervical Cancer Screening (ECDS)				
21–64 Years	46.09%	32.53%	40.67%	41.17%
Colorectal Cancer Screening (ECDS)				
Total (45–75 Years)	34.57%	29.51%	41.90%	37.95%
Appropriate Utilization of Services				
Plan All-Cause Readmissions				
Observed/Expected (O/E) Ratio—Total (18–64 Years)*	1.7578	1.4756	1.7602	1.7390
Oral Health				
Oral Evaluation, Dental Services				
Total (0–20 Years)	25.44%	20.41%	34.04%	31.45%

* A lower rate indicates better performance for this measure.

+ Indicates the measure was reported using hybrid methodology.

NA⁺⁺ indicates the denominator was too small to report a valid rate, based on the applicable measure specification.

 and ^ indicates that the rate met or exceeded the MY 2024 national Medicaid mean.

^N Measure has no NCQA Medicaid mean for comparison

Table 6-3 presents the CY 2023 and CY 2024 ACC-RBHA SMI-Designated Program aggregate results measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and/or MY 2024. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 6-3—CY 2023 and CY 2024 Performance Measure Aggregate Results for ACC-RBHA Program Contractors

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	69.39%	79.41%	→	★
Postpartum Care	62.24%	71.56%	→	★
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	58.97%	65.65% [^]	↑	★★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	52.30%	52.74%	→	★
Effective Continuation Phase Treatment—Total (18+ Years)	39.04%	39.44%	→	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	86.49% [^]	85.93% [^]	→	★★★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	54.94% [^]	59.09% [^]	→	★★★★★
30-Day Follow-Up—Total (6+ Years)	71.95% [^]	75.54% [^]	→	★★★★★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	50.63% [^]	56.40% [^]	→	★★★★★
30-Day Follow-Up—Total (13+ Years)	69.68% [^]	72.02% [^]	→	★★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	68.99% [^]	68.38% [^]	→	★★★★★
30-Day Follow-Up—Total (6+ Years)	84.01% [^]	84.51% [^]	→	★★★★★
Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	52.38% [^]	52.54% [^]	→	★★★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	15.99% [^]	16.87% [^]	→	★★★
Use of Opioids at High Dosage				
18+ Years*	8.32%	8.25%	→	★
Care of Acute and Chronic Conditions				
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status <8.0%—Total (18–75 Years)	61.27% ^{+^}	62.94% [^]	→	★★★
Glycemic Status >9.0%—Total (18–75 Years*)	30.28% ^{+^}	31.91% [^]	→	★★
Pediatric Health				
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	—	34.80%	—	★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	45.03%	45.09%	→	NC±
Breast Cancer Screening (ECDS)				
Total (50–74 Years)	—	45.05%	—	★
Cervical Cancer Screening				
21–64 Years	42.98% ⁺	43.95%	→	★
Cervical Cancer Screening (ECDS)				
21–64 Years	—	41.17%	—	★
Colorectal Cancer Screening (ECDS)				
Total (45–75 Years)	—	37.95%	—	★★
Appropriate Utilization of Services				
Plan All-Cause Readmissions				
Observed/Expected (O/E) Ratio—Total (18–64 Years)*	—	1.7390	—	★
Oral Health				
Oral Evaluation, Dental Services				
Total (0–20 Years)	—	31.45%	—	★

* A lower rate indicates better performance for this measure.

NC± indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

+ Indicates the measure was reported using hybrid methodology.

■ and ^ indicates that the rate met or exceeded the MY 2023 and/or MY 2024 national Medicaid mean.

— Indicates a 2023–2024 comparison is not presented in the CYE 2025 Annual Technical Report because either the CY 2023 rate was not presented in the CYE 2024 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

¹Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.

²Performance Levels for CY 2024 were based on comparisons of the HEDIS MY 2024 measure rates to the Quality Compass national Medicaid HEDIS MY 2024 benchmarks.

↑ Indicates statistically significant improvement of measure rates.

↓ Indicates statistically significant decline of measure rates.

→ Indicates no statistically significant change in measure rates.

Performance Levels for 2024 represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Table 6-4 highlights the ACC-RBHA SMI-Designated Program Contractors' performance for the current year by measure group. The table illustrates the Contractors' CY 2024 measure rates and their performance relative to the NCQA Quality Compass national Medicaid HEDIS MY 2024 percentiles, where applicable. The performance level star ratings are defined as follows:

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

Table 6-4—CY 2024 National Percentiles Comparison for the ACC-RBHA Program Contractors

Performance Measure	AzCH—CCP ACC-RBHA	Care1st ACC-RBHA	Mercy Care ACC-RBHA	Aggregate
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	★	NC [±]	★	★
Postpartum Care	★	NC [±]	★	★
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	★★	★★★	★★	★★
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	★	★★	★	★
Effective Continuation Phase Treatment—Total (18+ Years)	★	★★★	★	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	★★★★	★★★	★★★★	★★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years) ‡	★★★★	★★★★★	★★★★	★★★★
30-Day Follow-Up—Total (6+ Years) ‡	★★★★	★★★★★	★★★★	★★★★★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years) ‡	★★★★★	★★★★★	★★★★★	★★★★★
30-Day Follow-Up—Total (13+ Years) ‡	★★★★★	★★★★★	★★★★★	★★★★★

Performance Measure	AzCH-CCP ACC-RBHA	Care1st ACC-RBHA	Mercy Care ACC-RBHA	Aggregate
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years) ‡	★★★★★	★★★★★	★★★★★	★★★★★
30-Day Follow-Up—Total (6+ Years) ‡	★★★★★	★★★★★	★★★★★	★★★★★
Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years) ‡	★★★★★	★	★★★★★	★★★★★
Engagement of SUD Treatment—Total—Total (13+ Years) ‡	★★★★	★	★★★★	★★★★
Use of Opioids at High Dosage				
18+ Years*	★	★★	★	★
Care of Acute and Chronic Conditions				
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status <8.0%—Total (18–75 Years)	★★	★	★★★★★	★★★★
Glycemic Status >9.0%—Total (18–75 Years)*	★	★	★★★★★	★★
Pediatric Health				
Child and Adolescent Well-Care Visits				
Total (3–21 Years) ‡	★	★	★	★
Preventive Screening				
Breast Cancer Screening (ECDS)				
Total (50–74 Years)	★	★	★	★
Cervical Cancer Screening				
21–64 Years	★	★	★	★
Cervical Cancer Screening (ECDS)				
21–64 Years	★	★	★	★
Colorectal Cancer Screening (ECDS)				
Total (45–75 Years)	★	★	★★★★	★★
Appropriate Utilization of Services				
Plan All-Cause Readmissions				
Observed/Expected (O/E) Ratio—Total (18–64 Years)*	★	★	★	★

Performance Measure	AzCH–CCP ACC- RBHA	Care1st ACC- RBHA	Mercy Care ACC- RBHA	Aggregate
Oral Health				
Oral Evaluation, Dental Services				
Total (0–20 Years) ‡	★	★	★★	★

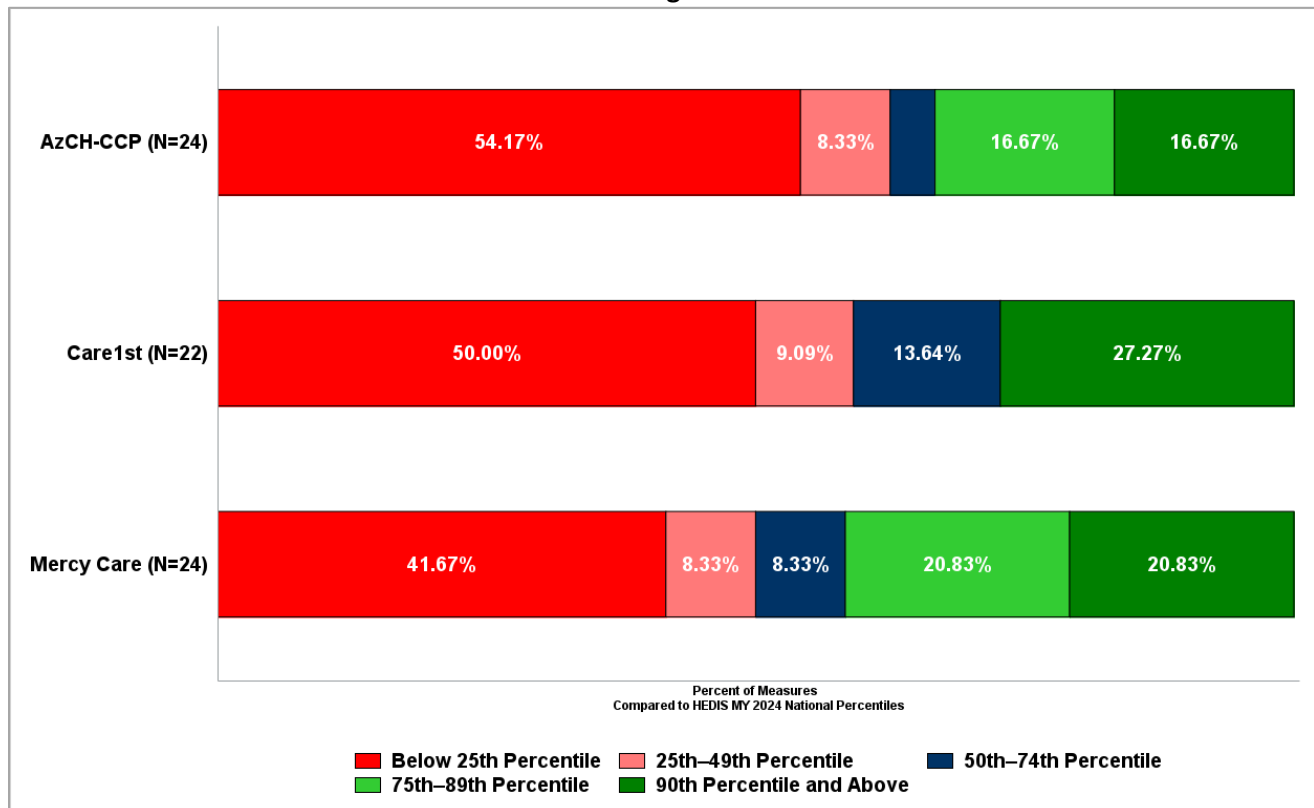
* A lower rate indicates better performance for this measure.

‡ Population ages do not align with those reflected within the Medicaid mean.

NC[±] indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

Figure 6-1 displays the ACC-RBHA SMI-Designated Program Contractors' HEDIS MY 2024 performance compared to NCQA MY 2024 National Percentiles. HSAG analyzed results from 17 performance measures for HEDIS MY 2024 for a total of 24 measure rates. Percentages in the figure may not total 100 percent due to rounding.

**Figure 6-1—Comparison of Measure Rates to HEDIS Medicaid National Percentiles
for ACC-RBHA Program Contractors**



Strengths and Opportunities for Improvement

Table 6-5 presents program-level strengths and opportunities for improvement for the ACC-RBHA SMI-Designated Program as related to performance measures. Please note that the age range for this population does not align with the age stratifications used to calculate the Medicaid mean for some measures. As a result, comparisons between this population's performance and the NCQA Medicaid mean and NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks should be interpreted with caution.

Table 6-5—ACC-RBHA Program Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations	
Strengths	
In the Behavioral Health measure group:	
- The <i>Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)</i> and <i>30-Day Follow-Up—Total (6+ Years)</i> measure rates for all ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. These results indicate that members may be receiving timely follow-up visits for mental illness after an ED visit. Research suggests that follow-up care for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function, and increased compliance with follow-up instructions.¹⁰⁹ [Quality, Timeliness, Access] - The <i>Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)</i> and <i>30-Day Follow-Up—Total (13+ Years)</i> measure rates for all ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Program Aggregate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. These results indicate that members enrolled with these Contractors may be receiving timely follow-up visits for substance use abuse or dependence after an ED visit. Timely follow-up care for individuals with substance use abuse or dependence who were seen in the ED is associated with a reduction in substance use and future ED use and hospital admissions, as well as a decrease in bed days.¹¹⁰ [Quality, Timeliness, Access] - The <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)</i> and <i>30-Day Follow-Up—Total (6+ Years)</i> measure rates for all ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. These results indicate that members enrolled with these Contractors may be receiving timely follow-up visits with a mental health provider after	

¹⁰⁹ National Committee for Quality Assurance. Follow-Up After ED Visit for Substance Use. Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/follow-up-after-emergency-department-visit-for-substance-use-fua/>. Accessed on: Feb 6, 2026.

¹¹⁰ National Committee for Quality Assurance Follow-Up After ED Visit for Mental Illness. Available at: <https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/>. Accessed on: Feb 6, 2026.

Strengths, Opportunities for Improvement, and Recommendations

inpatient discharge for a diagnosis of mental illness or intentional self-harm. Providing follow-up care to patients after a psychiatric hospitalization can improve patient outcomes and decrease the likelihood of rehospitalization and the overall cost of outpatient care.¹¹¹ **[Quality, Timeliness, Access]**

- For the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years* measure, the rates for all ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. This performance indicates that members receiving antipsychotic medications for schizophrenia who were enrolled with these Contractors may be receiving diabetes screenings. Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health, quality of life, and economic outcomes downstream.¹¹² **[Quality]**

Opportunities for Improvement

In the Maternal and Perinatal Care measure group, the rates for two ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Program Aggregate rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean and also fell below the 25th percentile for HEDIS MY 2024. These results indicate that not all women were having timely prenatal and postpartum care visits. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.¹¹³ **[Quality, Timeliness, Access]**

Recommendations: HSAG recommends that these Contractors continue to implement appropriate interventions to improve performance relative to prenatal and postpartum care. HSAG also recommends that the Contractors continue to monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measures. In addition, HSAG recommends that Contractors consider whether there are disparities/social determinants of health (SDOH) within their populations that contributed to lower access to care. A few strategies could include providing expanded access appointments outside of business hours to accommodate work schedules or childcare needs. Further, HSAG recommends that Contractors identify payment structure types that will incentivize quality care. Bundling payments may cause disincentives for postpartum care, as

¹¹¹ National Committee for Quality Assurance. Follow-Up After Hospitalization for Mental Illness. Available at: <https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/>. Accessed on: Feb 6, 2026.

¹¹² National Committee for Quality Assurance. Diabetes and Cardiovascular Disease Screening and Monitoring for People With Schizophrenia or Bipolar Disorder. Available at: <https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/>. Accessed on: Feb 6, 2026.

¹¹³ National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: <https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/>. Accessed on: Feb 6, 2026.

Strengths, Opportunities for Improvement, and Recommendations

providers might receive the same payment regardless of whether the member attends the postpartum visit.¹¹⁴

In the Behavioral Health measure group, for two of three ACC-RBHA Contractors, the performance rates for *Use of Opioids at High Dosage—18+ Years* and the ACC-RBHA SMI-Designated Program Aggregate rate did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean and also fell below the 25th percentile for HEDIS MY 2024. This result indicates a continued opportunity for these Contractors to monitor prescribing and utilization data and to implement interventions to improve care and services around opioid prescribing. The Centers for Disease Control and Prevention (CDC) guidelines on opioid prescribing for chronic, nonmalignant pain recommend the use of “additional precautions” when prescribing dosages ≥ 50 MED and that providers avoid or “carefully justify” increasing dosages ≥ 90 mg MED.¹¹⁵ **[Quality]**

Recommendations: HSAG recommends that these Contractors continue to implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid misuse. HSAG also recommends that Contractors monitor and expand on interventions currently in place to improve performance related to the *Use of Opioids at High Dosage—18+ Years* measure. HSAG also recommends that the Contractors identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts.

In the Preventive Screening measure group:

- The rates for all three ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Program Aggregate rate for *Breast Cancer Screening (ECDS)—Total (50–74 Years)* fell below the NCQA Quality Compass national Medicaid HMO HEDIS MY 2024 25th percentile, indicating that not all women were receiving timely screening for breast cancer. Early detection reduces the risk of dying from this type of cancer and can lead to a greater range of treatment options and lower healthcare costs.¹¹⁶ **[Quality]**
- The rates for all three ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Program Aggregate rate for *Cervical Cancer Screening—21–64 Years* and *Cervical Cancer Screening (ECDS)—21–64 Years* fell below both the NCQA Quality Compass national Medicaid HMO mean and the 25th percentile for HEDIS MY 2024, indicating that not all women were receiving timely screening for cervical cancer. Cervical cancer is one of the most common causes of cancer-related

¹¹⁴ Centers for Medicare & Medicaid Services. Lessons Learned about Payment Strategies to Improve Postpartum Care in Medicaid and CHIP. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/postpartum-payment-strategies.pdf>. Accessed on: Feb 6, 2026.

¹¹⁵ National Committee for Quality Assurance. Use of Opioids at High Dosage (HDO). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/use-of-opioids-at-high-dosage-hdo/>. Accessed on: Feb 11, 2026.

¹¹⁶ National Committee for Quality Assurance. Breast Cancer Screening (BCS-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/breast-cancer-screening-bcs-e/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

deaths for American women; effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate.¹¹⁷ **[Quality]**

Recommendations: HSAG recommends that the ACC-RBHA Contractors leverage the current PIP activities to continue to implement appropriate interventions to improve performance related to preventive screenings. HSAG also recommends that these Contractors monitor and expand on interventions currently in place to improve performance related to the *Breast Cancer Screening* and *Cervical Cancer Screening* measures. Additionally, HSAG recommends that Contractors consider utilizing one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve screenings. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness.

In the Appropriate Utilization of Services measure group, the *Plan All-Cause Readmissions—O/E Ratio—Total (18–64 Years)* measure rates for the ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Program Aggregate rate fell below the NCQA Quality Compass national Medicaid HMO HEDIS MY 2024 25th percentile, indicating that some members experienced unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay. **[Quality]**

Recommendations: While these Contractors initiated efforts to identify best practices for reducing unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay, their rates remained below the 25th percentile for CY 2024. The Contractors also followed the recommendation of conducting a root cause analysis to identify factors contributing to members experiencing unplanned acute readmissions, which should include evaluating that appropriate follow-up care is available to members upon discharge from an acute inpatient admission or observation. However, HSAG recommends that these Contractors continue to follow through on these performance improvement strategies to increase provider and member outreach and improve follow-up care after discharge from an acute inpatient admission or observation. HSAG recommends that Contractors consider reviewing the Re-Engineered Discharge (RED), which has been shown to reduce readmissions and posthospital ED visits.¹¹⁸ Other interventions that might be effective include technology platforms, including artificial intelligence (AI) or machine learning, that can assist the plans in identifying members more at risk of readmission. HSAG recommends that Contractors utilize case management strategies which focus on person-centered techniques, addressing barriers and/or SDOH as needed.

Starting as part of MY 2022 performance measure reporting, RES is required based on NCQA HEDIS specifications. While HSAG did not identify Contractor-specific opportunities to improve RES, all

¹¹⁷ National Committee for Quality Assurance. Cervical Cancer Screening (CCS-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/cervical-cancer-screening-ccs-e/>. Accessed on: Feb 11, 2026.

¹¹⁸ Agency for Healthcare Research and Quality. Re-Engineered Discharge (RED) Toolkit. Available at: <https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool1.html>. Accessed on Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

ACC-RBHA Contractors could benefit from continuing to focus on refining RES reporting where required in keeping with measure specifications. **[Quality]**

Recommendation: HSAG recommends that the ACC-RBHA Contractors explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratifications related to RES. The Contractors should continue to collaborate with AHCCCS to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information.

Validation of Performance Improvement Projects

Preventive Screening PIP

Breast cancer is the most common female cancer in the United States for every major ethnic group, the second most common cause of cancer death in women,¹¹⁹ and accounts for 15 percent of all new cancer diagnoses in the U.S.¹²⁰ Ensuring that all women receive regular breast cancer screening is critically important in disease prevention, early detection, and treatment. In 2019, an estimated 268,600 new cases of invasive breast cancer will be diagnosed among women.¹²¹ Breast cancer screening for women is aimed at identifying breast abnormalities as early as possible, and ideally, before warning signs or symptoms are present when the chances of survival are the highest. Approximately one in eight women (13 percent) will be diagnosed with invasive breast cancer in their lifetime and one in 39 women (3 percent) will die from breast cancer.¹²²

Breast cancer is most frequently diagnosed among women ages 55–64 with the median age of diagnosis at 62 years of age. While there are other factors that affect a woman’s risk of developing breast cancer, age is a primary risk factor. By age 40, the chances are 1 in 68; by age 50 it becomes 1 in 43; by age 60, it is 1 in 29.¹²³ Even if breast cancer incidences cannot be substantially reduced for some women who are at high risk for developing the disease, the risk of death from breast cancer can be reduced by regular screening.

¹¹⁹ Jemal A, Siegel R, Ward E, et al. Cancer Statistics, 2009. *CA: A Cancer Journal for Clinicians*. 2009 Jul-Aug;59(4):225-49. Epub 2009 May 27.

¹²⁰ Howlader N, Noone AM, Krapcho M, et al., eds. SEER Cancer Statistics Review, 1975-2016, National Cancer Institute. Bethesda, MD; 2016.

¹²¹ American Cancer Society. Breast Cancer Facts & Figures 2019-2020. Atlanta: American Cancer Society, Inc. 2019.

¹²² Howlader N, Noone AM, Krapcho M, et al., eds. SEER Cancer Statistics Review, 1975-2016. Bethesda, MD: National Cancer Institute; 2019.

¹²³ National Business Group on Health. 2011. “Pathways to Managing Cancer in the Workplace.” (May 8, 2012).

Cervical cancer is a type of cancer that occurs in the cells of the cervix. All women are at risk for cervical cancer; however, it occurs most often in women over age 30.¹²⁴ According to the American Cancer Society, in the United States for 2020, about 13,800 new cases of invasive cervical cancer will be diagnosed and about 4,290 women will die from the disease.¹²⁵ The risk of developing cervical cancer can be reduced by having screening tests and receiving a vaccine that protects against human papillomavirus (HPV) infection. Women who smoke, had many children, used birth control pills for a long time, or have a human immunodeficiency virus (HIV) infection are at higher risk. Cervical cancer used to be the leading cause of cancer death for women in the United States. However, in the past 40 years, the number of cases and the number of deaths from cervical cancer have decreased significantly due to women getting screened regularly. The HPV vaccine protects against the types of HPV that most often cause cervical, vaginal, and vulvar cancers. However, the most important thing someone can do to help prevent cervical cancer is to have regular screenings starting at the age of 21.

Between 30–50 percent of all cancer cases are preventable.¹²⁶ Breast and cervical cancer screenings increase the chances of detecting certain cancers early, when they might be easier to treat. Prevention offers the most cost-effective long-term strategy for the control of cancer. Policies, programs, and projects should be implemented to raise awareness, to reduce exposure to cancer risk factors, and to ensure that individuals are provided with the information and support needed to participate in preventive screenings.

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Preventive Screening* PIP for the ACC-RBHA population. The objective of the *Preventive Screening* PIP is to increase the number and percentage of breast cancer screenings and cervical cancer screenings.

ACC-RBHA Program-Level Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG's confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. Table 6-6 displays the overall confidence levels for the ACC-RBHA Program *Preventive Screening* PIP.

¹²⁴ Centers for Disease Control and Prevention. (2019, October 18). National Breast and Cervical Cancer Early Detection Program. Available at: https://www.cdc.gov/breast-cervical-cancer-screening/about/?CDC_AAref_Val=https://www.cdc.gov/cancer/nbccedp/about.htm. Accessed on: Feb 12, 2026.

¹²⁵ Fontham ETH, Wolf AMD, Church TR, et al. Cervical Cancer Screening for Individuals at Average Risk: 2020 Guideline Update from the American Cancer Society. *CA Cancer J Clin*. 2020. Available at: <https://doi.org/10.3322/caac.21628>. Accessed on: Feb 12, 2026.

¹²⁶ World Health Organization. (2025). Cancer. Available at: <https://www.who.int/cancer/prevention/en/>. Accessed on: Sep 1, 2025.

Table 6-6—ACC-RBHA Program Preventive Screening PIP Overall Confidence Levels for Remeasurement 3

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
AzCH-CCP ACC-RBHA	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>	100%	100%
Mercy Care ACC-RBHA	<i>High Confidence</i>	100%	100%	<i>Moderate Confidence</i>	33%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

ACC-RBHA Program-Level Measure Results

Table 6-7 and Table 6-8 provide the *Preventive Screening* PIP baseline, Remeasurement Year 1, Remeasurement Year 2, and Remeasurement Year 3 rates for each ACC-RBHA Program Contractor.

Table 6-7—ACC-RBHA Program Contractors' Preventive Screening PIP Comparative Rates for Indicator 1

Contractor	PIP Indicator 1: Breast Cancer Screening			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
AzCH-CCP ACC-RBHA	38.50%	39.09%	46.10%	49.82%
Mercy Care ACC-RBHA	35.82%	41.06%	44.35%	44.78%

Table 6-8—ACC-RBHA Program Contractors' Preventive Screening PIP Comparative Rates for Indicator 2

Contractor	PIP Indicator 2: Cervical Cancer Screening			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
AzCH-CCP ACC-RBHA	43.88%	36.71%	42.18%	46.04%
Mercy Care ACC-RBHA	43.46%	37.35%	38.16%	40.09%

ACC-RBHA Program-Level Interventions

For the *Preventive Screening* PIP, all Contractors provided lists of interventions that were in place for this validation cycle. These lists detailed the identified population, the intervention(s) in place, and whether or not the intervention(s) will be continued. The most common interventions across the ACC-RBHA Program Contractors included targeting members and providers for outreach and education related to breast cancer screenings and cervical cancer screenings. Outreach methods included interactive voice response (IVR), person-to-person, and automated phone calls; text message campaigns; emails; and letters and other mailing materials. Provider and member incentives were used as well as mobile services. Gap in care reports including supplemental data for providers identified members in need of screenings. For further descriptions of each Contractor's interventions, see [Section 7. ACC-RBHA SMI-Designated Program Contractor-Specific Results](#).

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

Table 6-9 presents program-level strengths, opportunities for improvement, and recommendations for the ACC-RBHA Program related to the *Preventive Screening* PIPs.

Table 6-9—ACC-RBHA Program Strengths, Opportunities for Improvement, and Recommendations Related to the *Preventive Screening* PIPs

Strengths, Opportunities for Improvement, and Recommendations	
Strengths	
HSAG identified the following strengths: - Both Contractors adhered to acceptable methodology through all phases of the PIP. [Quality, Access] - Both Contractors were able to measure the effectiveness of interventions and perform accurate statistical testing between the baseline rates and the Remeasurement 3 rates. [Quality, Access] - Both Contractors were able to achieve statistically significant improvement for Performance Indicator 1 (BCS) when comparing the baseline rate to the Remeasurement 3 rate. [Quality, Access]	
Opportunities for Improvement and Recommendations	
HSAG identified no opportunities for improvement. Recommendations: HSAG recommends that the Contractors consider the following for the future PIPs: - Apply lessons learned from the <i>Preventive Screening</i> PIP. - Seek technical assistance from HSAG to understand the CMS EQR Protocol 1 requirements. - Implement interventions with clearly defined intervention effectiveness measures.	

Prenatal and Postpartum Care PIP

According to the CDC, at least 50,000 women in the United States are affected by severe morbidity due to unexpected pregnancy-related health problems. In addition, more than 700 women die each year from pregnancy-related problems or delivery complications. Racial disparities exist among pregnancy-related deaths, as the CDC reports, “American Indian, Alaska Native, and Black women are two to three times more likely to die of pregnancy-related causes than White women.”¹²⁷ Every death related to pregnancy is a tragedy, especially considering the CDC found that four in five of the deaths are preventable.¹²⁸

According to Healthy People, “women’s health before, during, and after pregnancy can have a major impact on infants’ health and well-being.”¹²⁹ Strategies, such as maintaining a healthy lifestyle, receiving proper health care, and adopting healthy habits before and during pregnancy help prevent pregnancy complications and improve health outcomes for women and their babies. In addition, these strategies may assist in promoting infant health, development, and overall well-being.

In CYE 2022 (October 1, 2021, through September 30, 2022), AHCCCS implemented the *Prenatal and Postpartum Care* PIP for the ACC-RBHA population. The objective of the *Prenatal and Postpartum Care* PIP is to improve health outcomes for members and infants. This PIP focuses on increasing the number and percentage of members with live birth deliveries who 1) received a prenatal care visit, and 2) received a postpartum visit.

The ACC-RBHA program-level interventions are presented below.

ACC-RBHA Program-Level Validation Results

Table 6-10 displays the overall confidence levels for the ACC-RBHA Program for the *Prenatal and Postpartum Care* PIP.

¹²⁷ Centers for Disease Control and Prevention. Hear Her Campaign. Pregnancy-Related Deaths in the United States. Available at: <https://www.cdc.gov/hearher/pregnancy-related-deaths/index.html>. Accessed on: Feb 12, 2026.

¹²⁸ Ibid.

¹²⁹ U.S. Department of Health and Human Services. Healthy People 2030. Pregnancy and Childbirth. Available at: <https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth#:~:text=Women's%20health%20before%2C%20during%2C%20and%20after%20pregnancy%20can%20have%20a, and%20to%20have%20healthy%20babies>. Accessed on: Feb 12, 2026.

Table 6-10—ACC-RBHA Program *Prenatal and Postpartum* PIP Overall Confidence Levels for Remeasurement 1

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
AzCH-CCP ACC-RBHA	<i>High Confidence</i>	100%	100%	<i>Moderate Confidence</i>	67%	100%
Mercy Care ACC-RBHA	<i>Low Confidence</i>	90%	92%	<i>Moderate Confidence</i>	67%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

ACC-RBHA Program-Level Measure Results

Table 6-11 and Table 6-12 present indicator rates for each Contractor for the *Prenatal and Postpartum Care* PIP during the baseline year and Remeasurement Year 1.

Table 6-11—ACC-RBHA Program Contractor *Prenatal and Postpartum Care* PIP Comparative Rates for Indicator 1

Contractor	PIP Indicator 1: <i>Timeliness of Prenatal Care</i>	
	Baseline Year	Remeasurement 1
	CY 2022	CY 2024
AzCH-CCP ACC-RBHA	71.43%	74.55%
Mercy Care ACC-RBHA	78.57%	82.51%

Table 6-12—ACC-RBHA Program Contractor *Prenatal and Postpartum Care* PIP Comparative Rates for Indicator 2

Contractor	PIP Indicator 2: <i>Postpartum Care</i>	
	Baseline Year	Remeasurement 1
	CY 2022	CY 2024
AzCH-CCP ACC-RBHA	54.08%	58.18%
Mercy Care ACC-RBHA	73.63%	77.60%

ACC-RBHA Program-Level Interventions

For the *Prenatal and Postpartum Care* PIP, all Contractors provided AHCCCS lists of interventions that were in place for this validation cycle. These lists detailed the identified population, the intervention(s) in place, and whether or not the intervention(s) will be continued. The most common new interventions across ACC-RBHA Program Contractors included data dashboards and technology advancements to support members’ access to care and education materials. The most common continued interventions across the ACC-RBHA Program Contractors included targeting members and providers for outreach and education related to prenatal and postpartum visits. Outreach methods included person-to-person phone calls; text message campaigns; a mobile application; a Web portal; emails; and letters and other mailing materials. Additionally, provider and member incentives were used. Gap in care and NOP reports for providers/strategic partners identified members in need of prenatal and postpartum visits.

For further descriptions of each Contractor’s interventions, see [Section 7. ACC-RBHA SMI-Designated Program Contractor-Specific Results](#).

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

Table 6-13 presents program-level strengths, opportunities for improvement, and recommendations for the ACC-RBHA Program related to the *Prenatal and Postpartum Care* PIPs.

Table 6-13—ACC-RBHA Program Strengths, Opportunities for Improvement, and Recommendations Related to the *Prenatal and Postpartum Care* PIPs

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: The Contractors developed and implemented measurement systems for interventions that led to improvement in both indicators at Remeasurement 1. [Quality, Access]
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: The improvement reported for both indicators was not statistically significant improvement. [Quality]

Strengths, Opportunities for Improvement, and Recommendations

Recommendations: As the PIP progresses, HSAG recommends that the Contractors:

- Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.
- Continue implementing identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.
- Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.

Compliance Reviews

ACC-RBHA Program-Level Results

Prior to AHCCCS contracting with HSAG to conduct compliance reviews, AHCCCS conducted a full compliance review for each Contractor every three years. During CYE 2024, AHCCCS conducted a compliance review of the ACC-RBHA Contractors. In CYE 2025, AHCCCS continued its monitoring of the one ACC-RBHA with outstanding CAPs from the CYE 2024 compliance review. On May 19, 2025, AHCCCS reviewed Mercy Care ACC-RBHA's CAP status and determined that all CAPs had been completed and approved for closure. Results and CAP updates for the ACC-RBHA Contractors are available in [Section 7. ACC-RBHA SMI-Designated Program Contractor-Specific Results](#).

HSAG will conduct compliance reviews of the ACC-RBHA Program Contractors in CYE 2026, which starts a new three-year compliance review cycle.

ACC-RBHA Program-Level Strengths, Opportunities for Improvement, and Recommendations Related to Compliance Review

Table 6-14 presents program-level strengths, opportunities for improvement, and recommendations for the ACC-RBHA Program related to compliance.

Table 6-14—ACC-RBHA Program Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG did not identify any ACC-RBHA SMI-Designated Program strengths related to compliance reviews.

Strengths, Opportunities for Improvement, and Recommendations**Opportunities for Improvement and Recommendations**

HSAG did not identify any opportunities for improvement or recommendations related to compliance reviews.

Network Adequacy Validation

ACC-RBHA Program-Level Results

ISCA Results

HSAG completed an ISCA for each of the ACC-RBHA Program Contractors contracted to deliver services to Medicaid managed care members in Arizona and this report presents findings and validation ratings based on the ACC-RBHA Program Contractors' ISCA and live system demonstrations. For each of the ACC-RBHA Program Contractors assessed, HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data systems. Additionally, HSAG determined that each ACC-RBHA Program Contractor's data collection procedures were acceptable. For the ACC-RBHA Program Contractors that used external delegated entities to complete network adequacy indicator reporting during the reporting period, no issues were identified.

Based on the results of the ISCA's combined with the detailed validation of each NAV indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and whether the ACC-RBHA Program Contractors' interpretation of data was accurate. All ACC-RBHA Program Contractors received *High Confidence* for both appointment availability and time/distance indicators. However, there were identified areas for improvement for some of the ACC-RBHA Program Contractors; please refer to [Section 7. ACC-RBHA SMI-Designated Program Contractor-Specific Results](#).

NAV Results

HSAG's validation of the ACC-RBHA Program Contractors' results showed minor discrepancies between the ACC-RBHA Program Contractors' self-reported ACOM 436 results and HSAG's time/distance calculations for all ACC-RBHA Program Contractors for which data could be compared. While minor differences (i.e., less than 1 percentage point) between HSAG's time/distance calculation results and each ACC-RBHA Program Contractor's time/distance calculation results were common, these findings are most likely attributable to the timing of the input data, software versions used by each ACC-RBHA Program Contractor, or due to a small number of members eligible for inclusion in time/distance calculations for the standard and county.

Table 6-15 summarizes HSAG's assessment of each ACC-RBHA Program Contractor's compliance with AHCCCS' minimum time/distance network standards. A check mark indicates that the ACC-RBHA Program Contractor met the minimum network standard for all assigned counties during the CYE

2024 S2 assessment, and an “X” indicates that the ACC-RBHA Program Contractor did not meet one or more minimum network standards in any assigned county. [Section 7. ACC-RBHA SMI-Designated Program Contractor-Specific Results](#) contains NAV results specific to each ACC-RBHA Program Contractor.

Table 6-15—Summary of CYE 2024 Compliance With Minimum Time/Distance Network Requirements for ACC-RBHA Program Contractors

Minimum Network Requirement	AzCH-CCP ACC-RBHA	Care1st ACC-RBHA	Mercy Care ACC-RBHA
Behavioral Health Outpatient and Integrated Clinic, Adult	✓	✓	✓
Behavioral Health Residential Facility (BHRF)	✓	NA	✓
Cardiologist, Adult	✓	✓	✓
Cardiologist, Pediatric	✓	✓	✓
Crisis Stabilization Facility	X	✓	✓
Dentist, Pediatric	X	✓	✓
Hospital	✓	✓	✓
OB/GYN	✓	✓	✓
PCP, Adult	✓	✓	✓
PCP, Pediatric	✓	✓	✓
Pharmacy	X	✓	✓

NA indicates the time/distance standard does not apply based on the program and county associated with each Contractor.

ACC-RBHA Program Contractors’ performance consistently met the BHRF; Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult and Pediatric; Hospital; OB/GYN; and PCP, Adult and Pediatric standards.

No isolated data issues were identified affecting ACC-RBHA Program Contractors’ compliance with time/distance standards.

As part of the NAV, AHCCCS maintained its feedback process for ACC-RBHA Program Contractors to review and improve the accuracy of their data submissions. Specifically, AHCCCS supplied each ACC-RBHA Program Contractor with a copy of HSAG’s quarterly network adequacy analysis, a copy of the PAT file that HSAG used to conduct the analysis, and a copy of HSAG’s saturation analysis results. When issues were identified, the ACC-RBHA Program Contractors were expected to research the instances and make corrections for future PAT data and/or ACOM 436 submissions.

Overall, the applicable ACC-RBHA Program Contractors met all minimum time/distance network standards in Apache, Coconino, Gila, Graham, Greenlee, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. Based on the CYE 2024 S2 NAV results, Care1st ACC-RBHA and Mercy Care ACC-RBHA met all requirements for all standards in their respective counties.

ACC-RBHA Program Conclusions, Opportunities for Improvement, and Recommendations Related to Network Adequacy Validation

Table 6-16 presents program-level strengths, opportunities for improvement, and recommendations for the ACC-RBHA Program related to NAV.

Table 6-16—ACC-RBHA Program Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths HSAG identified the following strengths: - The ACC-RBHA Program Contractors received <i>High Confidence</i> for both appointment availability and time/distance indicators. [Access] - The applicable ACC-RBHA Program Contractors met all minimum time/distance network standards in Apache, Coconino, Gila, Graham, Greenlee, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. [Access] - The ACC-RBHA Program Contractors’ performance consistently met the BHRF; Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult and Pediatric; Hospital; OB/GYN; and PCP, Adult and Pediatric standards. [Access]
Opportunities for Improvement and Recommendations HSAG identified the following opportunities for improvement: - Based on the NAV results, one ACC-RBHA Program Contractor did not meet the standard for Dentist, Pediatric in more than one county. [Access] Recommendation: HSAG recommends that AHCCCS support the ACC-RBHA Program Contractor in continuing to monitor and maintain its existing provider network coverage as of CYE 2024 S2, with specific attention to ensuring the availability of the following provider category for which one ACC-RBHA Program Contractor did not meet the network requirement in more than one county: - Dentist, Pediatric in Cochise and La Paz counties.

Consumer Assessment of Healthcare Providers and Systems Results

ACC-RBHA SMI-Designated Program Results

HSAG administered member experience surveys on AHCCCS' behalf to adult members enrolled with an ACC-RBHA SMI-Designated Program Contractor from the statewide sample and the ACC-RBHA SMI-Designated Program oversample provided by AHCCCS.

Table 6-17 shows the 2024 and 2025 scores, including the overall members' experience ratings, trend analysis, and national average comparison results for each CAHPS measure for the adult Medicaid population.

Table 6-17—ACC-RBHA SMI-Designated Program CAHPS Comparative Analyses

Measure	Adult Medicaid	
	2024	2025
Global Ratings		
<i>Rating of Health Plan</i>	★ 55.7%	★ 56.2%
<i>Rating of All Health Care</i>	★ 52.2%	★ 47.7% L
<i>Rating of Personal Doctor</i>	★★ 64.6%	★★ 66.9%
<i>Rating of Specialist Seen Most Often</i>	★ 60.0%	★ 61.0%
Composite Measures		
<i>Getting Needed Care</i>	★★ 78.2%	★★ 79.1%
<i>Getting Care Quickly</i>	★★ 76.3%	★★ 80.9%
<i>How Well Doctors Communicate</i>	★ 90.9%	★ 91.4%
<i>Customer Service</i>	★ 83.6%	★ 86.1% ⁺
Individual Item Measure		
<i>Coordination of Care</i>	★★ 84.5%	★ 82.0%

Measure	Adult Medicaid	
	2024	2025
Medical Assistance with Smoking and Tobacco Use Cessation Items		
<i>Advising Smokers and Tobacco Users to Quit</i>	★★★ 75.8%	★★★★★ 78.8%
<i>Discussing Cessation Medications</i>	★★★★★ 61.3%	★★★★★ 58.8%
<i>Discussing Cessation Strategies</i>	★★★ 49.2%	★★★★★ 50.5%

Star Assignments Based on Percentiles:

★★★★★ 90th or Above ★★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

▲ Indicates the 2025 score is statistically significantly higher than the 2024 score.

▼ Indicates the 2025 score is statistically significantly lower than the 2024 score.

H Indicates the 2025 score is statistically significantly higher than the NCQA national average.

L Indicates the 2025 score is statistically significantly lower than the NCQA national average.

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

ACC-RBHA SMI-Designated Program Strengths, Opportunities for Improvement, and Recommendations Related to Consumer Assessment of Healthcare Providers and Systems Results

Table 6-18 presents the ACC-RBHA SMI-Designated Program strengths, opportunities for improvement, and recommendations for the 2025 adult Medicaid SMI-Designated Population CAHPS results.

Table 6-18—ACC-RBHA SMI-Designated Program Strengths, Opportunities for Improvement, and Recommendations Related to CAHPS

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: The ACC-RBHA SMI-Designated Program’s member experience ratings for <i>Advising Smokers and Tobacco Users to Quit</i>, <i>Discussing Cessation Medications</i>, and <i>Discussing Cessation Strategies</i> were at or between the 75th and 89th percentiles for the adult Medicaid population. [Quality]
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: The ACC-RBHA SMI-Designated Program’s member experience ratings for <i>Rating of Health Plan</i>, <i>Rating of All Health Care</i>, <i>Rating of Specialist Seen Most Often</i>, <i>How Well Doctors</i>

Strengths, Opportunities for Improvement, and Recommendations

Communicate, Customer Service, and Coordination of Care were below the 25th percentiles for the adult Medicaid population. **[Quality]**

- The ACC-RBHA SMI-Designated Program's member experience ratings for *Rating of Personal Doctor, Getting Needed Care, and Getting Care Quickly* were at or between the 25th and 49th percentiles for the adult Medicaid population. **[Quality, Timeliness, Access]**

Recommendation: HSAG recommends that the ACC-RBHA SMI-Designated Program Contractors explore what may be driving lower experience scores and develop initiatives designed to improve the quality of and access to care, including a focus on improving adult members' overall experiences with their health plan, overall health care, the specialist they see most often, their doctor's ability to communicate, coordination of care, customer service, and getting needed care in a timely manner.

7. ACC-RBHA SMI-Designated Program Contractor-Specific Results

ACC-RBHA Contractors are responsible for the provision of services for the SMI-Designated population.

This section provides, by ACC-RBHA Contractor, activity-specific strengths, opportunities for improvement, and HSAG’s recommendations for performance improvement. This section also includes information about the extent to which each Contractor was able to address the prior year’s recommendations for each activity, as applicable.

AzCH-CCP ACC-RBHA

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2025, HSAG evaluated AzCH-CCP ACC-RBHA’s data system for processing of each data type used for reporting the Contractor’s CY 2024 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that AzCH-CCP ACC-RBHA followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 7-1 displays HSAG’s PMV findings for each data type reviewed during CYE 2025 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 7-1—CYE 2025 PMV Findings

Data Type	HSAG Findings
Medical Services Data	<i>No identified concerns</i>
Enrollment Data	<i>No identified concerns</i>
Provider Data	<i>No identified concerns</i>
Medical Record Review Process	<i>No identified concerns</i>
Supplemental Data	<i>No identified concerns</i>
Data Integration	<i>No identified concerns</i>

Results for Performance Measures

Table 7-2 presents the CY 2023 and CY 2024 AzCH-CCP ACC-RBHA results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and/or MY 2024. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 7-2—CY 2023 and CY 2024 AzCH-CCP ACC-RBHA Performance Measure Results

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	68.75% ⁺	74.55% ⁺	→	★
Postpartum Care	65.00% ⁺	58.18% ⁺	→	★
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	58.60%	63.42%	↑	★★
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	54.86%	52.68%	→	★
Effective Continuation Phase Treatment—Total (18+ Years)	41.00%	38.00%	→	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	86.13% [^]	85.98% [^]	→	★★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	50.37% [^]	57.21% [^]	→	★★★★
30-Day Follow-Up—Total (6+ Years)	69.49% [^]	72.52% [^]	→	★★★★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	48.04% [^]	56.83% [^]	↑	★★★★★
30-Day Follow-Up—Total (13+ Years)	67.67% [^]	71.81% [^]	→	★★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	63.31% [^]	62.11% [^]	→	★★★★★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
30-Day Follow-Up—Total (6+ Years)	79.49% [^]	79.10% [^]	→	★★★★★
Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	53.53% [^]	56.46% [^]	→	★★★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	18.01% [^]	18.90% [^]	→	★★★
Use of Opioids at High Dosage				
18+ Years*	10.06%	9.84%	→	★
Care of Acute and Chronic Conditions				
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status <8.0%—Total (18–75 Years)	61.31% ^{+^}	56.21%	→	★★
Glycemic Status >9.0%—Total (18–75 Years)*	31.87% ^{+^}	38.12%	↓	★
Pediatric Health				
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	—	32.47%	—	★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	46.10%	49.82%	↑	NC [±]
Breast Cancer Screening (ECDS)				
Total (50–74 Years)	—	49.78%	—	★
Cervical Cancer Screening				
21–64 Years	44.77% ⁺	46.04%	→	★
Cervical Cancer Screening (ECDS)				
21–64 Years	—	46.09%	—	★
Colorectal Cancer Screening (ECDS)				
Total (45–75 Years)	—	34.57%	—	★
Appropriate Utilization of Services				
Plan All-Cause Readmissions				
Observed/Expected (O/E) Ratio—Total (18–64 Years)*	—	1.7578	—	★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Oral Health				
Oral Evaluation, Dental Services				
Total (0–20 Years)	—	25.44%	—	★

* A lower rate indicates better performance for this measure.

NC± indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

+ Indicates the measure was reported using hybrid methodology.

 and ^ indicates that the rate met or exceeded the MY 2023 and/or MY 2024 national Medicaid mean.

— Indicates a 2023–2024 comparison is not presented in the CYE 2025 Annual Technical Report because either the CY 2023 rate was not presented in the CYE 2024 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

¹Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.

²Performance Levels for CY 2024 were based on comparisons of the HEDIS MY 2024 measure rates to NCQA Quality Compass national Medicaid HEDIS MY 2024 benchmarks.

↑ Indicates statistically significant improvement of measure rates.

↓ Indicates statistically significant decline of measure rates.

→ Indicates no statistically significant change in measure rates.

Performance Levels for 2024 represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 7-3 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC-RBHA related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 7-3—AzCH-CCP ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group: - Nine of 13 AzCH-CCP ACC-RBHA measure rates (69.23 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. [Quality, Timeliness, Access] <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years</i>

Strengths, Opportunities for Improvement, and Recommendations

- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)*
- *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years) and 30-Day Follow-Up—Total (13+ Years)*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)*
- *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Total (13+ Years) and Engagement of SUD Treatment—Total—Total (13+ Years)*
- AzCH-CCP ACC-RBHA’s performance measure rates for *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years) and 30-Day Follow-Up—Total (13+ Years)*, *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)*, and *30-Day Follow-Up—Total (6+ Years)* were at or above the 90th percentile, indicating good follow-up and continuity of care provided to members with substance use or mental illness, whether hospitalized or in the ED. **[Quality, Timeliness, Access]**
- AzCH-CCP ACC-RBHA’s performance measure rates for *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years*, *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)*, and *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Total* were at or between the 75th and 89th percentile. **[Quality, Timeliness, Access]**

Opportunities for Improvement and Recommendations

While AzCH-CCP ACC-RBHA was successful in reporting valid rates for all AHCCCS-required performance measures for its ACC population, the audit identified some considerations and recommendations for future years’ reporting. **[Quality]**

Recommendations: HSAG recommends that AzCH-CCP ACC-RBHA continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES. In addition, HSAG recommends that AzCH-CCP ACC-RBHA continue to ensure compliance with AHCCCS requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes AHCCCS requirements for MCO-enrolled members who switch product lines and members for whom AzCH-CCP ACC-RBHA does not hold the primary insurance contract.

In the Behavioral Health measure group:

- AzCH-CCP ACC-RBHA’s performance measure rate for *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years* fell below both the 50th percentile and the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024, indicating opportunities to improve psychotropic medication compliance for members. **[Quality]**

Strengths, Opportunities for Improvement, and Recommendations

Recommendations: Schizophrenia is a chronic and disabling psychiatric disorder that requires ongoing treatment and monitoring. Symptoms include hallucinations, illogical thinking, memory impairment, and incoherent speech. Medication nonadherence is common and a major concern in the treatment of schizophrenia. Using antipsychotic medications as prescribed reduces the risk of relapses or hospitalization.¹³⁰ In a systematic review of medication adherence studies, several interventions that worked were motivational interviewing, daily texts to individuals with schizophrenia, and other medication reminders. Other effective studies utilized Meds-Help, a pharmacy-based intervention, environmental support through home visits and reminders to adhere to medication, a psychoeducational program (Family Schizophrenia Psychoeducation Program [FSPP]), an intervention called Supervised Treatment in Outpatients for Schizophrenia (STOPS) that focuses on the importance of the supervisor's role for patients during treatment, and an individualized occupational therapy (IOT) program.¹³¹ HSAG recommends that AzCH-CCP ACC-RBHA consider implementing one or more of these interventions that have been associated with increased medication adherence for members with schizophrenia. In addition, HSAG recommends that AzCH-CCP ACC-RBHA consider utilizing financial incentives offered to patients with severe mental illness to improve treatment adherence.

- AzCH-CCP ACC-RBHA's performance measure rate for *Use of Opioids at High Dosage—18+ Years* fell below both the 25th percentile and the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024. **[Quality]**

Recommendations: HSAG recommends that AzCH-CCP ACC-RBHA continue to evaluate its opioid prescription monitoring efforts to identify opportunities to enhance oversight of prescription opioids at a high dosage. Through this process, AzCH-CCP ACC-RBHA should determine if it is necessary to deploy additional mechanisms to identify members who may be at high risk for opioid overuse and misuse, as literature suggests there is a correlation between high dosages of prescription opioids and the risk of both fatal and nonfatal overdoses.¹³² AzCH-CCP ACC-RBHA should continue to report any completed prescription opioid monitoring effort enhancements to AHCCCS. HSAG also recommends that AzCH-CCP ACC-RBHA identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts.

¹³⁰ National Committee for Quality Assurance. Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/adherence-to-antipsychotic-medications-for-individuals-with-schizophrenia-saa/>. Accessed on: Feb 11, 2026.

¹³¹ Cahaya N, Kristina SA, Widayanti AW, et al. Interventions to Improve Medication Adherence in People with Schizophrenia: A Systematic Review. Patient preference and adherence vol. 16 2431-2449. 1 Sep. 2022, doi:10.2147/PPA.S378951. Available at: <https://pubmed.ncbi.nlm.nih.gov/36072918/>. Accessed on: Feb 11, 2026.

¹³² National Committee for Quality Assurance. Use of Opioids at High Dosage (HDO). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/use-of-opioids-at-high-dosage-hdo/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

In the Pediatric Health measure group, AzCH-CCP ACC-RBHA's performance measure rate for *Child and Adolescent Well-Care Visits—Total (3–21 Years)* fell below the 25th percentile, indicating opportunities for children and adolescents ages 3–21 years to have at least one well-child visit with a PCP during the measurement year. **[Quality, Access]**

Recommendations: HSAG recommends that AzCH-CCP ACC-RBHA draw as needed from other states' performance improvement initiatives. For instance, as part of a federal performance initiative to improve well-child care, California and Virginia have focused on reducing delays in newborn enrollment data, and Missouri and Texas focused on beneficiary barriers and implemented interventions such as utilizing patient portals and phone outreach. HSAG recommends that plans identify other barriers to care and conduct a focus group on identifying ways to address barriers.¹³³

In the Preventive Screening measure group:

- AzCH-CCP ACC-RBHA's performance measure rate for *Breast Cancer Screening—Total (50–74 Years)*, *Cervical Cancer Screening—21–64 Years*, and *Cervical Cancer Screening (ECDS)—21–64 Years* fell below the 25th percentile, indicating opportunities for members to receive timely screening for breast and cervical cancers. Early detection reduces the risk of dying from these types of cancers and can lead to a greater range of treatment options and lower healthcare costs.¹³⁴ **[Quality]**

Recommendations: While AzCH-CCP ACC-RBHA conducted a root cause analysis and implemented interventions specific to the MY 2022 *Breast Cancer Screening* and *Cervical Cancer Screening* rates, these rates remained low for MY 2023 and MY 2024. HSAG therefore recommends that AzCH-CCP ACC-RBHA continue to implement appropriate interventions to improve performance related to preventive screenings. HSAG also recommends that AzCH-CCP ACC-RBHA monitor and expand on interventions currently in place to improve performance related to the *Breast Cancer Screening* and *Cervical Cancer Screening* measures. HSAG recommends that AzCH-CCP ACC-RBHA consider utilizing one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve cervical cancer screening rates.

- AzCH-CCP ACC-RBHA's performance measure rate for *Colorectal Cancer Screening (ECDS)—Total (45–75 Years)* fell below the 25th percentile, indicating opportunities for members to receive timely screening for colorectal cancer. Screening can be effective for finding precancerous lesions

¹³³ Centers for Medicare & Medicaid Services. Well-Child Care. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html>. Accessed on: Feb 11, 2026.

¹³⁴ National Committee for Quality Assurance. Breast Cancer Screening (BCS-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/breast-cancer-screening-bcs-e/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

(polyps) that could later become malignant, and for detecting early cancers that can be more easily and effectively treated.¹³⁵ **[Quality]**

Recommendations: HSAG recommends that AzCH-CCP ACC-RBHA implement appropriate interventions to improve performance related to preventive screenings. HSAG recommends that AzCH-CCP ACC-RBHA consider utilizing one-on-one interactions with healthcare professionals, which have been shown to improve cancer screening rates. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness.

In the Appropriate Utilization of Services measure group, AzCH-CCP ACC-RBHA's performance measure rate for *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total (18–64 Years)* fell below the 25th percentile, indicating that members who were admitted for an acute inpatient and observation stay might have followed that stay with an unplanned acute readmission for any diagnosis within 30 days.¹³⁶ **[Quality]**

Recommendations: HSAG recommends that AzCH-CCP ACC-RBHA consider reviewing the Re-Engineered Discharge (RED), which has been shown to reduce readmissions and posthospital ED visits.¹³⁷ Other interventions that might be effective include technology platforms, including AI or machine learning, that can assist the plan in identifying members more at risk of readmission. HSAG recommends that AzCH-CCP ACC-RBHA continue to utilize case management strategies that focus on person-centered techniques, addressing barriers and/or SDOH as needed.

Validation of Performance Improvement Projects

Preventive Screening PIP

In CY 2025, AzCH-CCP ACC-RBHA continued the *Preventive Screening* PIP, which was initiated in CYE 2019. As the PIP had progressed through Remeasurement 3, PIP validation activities focused on improvement from the baseline results. AzCH-CCP ACC-RBHA submitted Remeasurement 3 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes to or possible discontinuation of the interventions.

HSAG conducted an annual validation of the third remeasurement year reflective of CY 2024 (January 1, 2024, through December 31, 2024) using AHCCCS-calculated and validated indicator rates. HSAG

¹³⁵ National Committee for Quality Assurance. Colorectal Cancer Screening (COL-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/colorectal-cancer-screening-col-e/>. Accessed on: Feb 11, 2026.

¹³⁶ National Committee for Quality Assurance. Plan All Cause Readmissions. Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/plan-all-cause-readmissions-pcr/>. Accessed on: Feb 11, 2026.

¹³⁷ Agency for Healthcare Research and Quality. Re-Engineered Discharge (RED) Toolkit. Available at: <https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool1.html>. Accessed on Feb 11, 2026.

evaluated AzCH-CCP ACC-RBHA’s performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of [Appendix A. Methodology](#).

Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG’s confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG’s confidence that the PIP’s performance indicator results demonstrated evidence of significant improvement. Table 7-4 displays the overall confidence levels for the AzCH-CCP ACC-RBHA *Preventive Screening* PIP.

Table 7-4—AzCH-CCP ACC-RBHA *Preventive Screening* PIP Overall Confidence Levels for Remeasurement 3

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
AzCH-CCP ACC-RBHA	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>	100%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Measure Results

Table 7-5 and Table 7-6 provide the *Preventive Screening* PIP baseline, Remeasurement Year 1, Remeasurement Year 2, and Remeasurement Year 3 rates for each indicator for AzCH-CCP ACC-RBHA.

Table 7-5—AzCH-CCP ACC-RBHA Preventive Screening PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: <i>Breast Cancer Screening</i>			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
AzCH-CCP ACC-RBHA	38.50%	39.09%	46.10%	49.82%

Table 7-6—AzCH-CCP ACC-RBHA Preventive Screening PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: <i>Cervical Cancer Screening</i>			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
AzCH-CCP ACC-RBHA	43.88%	36.71%	42.18%	46.04%

Interventions

Table 7-7 presents PIP interventions for AzCH-CCP ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 7-7—AzCH-CCP ACC-RBHA Preventive Screening PIP Interventions

Contractor	Intervention
AzCH-CCP ACC-RBHA	• Mobile mammogram events increased access to breast cancer screenings. Please note, these events are open to the public to encourage breast cancer screening education, reduce stigma, and encourage completion. • Promotoras (community health workers [CHWs]/representatives) served those members who are hard to locate in the community by linking them with resources that support health education, access to care, and prevention, as well as addressing any social determinants that may impact their ability to get the services they need. • Education and promotion of the annual MHP member incentive for members who obtained their cervical cancer screening. • Multi-prong member outreach campaigns consisted of mailers and emails that educated and encouraged members to obtain needed screenings and tests. • Quarterly Provider-Facing Motivational Interviewing Training focused on how to address barriers and engage members to complete recommended cancer screenings.

Contractor	Intervention
	• Court Ordered Treatment (COT) Care Gap Initiative—Quarterly gap lists sent to the AzCH-CCP ACC-RBHA COT team for coordination with each COT member's assigned health home. • Gap Closure Program—Members who are already enrolled in the program for psychiatric medication adherence and based on the member's open care gaps, the member was prompted through behavioral prompts and check-ins to explore more information relevant to the member's health and services that are beneficial to the member inclusive of breast cancer and cervical cancer screening. • BHRF Care Gap Initiative. Targeting Integrated SMI/RBHA adult members (ages 18–64) admitted to a BHRF. Collaboration with BHRFs to coordinate preventive care for members within their care reducing transportation issues and increasing communication, education, and access to care. • Population Health Management Workgroup to achieve three main goals: Advance the health of populations, improve member experience, and deliver systemwide transformation to better serve member population health needs. • Care Management and Quality Management Collaboration Workgroup met monthly to coordinate efforts, refine interventions, and identify barriers and opportunities. • Path to 5—provider educational material. • Care Gap Passport, a customized list of open care gaps sent out to members and how to access member rewards per their health plan. • Care Gap Initiative—Coordination with a company that serves high acuity and vulnerable members referred by case management. This initiative seeks to capitalize on the existing outreach to engage members in physical healthcare measures.

Strengths, Opportunities for Improvement, and Recommendations

Table 7-8 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC-RBHA related to the *Preventive Screening* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 7-8—AzCH-CCP ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to the *Preventive Screening* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths:

Strengths, Opportunities for Improvement, and Recommendations
- The Contractor adhered to acceptable methodology through all phases of the PIP and was able to measure the effectiveness of interventions and perform accurate statistical testing between the baseline rate and the Remeasurement 3 rate. [Quality] - The Contractor was able to achieve statistically significant improvement for both indicators when comparing the baseline rate to the Remeasurement 3 rate. [Quality, Access]
Opportunities for Improvement and Recommendations
No opportunities for improvement were identified for the AzCH-CCP ACC-RBHA <i>Preventive Screening</i> PIP. Recommendations: HSAG recommends that AzCH-CCP ACC-RBHA consider the following for the future PIP selected to replace the <i>Preventive Screening</i> PIP: - Apply lessons learned from the <i>Preventive Screening</i> PIP. - Seek technical assistance from HSAG to understand the CMS EQR Protocol 1 PIP requirements. - Implement interventions with clearly defined intervention effectiveness measures that are directly linked to the intervention to assess the effectiveness of each intervention.

Prenatal and Postpartum Care PIP

In CY 2025, AzCH-CCP ACC-RBHA submitted Remeasurement 1 results for the *Prenatal and Postpartum Care* PIP, which was initiated in CY 2022. AzCH-CCP ACC-RBHA submitted Remeasurement 1 performance indicator results and interventions implemented.

HSAG conducted an annual validation of the Remeasurement year 1 reflective of CY 2024 (January 1, 2024, through December 31, 2024) using AHCCCS-calculated and validated indicator rates. HSAG evaluated AzCH-CCP ACC-RBHA's performance indicator results based on an analysis of improvement strategies implemented as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection in [Appendix A. Methodology](#).

Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG's confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. Table 7-9 displays the overall confidence levels for the AzCH-CCP ACC-RBHA *Prenatal and Postpartum Care* PIP.

Table 7-9—AzCH-CCP ACC-RBHA Prenatal and Postpartum Care PIP Overall Confidence Levels for Remeasurement 1

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
AzCH-CCP ACC-RBHA	<i>High Confidence</i>	100%	100%	<i>Moderate Confidence</i>	67%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Measure Results

Table 7-10 and Table 7-11 provide the *Prenatal and Postpartum Care* PIP baseline rates for each indicator for AzCH-CCP ACC-RBHA.

Table 7-10—AzCH-CCP ACC-RBHA Prenatal and Postpartum Care PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: <i>Timeliness of Prenatal Care</i>	
	Baseline Year	Remeasurement 1
	CY 2022	CY 2024
AzCH-CCP ACC-RBHA	71.43%	74.55%

Table 7-11—AzCH-CCP ACC-RBHA Prenatal and Postpartum Care PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: <i>Postpartum Care</i>	
	Baseline Year	Remeasurement 1
	CY 2022	CY 2024
AzCH-CCP ACC-RBHA	54.08%	58.18%

Interventions

Table 7-12 presents PIP interventions for AzCH-CCP ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 7-12—AzCH-CCP ACC-RBHA Prenatal and Postpartum Care PIP Interventions

Contractor	Interventions
AzCH-CCP ACC-RBHA	• Start Smart for Your Baby (SSFB) program, enrollment into care management (until 6 weeks after delivery). • A mobile app that provides a specialized care plan for pregnant and postpartum members with a specialized daily health checklist; providers alerts, care gaps, and progress tracking to CMs; allows for two-way video/text communication with Care Management. • QI and Maternal Child Health (MCH)/CM collaboration to build a proactive outreach program. • Notice of Pregnancy Reports are sent to strategic partners and FQHCs to begin outreach and engage members in a timely manner for prenatal and postpartum care. • The PPC Workgroup is an internal workgroup to include CM, QM, and other departments to increase prenatal/postpartum outcome measures. • A Strategic Partner Collaboration to target members for prenatal care. Strategic partner assists by outreaching, scheduling, and completing in-home or telehealth visits with appropriate physicians. • A self-management tool provides multiple resources, support, and education across a variety of topics inclusive of PPC, is accessible through the member portal. • A mobile application to address loneliness and social isolation, assist in developing a support system, and provide resources to address SDOH. The program also offers the ability to connect with a care coordinator for personalized coordination and resource navigation, along with empathy-led coaching for behavior change and self-reliance. • OB/GYN Specialty Outreach. Provider quality liaisons engage high-volume OB/GYN providers with education and resources to support improvement in both <i>PPC</i> indicator rates. Education and resources include (but are not limited to) NOP forms and where to find them on the AzCH Provider Portal, Path to 5 Stars pages for measures including <i>PPC</i>, the group's performance rates for prenatal/postpartum care, postpartum care gaps for assigned members, coding guidance, information on medical records submission, and appointment availability flyer.

Contractor	Interventions
	- Partner with CHW program in Yuma County to complete face-to-face outreach for high-risk OB members that the health plan has been unable to reach to try to engage them in care management. - Member incentive. Implement new incentive for completing a prenatal visit within the first trimester or 42 days of joining the health plan.

Strengths, Opportunities for Improvement, and Recommendations

Table 7-13 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC-RBHA related to the *Prenatal and Postpartum Care* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 7-13—AzCH-CCP ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to the *Prenatal and Postpartum Care* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: The Contractor implemented and developed measurement systems for interventions that led to improvement in indicator outcomes at Remeasurement 1. [Quality, Access]
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: - The improvement reported for both indicators at Remeasurement 1 was not statistically significant improvement. [Quality, Access] Recommendations: As the PIP progresses, HSAG recommends that AzCH-CCP ACC-RBHA: - Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. - Continue implementing identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. - Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.

Compliance Reviews

AzCH-CCP ACC-RBHA completed all corrective actions in CYE 2024; therefore, no compliance review activities were required in CYE 2025. HSAG will conduct a compliance review of AzCH-CCP ACC-RBHA in 2026, which starts a new three-year compliance review cycle.

Network Adequacy Validation

ISCA Results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if AzCH-CCP ACC-RBHA's interpretation of data was accurate.

Table 7-14 summarizes HSAG's validation ratings for AzCH-CCP ACC-RBHA by indicator type.

Table 7-14—Summary of AzCH-CCP ACC-RBHA's Validation Ratings by Indicator Type

Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Appointment Availability	100%	0%	0%	0%
Time/Distance	100%	0%	0%	0%

Of the network adequacy indicators assessed, AzCH-CCP ACC-RBHA received *High Confidence* for both appointment availability and time/distance indicator types.

NAV Results

HSAG evaluated AzCH-CCP ACC-RBHA's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents CYE 2024 S2 validation findings specific to the ACC-RBHA program, with one results table for the following GSA:

- South GSA: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma counties

Each Contractor-specific table summarizes validation results containing the percentage of members meeting each time/distance standard by county, with color coding to identify whether the time/distance standard was “Met” or “Not Met.”

Table 7-15—Time/Distance Validation Results for AzCH-CCP ACC-RBHA South GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Cochise	Graham	Greenlee	La Paz	Pima	Santa Cruz	Yuma
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0 [^]	100.0 [^]	100.0	100.0 [^]	98.1 ^{^Y}	100.0 [^]	100.0 [^]
BHRF	NA	NA	NA	NA	94.0	NA	NA
Cardiologist, Adult	100.0 [^]	100.0 [^]	100.0	100.0 [^]	99.5 [^]	100.0 [^]	100.0 [^]
Cardiologist, Pediatric	100.0 [^]	100.0 ^{*^}	NR	100.0 ^{*^}	100.0 [^]	100.0 ^{*^Y}	100.0 [^]
Crisis Stabilization Facility	99.8 ^Y	100.0 ^Y	100.0	89.6 ^R	98.0 ^Y	100.0	99.7 ^Y

Provider Category	Cochise	Graham	Greenlee	La Paz	Pima	Santa Cruz	Yuma
Dentist, Pediatric	80.0 ^R	100.0*	NR	50.0* ^R	99.2	100.0* ^Y	100.0
Hospital	100.0	100.0	100.0	100.0	99.7 ^Y	100.0	100.0
OB/GYN	100.0	100.0	100.0*	100.0	99.8 ^Y	100.0	100.0
Pharmacy	99.5 ^Y	100.0 ^Y	100.0	88.1 ^R	98.8 ^Y	100.0	99.6
PCP, Adult	99.8 [^]	100.0 ^{^Y}	100.0 [^]	100.0 [^]	99.9 [^]	100.0 [^]	99.6 [^]
PCP, Pediatric	100.0 [^]	100.0* [^]	NR [^]	100.0* [^]	99.2 [^]	100.0* ^{^Y}	100.0 [^]

Y	represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
R	represents time/distance standard results that do not meet the compliance standard based on HSAG's results.
NR	represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.
* indicates that fewer than 10 members were included in the denominator of HSAG's results.	
^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.	
NA indicates results are not applicable to the county.	

Strengths, Opportunities for Improvement, and Recommendations

Table 7-16 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC-RBHA related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 7-16—AzCH-CCP ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: - AzCH-CCP ACC-RBHA established robust processes to ensure provider data remain accurate and up to date. These processes include several key initiatives, such as ongoing collaboration with providers through on-site visits; use of the business intelligence tools; the biannual Preferences and Trends report; and multiple internal quality reports used to monitor, identify errors, and assess the accuracy of provider data. Additionally, AzCH-CCP ACC RBHA has partnered with an external vendor to conduct quarterly reviews of key demographic data, further supporting the integrity and accuracy of provider data elements. [Access] - AzCH-CCP ACC-RBHA met all the minimum network requirements for all assigned counties except in Cochise and La Paz counties. [Access] - AzCH-CCP ACC-RBHA met all minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Adult; BHRF; Cardiologist, Adult and Pediatric; Hospital; OB/GYN; and PCP, Adult and Pediatric. [Access]

Strengths, Opportunities for Improvement, and Recommendations
Note: AzCH-CCP ACC-RBHA provides coverage in the following counties: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma.
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: AzCH-CCP ACC-RBHA did not meet the minimum network requirements for Crisis Stabilization Facility; Dentist, Pediatric; and Pharmacy. [Access] Recommendation: HSAG recommends that AzCH-CCP ACC-RBHA maintain current compliance with network standards and continue to address network gaps, as applicable.

Consumer Assessment of Healthcare Providers and Systems Results

HSAG administered member experience surveys on AHCCCS' behalf to adult members enrolled with an ACC-RBHA SMI-Designated Program Contractor from the statewide sample and the ACC-RBHA SMI-Designated Program oversample provided by AHCCCS. Based on the results in [Section 6—ACC-RBHA SMI-Designated Program-Level Comparative Results](#), HSAG provides AzCH-CCP ACC-RBHA opportunities for improvement and recommendations on how the Contractor can improve member experience in the table below.

Table 7-17—AzCH-CCP ACC-RBHA Opportunities for Improvement and Recommendations Related to CAHPS

Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: - The ACC-RBHA SMI-Designated Program's member experience ratings for <i>Rating of Health Plan, Rating of All Health Care, Rating of Specialist Seen Most Often, How Well Doctors Communicate, Customer Service, and Coordination of Care</i> were below the 25th percentiles for the adult Medicaid population. [Quality] - The ACC-RBHA SMI-Designated Program's member experience ratings for <i>Rating of Personal Doctor, Getting Needed Care, and Getting Care Quickly</i> were at or between the 25th and 49th percentiles for the adult Medicaid population. [Quality, Timeliness, Access] Recommendation: HSAG recommends that AzCH-CCP ACC-RBHA explore what may be driving lower experience scores and develop initiatives designed to improve the quality of and access to care, including a focus on improving adult members' overall experiences with their health plan, overall health care, the specialist they see most often, their doctor's ability to communicate, coordination of care, customer service, and getting needed care in a timely manner.

Care1st ACC-RBHA

As of October 1, 2024, Care1st ACC-RBHA merged with AzCH-CCP ACC-RBHA. While Care1st ACC-RBHA no longer held a contract with AHCCCS during CYE 2025, it was required to participate in EQR activities related to CY 2024 performance measure data and NAV data. Results, strengths, and opportunities for improvement are presented below for PMV and NAV. Care1st ACC-RBHA was not subject to OR, PIPs, or CAHPS activities.

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2025, HSAG evaluated Care1st ACC-RBHA's data system for processing of each data type used for reporting the Contractor's CY 2024 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that Care1st ACC-RBHA followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 7-18 displays HSAG's PMV findings for each data type reviewed during CYE 2025 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 7-18—CYE 2025 PMV Findings

Data Type	HSAG Findings
Medical Services Data	<i>No identified concerns</i>
Enrollment Data	<i>No identified concerns</i>
Provider Data	<i>No identified concerns</i>
Medical Record Review Process	<i>No identified concerns</i>
Supplemental Data	<i>No identified concerns</i>
Data Integration	<i>No identified concerns</i>

Results for Performance Measures

Since Care1st ACC-RBHA merged with AzCH-CCP ACC-RBHA, Care1st ACC-RBHA performance measure rates and the combined AzCH-CCP ACC-RBHA/Care1st ACC-RBHA performance measure rates are reflective of the following conditions:

- Continuous enrollment aligned with the measure technical specifications and AHCCCS guidance.

- Members that transferred to AzCH-CCP ACC-RBHA as of October 1, 2024, were considered continuously enrolled in Care1st ACC-RBHA for the purposes of measure calculation (e.g., nine months in Care1st ACC-RBHA and three months in AzCH-CCP ACC-RBHA for measures that require a full year of continuous enrollment).

The Combined AzCH-CCP ACC-RBHA/Care1st ACC-RBHA performance measure rates are located in [Appendix B. CY 2024 Combined Performance Measure Results for AzCH-CCP ACC-RBHA and Care1st ACC-RBHA](#).

Table 7-19 presents the CY 2023 and CY 2024 Care1st ACC-RBHA results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and/or MY 2024. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 7-19—CY 2023 and CY 2024 Care1st ACC-RBHA Performance Measure Results

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	60.86%	68.50%^	↑	★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	63.29%^	64.14%^	→	★★
Effective Continuation Phase Treatment—Total (18+ Years)	50.63%^	47.81%^	→	★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	77.06%	83.52%^	↑	★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	59.74%^	70.25%^	→	★★★★★
30-Day Follow-Up—Total (6+ Years)	74.68%^	86.08%^	↑	★★★★★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	45.00%^	47.79%^	→	★★★★★
30-Day Follow-Up—Total (13+ Years)	67.86%^	66.37%^	→	★★★★★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	59.58% [^]	60.86% [^]	→	★★★★★
30-Day Follow-Up—Total (6+ Years)	77.68% [^]	81.09% [^]	→	★★★★★
Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	35.03%	34.06%	→	★
Engagement of SUD Treatment—Total—Total (13+ Years)	7.22%	8.07%	→	★
Use of Opioids at High Dosage				
18+ Years*	4.39% [^]	5.11% [^]	→	★★
Care of Acute and Chronic Conditions				
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status <8.0%—Total (18–75 Years)	47.69% ⁺	44.75%	→	★
Glycemic Status >9.0%—Total (18–75 Years)*	44.04% ⁺	49.80%	→	★
Pediatric Health				
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	—	33.82%	—	★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	50.00%	36.10%	→	NC [±]
Breast Cancer Screening (ECDS)				
Total (50–74 Years)	—	35.85%	—	★
Cervical Cancer Screening				
21–64 Years	32.85% ⁺	32.60%	→	★
Cervical Cancer Screening (ECDS)				
21–64 Years	—	32.53%	—	★
Colorectal Cancer Screening (ECDS)				
Total (45–75 Years)	—	29.51%	—	★
Appropriate Utilization of Services				
Plan All-Cause Readmissions				
Observed/Expected (O/E) Ratio—Total (18–64 Years)*	—	1.4756	—	★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Oral Health				
Oral Evaluation, Dental Services				
Total (0–20 Years)	—	20.41%	—	★

* A lower rate indicates better performance for this measure.

NC± indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

+ Indicates the measure was reported using hybrid methodology.

NA⁺⁺ indicates the denominator was too small to report a valid rate, based on the applicable measure specification.

■ and ^ indicates that the rate met or exceeded the MY 2023 and/or MY 2024 national Medicaid mean.

— Indicates a 2023–2024 comparison is not presented in the CYE 2025 Annual Technical Report because either the CY 2023 rate was not presented in the CYE 2024 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

¹Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.

²Performance Levels for CY 2024 were based on comparisons of the HEDIS MY 2024 measure rates to NCQA Quality Compass national Medicaid HEDIS MY 2024 benchmarks.

↑ Indicates statistically significant improvement of measure rates.

↓ Indicates statistically significant decline of measure rates.

→ Indicates no statistically significant change in measure rates.

Performance Levels for 2024 represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Strengths and Opportunities for Improvement

Table 7-20 presents strengths and opportunities for improvement for Care1st ACC-RBHA related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement. As of October 1, 2024, Care1st ACC-RBHA no longer holds an AHCCCS contract; therefore, the information in this section does not include recommendations.

Table 7-20—Care1st ACC-RBHA Strengths and Opportunities for Improvement Related to Performance Measures

Strengths and Opportunities for Improvement
Strengths
In the Behavioral Health measure group: - Eleven of 13 Care1st ACC-RBHA measure rates (84.62 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. [Quality, Timeliness, Access] <i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years</i>

Strengths and Opportunities for Improvement

- *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years) and Effective Continuation Phase Treatment—Total (18+ Years)*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)*
- *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years) and 30-Day Follow-Up—Total (13+ Years)*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)*
- *Use of Opioids at High Dosage—18+ Years*
- Care1st ACC-RBHA’s performance measure rates for *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years*, *Antidepressant Medication Management—Effective Continuation Phase Treatment—Total (18+ Years)*, and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years* were at or between the 50th and 74th percentile. **[Quality, Timeliness, Access]**
- Care1st ACC-RBHA’s performance measure rates for *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)*, *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years) and 30-Day Follow-Up—Total (13+ Years)*, *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)* were at or above the 90th percentile. **[Quality, Timeliness, Access]**

Opportunities for Improvement

In the Behavioral Health measure group, Care1st ACC-RBHA’s performance measure rates for *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* and *Engagement of SUD Treatment—Total—Total (13+ Years)* fell below the 25th percentile. These results provide an opportunity for Care1st ACC-RBHA to implement interventions to improve care and services around SUD treatments. **[Quality]**

In the Care of Acute and Chronic Conditions measure group, Care1st ACC-RBHA’s performance measure rates for *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total (18–75 Years)* and *Glycemic Status >9.0%—Total (18–75 Years)* fell below the 25th percentile, indicating poor control over diabetes. **[Quality]**

In the Preventive Screening measure group:

- Care1st ACC-RBHA’s performance measure rates for *Breast Cancer Screening (ECDS)—Total (50–74 Years)*, *Cervical Cancer Screening—21–64 Years*, and *Cervical Cancer Screening (ECDS)—21–64 Years* fell below the 25th percentile, indicating that some women were not receiving timely screening for breast and cervical cancers. Early detection reduces the risk of

Strengths and Opportunities for Improvement
dying from these types of cancers and can lead to a greater range of treatment options and lower health care costs. [Quality] Care1st ACC-RBHA's performance measure rates for <i>Colorectal Cancer Screening (ECDS)—Total (45–75 Years)</i> fell below the 25th percentile, indicating that some members were not receiving timely screening for colorectal cancer. Early detection reduces the risk of dying from cancer and can lead to a greater range of treatment options and lower health care costs. [Quality]
In the Pediatric Health measure group, Care1st ACC-RBHA's performance measure rates for <i>Child and Adolescent Well-Care Visits—Total (3–21 Years)</i> fell below the 25th percentile, indicating that children and adolescents were not always receiving well-care visits at the recommended intervals. Assessing physical, emotional, and social development is important at every stage of life, particularly for children and adolescents. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.¹³⁸ [Quality, Access]
In the Appropriate Utilization of Services measure group, Care1st ACC-RBHA's performance measure rates for <i>Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total (18–64 Years)</i> fell below the 25th percentile, indicating possible inadequate quality of care in the initial hospital visit and poor post-discharge planning and care coordination. Hospital readmissions can increase preventable adverse outcomes for patients; therefore, it is crucial to decrease hospital readmissions by focusing on quality and coordination of care at the time of the first admission.¹³⁹ [Quality]
In the Oral Health measure group, Care1st ACC-RBHA's performance measure rates for <i>Oral Evaluation, Dental Services—Total (0–20 Years)</i> fell below the 25th percentile, indicating that children and adolescents under 21 years of age were not always receiving the recommended routine dental services. Dental cavities are the most common chronic disease in children in the United States. Regular oral examinations are key in preventing untreated cavities and associated adverse outcomes, such as pain, infection, and decreased quality of life.¹⁴⁰ [Access]

¹³⁸ National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/child-and-adolescent-well-care-visits-wcv/>. Accessed on: Feb 11, 2026.

¹³⁹ National Committee for Quality Assurance. Plan All-Cause Readmissions (PCR). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/plan-all-cause-readmissions-pcr/>. Accessed on: Feb 11, 2026.

¹⁴⁰ National Committee for Quality Assurance. Oral Evaluation, Dental Services (OED)*. Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/oral-evaluation-dental-services-oed/>. Accessed on: Feb 18, 2026.

Network Adequacy Validation

ISCA Results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Care1st ACC-RBHA’s interpretation of data was accurate.

Table 7-21 summarizes HSAG’s validation ratings for Care1st ACC-RBHA by indicator type.

Table 7-21—Summary of Care1st ACC-RBHA’s Validation Ratings by Indicator Type

Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Appointment Availability	100%	0%	0%	0%
Time/Distance	100%	0%	0%	0%

Of the network adequacy indicators assessed, Care1st ACC-RBHA received *High Confidence* for both appointment availability and time/distance indicator types.

NAV Results

HSAG evaluated Care1st ACC-RBHA’s compliance results with AHCCCS’ time/distance standards by GSA and county. This section presents CYE 2024 S2 validation findings specific to the ACC-RBHA Program, with one results table for the following GSA:

- North GSA: Apache, Coconino, Mohave, Navajo, and Yavapai counties

Each Contractor-specific table summarizes validation results containing the percentage of members meeting each time/distance standard by county, with color coding to identify whether the time/distance standard was “*Met*” or “*Not Met*.”

Table 7-22—Time/Distance Validation Results for Care 1st ACC-RBHA North GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Apache	Coconino	Mohave	Navajo	Yavapai
Behavioral Health Outpatient and Integrated Clinic, Adult	97.4 ^Y	99.3 ^Y	99.8 [^]	99.4 ^Y	100.0 [^]
BHRF	NA	NA	NA	NA	NA
Cardiologist, Adult	99.0 [^]	99.3 ^Y	100.0 [^]	99.2 ^Y	100.0 [^]
Cardiologist, Pediatric	NR [^]	100.0 [^]	100.0 [^]	100.0 ^{*^}	100.0 [^]
Crisis Stabilization Facility	95.9 ^Y	96.9 ^Y	98.2	99.2 ^Y	98.8 ^Y

Provider Category	Apache	Coconino	Mohave	Navajo	Yavapai
Dentist, Pediatric	NR	92.9	100.0	100.0*	100.0
Hospital	99.5	100.0	100.0 ^Y	99.7	100.0
OB/GYN	100.0	100.0	100.0	100.0	100.0
Pharmacy	100.0 ^Y	98.5 ^Y	99.2	99.8	99.1 ^Y
PCP, Adult	99.0 [^]	99.9 ^{^Y}	99.1 [^]	100.0 [^]	100.0 [^]
PCP, Pediatric	NR [^]	100.0 [^]	100.0 [^]	100.0* [^]	100.0 [^]

Y	represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
NR	represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.
	* indicates that fewer than 10 members were included in the denominator of HSAG's results.
	[^] indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
	NA indicates results are not applicable to the county.

Strengths, Opportunities for Improvement, and Recommendations

Table 7-23 presents strengths and opportunities for improvement for Care1st ACC-RBHA related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement. As of October 1, 2024, Care1st ACC-RBHA no longer holds an AHCCCS contract; therefore, the information in this section does not include recommendations.

Table 7-23—Care1st ACC-RBHA Strengths and Opportunities for Improvement Related to NAV

Strengths and Opportunities for Improvement
Strengths
HSAG identified the following strengths: - Care1st ACC-RBHA established robust processes to ensure provider data remain accurate and up to date. These processes include several key initiatives, such as ongoing collaboration with providers through on-site visits; use of business intelligence tools; the biannual Preferences and Trends report; and multiple internal quality reports used to monitor, identify errors, and assess the accuracy of provider data. Additionally, Care1st ACC-RBHA has partnered with an external vendor to conduct quarterly reviews of key demographic data, further supporting the integrity and accuracy of provider data elements. [Access] - Care1st ACC-RBHA met all minimum network requirements for all assigned counties. [Access] Note: Care1st ACC-RBHA provides coverage in the following counties: Apache, Coconino, Mohave, Navajo, and Yavapai.
Opportunities for Improvement
HSAG identified no opportunities for improvement for Care1st ACC-RBHA.

Mercy Care ACC-RBHA

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2025, HSAG evaluated Mercy Care ACC-RBHA's data system for processing of each data type used for reporting the Contractor's CY 2024 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that Mercy Care ACC-RBHA followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 7-24 displays HSAG's PMV findings for each data type reviewed during CYE 2025 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 7-24—CYE 2025 PMV Findings

Data Type	HSAG Findings
Medical Services Data	<i>No identified concerns</i>
Enrollment Data	<i>No identified concerns</i>
Provider Data	<i>No identified concerns</i>
Medical Record Review Process	<i>No identified concerns</i>
Supplemental Data	<i>No identified concerns</i>
Data Integration	<i>No identified concerns</i>

Results for Performance Measures

Table 7-25 presents the CY 2023 and CY 2024 Mercy Care ACC-RBHA performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and/or MY 2024. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 7-25—CY 2023 and CY 2024 Mercy Care ACC-RBHA Performance Measure Results

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	NA ⁺⁺	82.51% ⁺	—	★
Postpartum Care	NA ⁺⁺	77.60% ⁺	—	★
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	58.86%	66.05% [^]	↑	★★
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	50.56%	50.77%	→	★
Effective Continuation Phase Treatment—Total (18+ Years)	37.54%	38.56%	→	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	87.95% [^]	86.23% [^]	↓	★★★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	55.89% [^]	56.36% [^]	→	★★★★★
30-Day Follow-Up—Total (6+ Years)	72.43% [^]	73.54% [^]	→	★★★★★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	53.22% [^]	58.00% [^]	→	★★★★★
30-Day Follow-Up—Total (13+ Years)	71.11% [^]	73.27% [^]	→	★★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	71.59% [^]	70.85% [^]	→	★★★★★
30-Day Follow-Up—Total (6+ Years)	85.96% [^]	86.38% [^]	→	★★★★★
Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	53.99% [^]	54.04% [^]	→	★★★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	16.12% [^]	17.52% [^]	→	★★★
Use of Opioids at High Dosage				
18+ Years*	8.71%	8.59%	→	★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Care of Acute and Chronic Conditions				
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status <8.0%—Total (18–75 Years)	63.26% [^]	69.10% ^{+^}	→	★★★★★
Glycemic Status >9.0%—Total (18–75 Years)*	27.49% [^]	26.03% ^{+^}	→	★★★★★
Pediatric Health				
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	—	35.46%	—	★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	44.35%	44.78%	→	NC [±]
Breast Cancer Screening (ECDS)				
Total (50–74 Years)	—	44.78%	—	★
Cervical Cancer Screening				
21–64 Years	44.28%	45.26% ⁺	→	★
Cervical Cancer Screening (ECDS)				
21–64 Years	—	40.67%	—	★
Colorectal Cancer Screening (ECDS)				
Total (45–75 Years)	—	41.90%	—	★★★
Appropriate Utilization of Services				
Plan All-Cause Readmissions				
Observed/Expected (O/E) Ratio—Total (18–64 Years)*	—	1.7602	—	★
Oral Health				
Oral Evaluation, Dental Services				
Total (0–20 Years)	—	34.04%	—	★★

* A lower rate indicates better performance for this measure.

NA⁺⁺ indicates the denominator was too small to report a valid rate, based on the applicable measure specification.

NC[±] indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.+ Indicates the measure was reported using hybrid methodology.

■ and ^ indicates that the rate met or exceeded the MY 2023 and/or MY 2024 national Medicaid mean.

— Indicates a 2023–2024 comparison is not presented in the CYE 2025 Annual Technical Report because either the CY 2023 rate was not presented in the CYE 2024 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

¹ Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.

² Performance Levels for CY 2024 were based on comparisons of the HEDIS MY 2024 measure rates to NCQA Quality Compass national Medicaid HEDIS MY 2024 benchmarks.

↑ Indicates statistically significant improvement of measure rates.

↓ Indicates statistically significant decline of measure rates.

→ Indicates no statistically significant change in measure rates.

Performance Levels for 2024 represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 7-26 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 7-26—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group, 10 Mercy Care ACC-RBHA measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. [Quality, Timeliness, Access] <i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years</i> <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years</i> <i>Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)</i> <i>Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years) and 30-Day Follow-Up—Total (13+ Years)</i> <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)</i> <i>Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Total (13+ Years) and Engagement of SUD Treatment—Total—Total (13+ Years)</i> In the Care of Acute and Chronic Conditions measure group, Mercy Care ACC-RBHA’s measure rate for <i>Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total (18–75 Years)</i> met or exceeded the 90th percentile and <i>Glycemic Status >9.0%—Total (18–75 Years)</i> met the 75th to 89th percentile. [Quality]

Strengths, Opportunities for Improvement, and Recommendations

Opportunities for Improvement and Recommendations

While Mercy Care was successful in reporting valid rates for all AHCCCS-required performance measures, the audit identified the following recommendations for future years' reporting **[Quality]**:

Recommendations: HSAG recommends that Mercy Care continue to work with AHCCCS to explore the use of additional data sources for capturing member race and ethnicity information from members to support performance measure reporting. This could involve investigating supplemental data sources and implementing new collection strategies to ensure more complete member profiles. In addition, HSAG recommends that Mercy Care continue to uphold its adherence to continuous enrollment criteria to maintain compliance with AHCCCS requirements for performance measure reporting. This includes accurately accounting for members who switch product lines, and those for whom Mercy Care is the secondary payer.

In the Prenatal and Postpartum Care measure group, Mercy Care ACC-RBHA's performance measure rates for *Timeliness of Prenatal Care* and *Postpartum Care* fell below the 25th percentile, indicating a continued opportunity to increase access to timely postpartum care. **[Quality, Timeliness, Access]**

Recommendation: As noted by the American College of Obstetricians (ACOG), all women should have contact with their obstetrician/gynecologist or other obstetric provider within three weeks postpartum, followed by ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth.¹⁴¹ To positively impact women in need of postpartum care, Mercy Care ACC-RBHA is currently conducting the *Prenatal and Postpartum Care* PIP, which includes a root cause analysis and interventions to address this measure. HSAG recommends that Mercy Care ACC-RBHA continue monitoring the success of interventions and submit results as required by AHCCCS.

In the Behavioral Health measure group, Mercy Care ACC-RBHA's performance measure rates for *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total (18+ Years)* fell below the 25th percentile, indicating an opportunity to identify trends leading to antidepressant medication mismanagement. **[Quality]**

Recommendation: Suicide is the 10th leading cause of death in the United States. Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy, and self-esteem, and can lead to suicide. Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness, and identifying and managing side effects. HSAG recommends that Mercy Care ACC-RBHA consider clinical recommendations shown to improve adherence to antidepressants, such as assessing depressive symptoms at baseline and at each follow-up, as well as providing psychoeducation to the member and family.

¹⁴¹ National Committee for Quality Assurance. Prenatal and Postpartum Care. Available at: <https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

In the Pediatric Health measure group, Mercy Care ACC-RBHA's performance measure rate for *Child and Adolescent Well-Care Visits—Total (3–21 Years)* fell below the 25th percentile. **[Quality]**

Recommendation: HSAG recommends that Mercy Care ACC-RBHA continue implementing interventions as part of the *Back to Basics* PIP, which includes a root cause analysis and interventions to address both the *Child and Adolescent Well-Care Visits—Total (3–21 Years)* and the *Well-Child Visits in the First 30 Months of Life—15 Months to 30 Months—Two or More Well-Child Visits* measures. HSAG recommends that Mercy Care ACC-RBHA draw as needed from other states' performance improvement initiatives. For instance, as part of a federal performance initiative to improve well-child care, California and Virginia have focused on reducing delays in newborn enrollment data, and Missouri and Texas focused on beneficiary barriers and implemented interventions such as utilizing patient portals and phone outreach. HSAG recommends that Mercy Care ACC-RBHA identify other barriers to care and conduct a focus group on identifying ways to address barriers.¹⁴²

In the Preventive Screening measure group, Mercy Care ACC-RBHA's performance measure rates for *Breast Cancer Screening (ECDS)—Total (50–74 Years)*, *Cervical Cancer Screening—21–64 Years*, and *Cervical Cancer Screening (ECDS)—21–64 Years* fell below the 25th percentile, indicating that women were not always receiving timely screening for breast or cervical cancer. Early detection reduces the risk of dying from these types of cancer and can lead to a greater range of treatment options and lower health care costs. Prolonged delays in screening may lead to delayed diagnoses, poor health consequences, and an increase in cancer disparities among women already experiencing health inequities.¹⁴³ **[Quality]**

Recommendations: HSAG recommends that Mercy Care ACC-RBHA leverage the current PIP activities to continue to implement appropriate interventions to improve performance related to preventive screenings. HSAG also recommends that Mercy Care ACC-RBHA monitor and expand on interventions currently in place to improve performance related to these measures. HSAG recommends that Mercy Care ACC-RBHA consider utilizing one-on-one interactions with health care professionals, such as CHWs, which have been shown to improve screenings. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness.

In the Appropriate Utilization of Services measure group, Mercy Care ACC-RBHA's performance measure rate for *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total (18–64 Years)* fell below the 25th percentile, indicating that members who were admitted to an acute inpatient

¹⁴² Centers for Medicare & Medicaid Services. Well-Child Care. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html>. Accessed on: Feb 11, 2026.

¹⁴³ Centers for Disease Control and Prevention. Sharp Declines in Breast and Cervical Cancer Screening. Available at: [Sharp Declines in Breast and Cervical Cancer Screening | CDC Archive](#). Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

and observation stay might have been followed by an unplanned acute readmission for any diagnosis within 30 days.¹⁴⁴ **[Quality]**

Recommendations: HSAG recommends that Mercy Care ACC-RBHA consider leveraging the RED, which has been shown to reduce readmissions and posthospital ED visits.¹⁴⁵ Other interventions that might be effective include technology platforms, including AI or machine learning, that can assist the plan in identifying members more at risk of readmission. HSAG also recommends that Mercy Care ACC-RBHA continue to utilize case management strategies that focus on person-centered techniques, addressing barriers and/or SDOH as needed.

Validation of Performance Improvement Projects

Preventive Screening PIP

In CYE 2025, Mercy Care ACC-RBHA continued the *Preventive Screening* PIP, which was initiated in CYE 2019. As the PIP had progressed through Remeasurement 3, PIP validation activities focused on improvement from the baseline results. Mercy Care ACC-RBHA submitted Remeasurement 3 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes to or possible discontinuation of the intervention.

HSAG conducted an annual validation of the third remeasurement year reflective of CY 2024 (January 1, 2024, through December 31, 2024) using AHCCCS-calculated and validated indicator rates. HSAG evaluated Mercy Care ACC-RBHA's performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of [Appendix A. Methodology](#).

Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG's confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. Table 7-27 displays the overall confidence levels for the Mercy Care ACC-RBHA *Preventive Screening* PIP.

¹⁴⁴ National Committee for Quality Assurance. Plan All Cause Readmissions. Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/plan-all-cause-readmissions-pcr/>. Accessed on: Feb 11, 2026.

¹⁴⁵ Agency for Healthcare Research and Quality. Re-Engineered Discharge (RED) Toolkit. Available at: <https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool1.html>. Accessed on: Feb 11, 2026.

Table 7-27—Mercy Care ACC-RBHA Preventive Screening PIP Overall Confidence Levels for Remeasurement 3

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
Mercy Care ACC-RBHA	<i>High Confidence</i>	100%	100%	<i>Moderate Confidence</i>	33%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Measure Results

Table 7-28 and Table 7-29 provide the *Preventive Screening* PIP baseline, Remeasurement Year 1, Remeasurement Year 2, and Remeasurement Year 3 rates for each indicator for Mercy Care ACC-RBHA.

Table 7-28—Mercy Care ACC-RBHA Preventive Screening PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: Breast Cancer Screening			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
Mercy Care ACC-RBHA	35.82%	41.06%	44.35%	44.78%

Table 7-29—Mercy Care ACC-RBHA Preventive Screening PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: Cervical Cancer Screening			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
Mercy Care ACC-RBHA	43.46%	37.35%	38.16%	40.09%

Interventions

Table 7-30 presents PIP interventions for Mercy Care ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 7-30—Mercy Care ACC-RBHA Preventive Screening PIP Interventions

Contractor	Intervention
Mercy Care ACC-RBHA	Mammogram Screening: - Additional provider education for those areas mentioned that are underutilized: - Worked with those providers to promote our incentive program for breast cancer screenings. - Worked with those providers to discuss how we can help utilize a mobile mammogram program to reach their members. - Partnered with a radiology group to outreach members specifically assigned to these providers. - Developed and implemented a written or multi-channel outreach (text/IVR/email) intervention for newly enrolled female members ages 50–74 years, as well as members ages 52–59 years. - Addition of <i>BCS</i> measure to value-based programs. - Surveyed providers that have a high compliance rate/have been successful in working with members with similar profiles to identify best practices and outreach to low-performing providers to share identified best practices; encouraged member outreach to close gaps in care. - Associate Chief Medical Officer (ACMO) targeted provider outreach for PCPs identified with the largest volume of members in need of screening—share best practices and list of members with a gap in care for outreach and care coordination. Cervical Cancer Screening: - Sent out cervical cancer screening mailer biannually. - Provider outreach and education. - Encouraged MD to ask members if they have received a Pap test at their OB; if not, help the member schedule for the provider’s office or the member’s OB office. - Encouraged MD to offer HPV vaccination to all members ages 11–26. - Provider site visits. Make it a priority for an MCH representative to meet with the MD and office staff, specifically in areas that are in need (Phoenix), at a minimum of once per year to review the provider outreach manual.

Contractor	Intervention
	- Increased community/tribal outreach and education. - Addition of two more tribal specialists (tribal relations positions) to the Mercy Care team who will function similarly to community health workers in that they engaged members who might be difficult to engage or find, provide health information, offer referral, assist with navigation, etc., to assist in addressing these disparities.

Strengths, Opportunities for Improvement, and Recommendations

Table 7-31 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA related to the *Preventive Screening* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 7-31—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to the *Preventive Screening* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: - The Contractor adhered to an acceptable methodology through all phases of the PIP and was able to measure the effectiveness of interventions and perform accurate statistical testing between the baseline rate and the Remeasurement 3 rate. [Quality, Access] - The Contractor was able to achieve statistically significant improvement for Performance Indicator 1 (<i>BCS</i>) when comparing the baseline rate to Remeasurement 3 rate. [Quality, Access]
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: - For Indicator 2 (<i>CCS</i>), Mercy Care ACC-RBHA had a decline of 3.37 percentage points between the baseline year and Remeasurement Year 3. [Quality, Access] Recommendations: HSAG recommends that the Contractor consider the following for future PIPs: - Apply lessons learned from the <i>Preventive Screening</i> PIP. - Seek technical assistance from HSAG to understand the CMS EQR Protocol 1 requirements. - Implement interventions with clearly defined intervention effectiveness measures.

Prenatal and Postpartum Care PIP

In CY 2025, Mercy Care ACC-RBHA submitted Remeasurement 1 results for the *Prenatal and Postpartum Care* PIP, which was initiated in CY 2022. Mercy Care ACC-RBHA submitted Remeasurement 1 performance indicator results and interventions implemented.

HSAG conducted an annual validation of the Remeasurement year 1 reflective of CY 2024 (January 1, 2024, through December 31, 2024) using AHCCCS-calculated and validated indicator rates. HSAG evaluated Mercy Care ACC-RBHA's performance indicator results based on an analysis of improvement strategies implemented as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection in [Appendix A. Methodology](#).

Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG's confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. Table 7-32 displays the overall confidence levels for the Mercy Care ACC-RBHA *Prenatal and Postpartum Care* PIP.

Table 7-32—Mercy Care ACC-RBHA *Prenatal and Postpartum Care* PIP Overall Confidence Levels for Remeasurement 1

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
Mercy Care ACC-RBHA	<i>Low Confidence</i>	90%	92%	<i>Moderate Confidence</i>	67%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Measure Results

Table 7-33 and Table 7-34 provide the *Prenatal and Postpartum Care* PIP baseline and Remeasurement Year 1 rates for each indicator for Mercy Care ACC-RBHA.

Table 7-33—Mercy Care ACC-RBHA Prenatal and Postpartum Care PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: <i>Timeliness of Prenatal Care</i>	
	Baseline Year	Remeasurement 1
	CY 2022	CY 2024
Mercy Care ACC-RBHA	78.57%	82.51%

Table 7-34—Mercy Care ACC-RBHA Prenatal and Postpartum Care PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: <i>Postpartum Care</i>	
	Baseline Year	Remeasurement 1
	CY 2022	CY 2024
Mercy Care ACC-RBHA	73.63%	77.60%

Interventions

Table 7-35 presents PIP interventions for Mercy Care ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 7-35—Mercy Care ACC-RBHA Prenatal and Postpartum Care PIP Interventions

Contractor	Interventions
Mercy Care ACC-RBHA	• Leveraging the ACOG data submitted to the perinatal ICM team for low-risk pregnancy identification, in addition to use by perinatal CM team. • Leveraging newborn notifications for identification of postpartum members. • Implementing a process to identify pregnant members through positive pregnancy tests in the HIE. • Revising the outreach process so that the postpartum mailing is sent to member regardless of whether the member's PCP or baby's PCP information is available. • Expanding education to OB/GYNs by MCH coordinators. • Improving medical record retrieval processes to ensure requested records for all sample members are received. • Prenatal and postpartum member incentives for all LOBs. • Health Assistant Application—member Web portal. • Add the prenatal care measure to Mercy Care's VBS contracts. • Sharing of gap in care data, which includes identified race and ethnicity, with Mercy Care VBS providers for outreach and care coordination. • Collecting available SDOH data from sources including but not limited to claims, analytics software, and mobile applications.

Strengths, Opportunities for Improvement, and Recommendations

Table 7-36 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA related to the *Prenatal and Postpartum Care* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 7-36—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to the *Prenatal and Postpartum Care* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: The Contractor implemented and developed measurement systems for interventions that led to improvement in indicator outcomes at Remeasurement 1. [Quality, Access]
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: - The improvement reported at Remeasurement 1 for both indicators was not statistically significant improvement. [Quality, Access] Recommendations: As the PIP progresses, HSAG recommends that Mercy Care ACC-RBHA: - Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. - Continue implementing identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. - Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.

Compliance Reviews

Results

AHCCCS conducted a compliance review of Mercy Care ACC-RBHA from February 12, 2024, through February 15, 2024. On May 2, 2024, AHCCCS finalized the report findings, provided Mercy Care ACC-RBHA with a CAP submission matrix, and required a CAP for any standard with a total score of less than 95 percent. On June 7, 2024, AHCCCS accepted Mercy Care ACC-RBHA's proposed CAPs and required the Contractor to submit updated policies, manuals, desktop procedures, and other vital documents to provide evidence of CAP completion. On May 19, 2025, AHCCCS reviewed Mercy Care ACC-RBHA's CAP status and determined that all CAPs had been completed and approved for closure.

Table 7-37—Mercy Care ACC-RBHA Compliance Review Results

AHCCCS Compliance Focus Areas	CYE 2024 Mercy Care ACC-RBHA Scores	CYE 2025 Mercy Care ACC-RBHA CAP Update
Corporate Compliance	100%	NA
Claims and Information Standards	99%	NA
Delivery Systems	97%	NA
General Administration	96%	NA
Grants Management	100%	NA
Grievance Systems	100%	NA
Adult; EPSDT; and Maternal Child Health	96%	NA
Medical Management	97%	NA
Member Information	90%	Met
Quality Management	95%	NA
Quality Improvement	100%	NA
Reinsurance	100%	NA
Third-Party Liability	100%	NA
Integrated Systems of Care	99%	NA

NA = Not applicable. A CAP was not required as the CYE 2024 score was 95% or above.
Met = AHCCCS accepted and closed the Contractor's CAP.

Strengths, Opportunities for Improvement, and Recommendations

Table 7-38 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA based on compliance activities conducted in CYE 2025, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 7-38—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
Mercy Care ACC-RBHA successfully closed CAPs in the following focus area: Member Information (MI) [Quality]
Opportunities for Improvement and Recommendations
As a result of its CAP interventions implemented in CYE 2025, Mercy Care ACC-RBHA was found to be fully compliant within all focus areas and had no continuing corrective actions or recommendations.

Network Adequacy Validation

ISCA Results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Mercy Care ACC-RBHA's interpretation of data was accurate.

Table 7-39 summarizes HSAG's validation ratings for Mercy Care ACC-RBHA by indicator type.

Table 7-39—Summary of Mercy Care ACC-RBHA's Validation Ratings by Indicator Type

Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Appointment Availability	100%	0%	0%	0%
Time/Distance	100%	0%	0%	0%

Of the network adequacy indicators assessed, Mercy Care ACC-RBHA received *High Confidence* for both appointment availability and time/distance indicator types.

NAV Results

HSAG evaluated Mercy Care ACC-RBHA's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents CYE 2024 S2 validation findings specific to the ACC-RBHA Program, with one results table for the following GSA:

- Central GSA: Gila, Maricopa, and Pinal counties

Each region-specific table summarizes validation results containing the percentage of members meeting each time/distance standard by county, with color coding to identify whether the time/distance standard was *Met* or *Not Met*.

Table 7-40—Time/Distance Validation Results for Mercy Care ACC-RBHA Central GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0 [^]	99.3 [^]	100.0 [^]
BHRF	NA	99.6	NA
Cardiologist, Adult	100.0 [^]	99.8 ^{^Y}	100.0 [^]
Cardiologist, Pediatric	100.0* [^]	100.0 ^{^Y}	100.0 [^]
Crisis Stabilization Facility	100.0	99.4 ^Y	100.0
Dentist, Pediatric	100.0*	99.8	100.0
Hospital	100.0	100.0 ^Y	100.0

Provider Category	Gila	Maricopa	Pinal
OB/GYN	100.0	100.0 ^Y	100.0
Pharmacy	100.0 ^Y	99.4 ^Y	100.0
PCP, Adult	100.0 [^]	99.8 ^{^Y}	100.0 [^]
PCP, Pediatric	100.0 ^{*^}	99.8 [^]	100.0 [^]

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

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

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

NA indicates results are not applicable to the county.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-56 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 7-41—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: - Mercy Care ACC-RBHA maintained a robust internal provider data management process supported by multiple data management platforms and applications. This system included weekly reconciliation between credentialing and operational systems, the application of USPS address standardization, and annual validations of the provider directory through direct provider attestations. These activities demonstrated a strong process for maintaining accurate and up-to-date provider information. [Access] - Mercy Care ACC-RBHA met all minimum network requirements for all assigned counties. [Access]
Opportunities for Improvement and Recommendations
HSAG identified no opportunities for improvement for Mercy Care ACC-RBHA.

Consumer Assessment of Healthcare Providers and Systems Results

HSAG administered member experience surveys on AHCCCS' behalf to adult members enrolled with an ACC-RBHA SMI-Designated Program Contractor from the statewide sample and the ACC-RBHA SMI-Designated Program oversample provided by AHCCCS. Based on the results in [Section 6—ACC-RBHA SMI-Designated Program-Level Comparative Results](#), HSAG provides Mercy Care ACC-RBHA

opportunities for improvement and recommendations on how the Contractor can improve member experience in the table below.

Table 7-42—Mercy Care ACC-RBHA Opportunities for Improvement and Recommendations Related to CAHPS

Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: - The ACC-RBHA SMI-Designated Program’s member experience ratings for <i>Rating of Health Plan</i>, <i>Rating of All Health Care</i>, <i>Rating of Specialist Seen Most Often</i>, <i>How Well Doctors Communicate</i>, <i>Customer Service</i>, and <i>Coordination of Care</i> were below the 25th percentiles for the adult Medicaid population. [Quality] - The ACC-RBHA SMI-Designated Program’s member experience ratings for <i>Rating of Personal Doctor</i>, <i>Getting Needed Care</i>, and <i>Getting Care Quickly</i> were at or between the 25th and 49th percentiles for the adult Medicaid population. [Quality, Timeliness, Access] Recommendation: HSAG recommends that Mercy Care ACC-RBHA explore what may be driving lower experience scores and develop initiatives designed to improve the quality of and access to care, including a focus on improving adult members’ overall experiences with their health plan, overall health care, the specialist they see most often, their doctor’s ability to communicate, coordination of care, customer service, and getting needed care in a timely manner.

8. DCS CHP Program Results

The **DCS CHP Program** provides medical, dental, and behavioral health services for children and youth in foster care throughout the State of Arizona.

This section provides, by EQR activity, DCS CHP activity-specific strengths, opportunities for improvement, and HSAG’s recommendations for performance improvement. This section also includes information about the extent to which DCS CHP was able to address the prior year’s recommendations for each activity. This section also includes CAHPS survey results for the DCS CHP Program. DCS CHP provides services through a subcontracted health plan, Mercy Care DCS CHP. This report uses DCS CHP when referring to the DCS CHP Contractor, and Mercy Care DCS CHP when referring to activities conducted by the DCS CHP subcontracted health plan (Mercy Care).

DCS CHP Program

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2025, HSAG evaluated DCS CHP’s data system for processing of each data type used for reporting the Contractor’s CY 2024 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that DCS CHP followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 8-1 displays HSAG’s PMV findings for each data type reviewed during CYE 2025 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 8-1—CYE 2025 PMV Findings

Data Type	HSAG Findings
Medical Services Data	<i>No identified concerns</i>
Enrollment Data	<i>No identified concerns</i>
Provider Data	<i>No identified concerns</i>
Medical Record Review Process	<i>No identified concerns</i>
Supplemental Data	<i>No identified concerns</i>
Data Integration	<i>CIS, DEV, LSC, PPC, and WCC measures were not calculated using the AHCCCS-required methodology and were reported as admin for Title XXI.</i>

Results for Performance Measures

Table 8-2 presents the CY 2023 and CY 2024 DCS CHP performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024. Performance measure rate cells shaded green indicate that DCS CHP met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and/or MY 2024.

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

Table 8-2—CY 2023 and CY 2024 Performance Measure Results for DCS CHP

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Behavioral Health				
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	86.60%^	86.96%^	→	★★★★★
30-Day Follow-Up—Total (6+ Years)	94.85%^	94.20%^	→	★★★★★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	68.92%^	67.21%^	→	★★★★★
30-Day Follow-Up—Total (13+ Years)	86.49%^	88.52%^	→	★★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	73.63%^	69.17%^	→	★★★★★
30-Day Follow-Up—Total (6+ Years)	92.08%^	87.32%^	↓	★★★★★
Follow-Up Care for Children Prescribed ADHD Medication (ECDS)				
Initiation Phase (6–12 Years)	—	88.37%^	—	★★★★★
Continuation and Maintenance Phase (6–12 Years)	—	82.50%^	—	★★★★★
Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	50.92%^	41.67%	→	★★
Engagement of SUD Treatment—Total—Total (13+ Years)	14.76%	9.38%	→	★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Total (1–17 Years)	87.08%^	86.08%^	→	★★★★★
Pediatric Health				
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	77.14%^	78.91%^	→	★★★★★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Childhood Immunization Status**				
Combination 3	66.67%^	70.32% ⁺	→	★★★
Combination 7	54.50%	53.28% ⁺	→	★★
Combination 10	30.17%^	29.20% ⁺	→	★★★
Childhood Immunization Status (ECDS)**				
Combination 3	—	68.85%^	—	★★★★
Combination 7	—	52.94%^	—	★★
Combination 10	—	28.10%^	—	★★★
Developmental Screening in the First Three Years of Life				
Total (0–3 Years)	23.84%	34.31% ⁺	↑	NC [±]
Immunizations for Adolescents**				
Combination 1 (Meningococcal, Tdap)	95.70%^	94.51% ⁺	→	★★★★★
Combination 2 (Meningococcal, Tdap, HPV)	54.48%^	53.16% ⁺	→	★★★★★
Immunizations for Adolescents (ECDS)**				
Combination 1 (Meningococcal, Tdap)	—	94.51%^	—	★★★★★
Combination 2 (Meningococcal, Tdap, HPV)	—	52.74%^	—	★★★★★
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	—	64.90%^	—	★★★★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total (3–17 Years)	84.18% ⁺	87.83% ⁺	→	★★★
Counseling for Nutrition—Total (3–17 Years)	79.08% ⁺	83.45% ⁺	→	★★★★
Counseling for Physical Activity—Total (3–17 Years)	74.94% ⁺	78.35% ⁺	→	★★★
Well-Child Visits in the First 30 Months of Life				
15 Months—Six or More Well-Child Visits	66.85%^	67.42%^	→	★★★
15 Months–30 Months—Two or More Well-Child Visits	77.93%^	81.23%^	→	★★★★
Oral Health				
Oral Evaluation, Dental Services				

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Total (0–20 Years)	—	76.85%^	—	★★★★★

* A lower rate indicates better performance for this measure.

** Table A-2 in [Appendix A. Methodology](#) outlines which immunizations are included within each combination.

NC± indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

+ Indicates the measure was reported using hybrid methodology.

NA⁺⁺ indicates the denominator was too small to report a valid rate, based on the applicable measure specification.

■ and ^ indicates that the rate met or exceeded the MY 2023 and/or MY 2024 national Medicaid mean.

— Indicates a 2023–2024 comparison is not presented in the CYE 2025 Annual Technical Report because either the CY 2023 rate was not presented in the CYE 2024 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

¹ Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.

² Performance Levels for CY 2024 were based on comparisons of the HEDIS MY 2024 measure rates to NCQA Quality Compass national Medicaid HEDIS MY 2024 benchmarks.

↑ Indicates statistically significant improvement of measure rates.

↓ Indicates statistically significant decline of measure rates.

→ Indicates no statistically significant change in measure rates.

Performance Levels for 2024 represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Table 8-3 highlights DCS CHP’s performance for the current year by measure group. The table illustrates the CY 2024 measure rates and performance relative to the NCQA Quality Compass national Medicaid HEDIS MY 2024 percentiles, where applicable. The performance level star ratings are defined as follows:

★★★★★ = 90th percentile and above

★★★★ = 75th percentile to 89th percentile

★★★ = 50th percentile to 74th percentile

★★ = 25th percentile to 49th percentile

★ = Below the 25th percentile

Table 8-3—CY 2024 National Percentiles Comparison for DCS CHP

Performance Measure	CY 2024 Performance
Behavioral Health	
Follow-Up After ED Visit for Mental Illness	
7-Day Follow-Up—Total (6+ Years) ‡	★★★★★

Performance Measure	CY 2024 Performance
30-Day Follow-Up—Total (6+ Years) ‡	★★★★★
Follow-Up After ED Visit for Substance Use	
7-Day Follow-Up—Total (13+ Years) ‡	★★★★★
30-Day Follow-Up—Total (13+ Years) ‡	★★★★★
Follow-Up After Hospitalization for Mental Illness	
7-Day Follow-Up—Total (6+ Years) ‡	★★★★★
30-Day Follow-Up—Total (6+ Years) ‡	★★★★★
Follow-Up Care for Children Prescribed ADHD Medication (ECDS)	
Initiation Phase (6–12 Years)	★★★★★
Continuation and Maintenance Phase (6–12 Years)	★★★★★
Initiation and Engagement of SUD Treatment	
Initiation of SUD Treatment—Total—Total (13+ Years) ‡	★★
Engagement of SUD Treatment—Total—Total (13+ Years) ‡	★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	
Total (1–17 Years)	★★★★★
Pediatric Health	
Child and Adolescent Well-Care Visits	
Total (3–21 Years)	★★★★★
Childhood Immunization Status**	
Combination 3	★★★
Combination 7	★★
Combination 10	★★★
Childhood Immunization Status (ECDS)**	
Combination 3	★★★★★
Combination 7	★★
Combination 10	★★★
Immunizations for Adolescents**	
Combination 1 (Meningococcal, Tdap)	★★★★★
Combination 2 (Meningococcal, Tdap, HPV)	★★★★★

Performance Measure	CY 2024 Performance
Immunizations for Adolescents (ECDS) **	
Combination 1 (Meningococcal, Tdap)	★★★★★
Combination 2 (Meningococcal, Tdap, HPV)	★★★★★
Metabolic Monitoring for Children and Adolescents on Antipsychotics	
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	★★★★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile—Total (3–17 Years)	★★★
Counseling for Nutrition—Total (3–17 Years)	★★★★★
Counseling for Physical Activity—Total (3–17 Years)	★★★
Well-Child Visits in the First 30 Months of Life	
15 Months—Six or More Well-Child Visits	★★★
15 Months–30 Months—Two or More Well-Child Visits	★★★★★
Oral Health	
Oral Evaluation, Dental Services	
Total (0–20 Years)	★★★★★

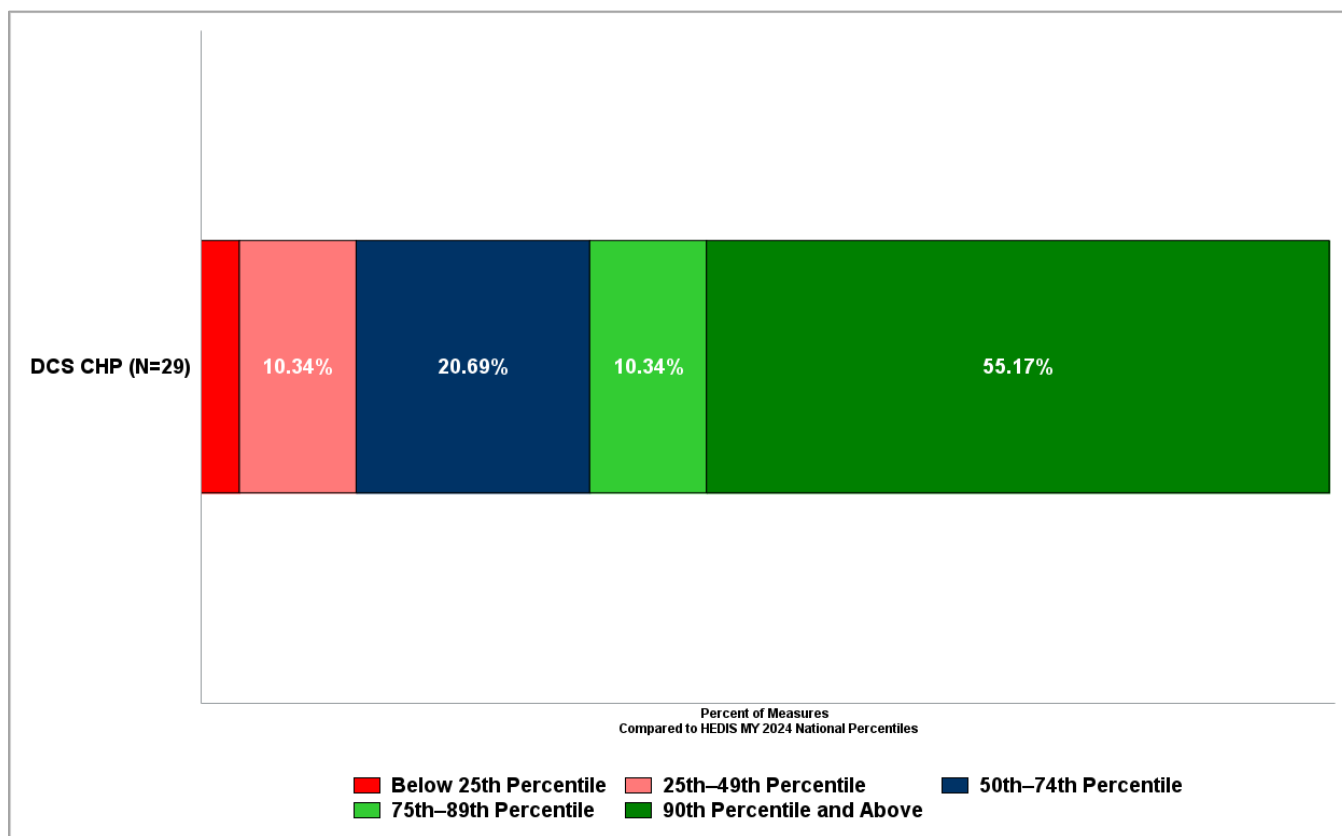
‡ Population ages do not align with those reflected within the Medicaid mean.

** Table A-2 in [Appendix A. Methodology](#) outlines which immunizations are included within each combination.

NC± indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

Figure 8-1 displays DCS CHP’s HEDIS MY 2024 performance compared to HEDIS MY 2024 National Percentiles. HSAG analyzed results from 15 performance measures and 29 total measure rates for HEDIS MY 2024.

Figure 8-1—Comparison of Measure Indicators to HEDIS Medicaid National Percentiles for DCS CHP



Strengths, Opportunities for Improvement, and Recommendations

Table 8-4 presents strengths, opportunities for improvement, and recommendations for DCS CHP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement. Please note that the age range for the DCS CHP population does not align with the age stratifications used to calculate the Medicaid mean for some measures. As a result, comparisons between this population's performance and the NCQA Medicaid mean and NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks should be interpreted with caution.

Table 8-4—DCS CHP Program Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group, nine of 11 DCS CHP rates for the following measures met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and were at or above the 90th percentile [Quality, Timeliness, Access]:

Strengths, Opportunities for Improvement, and Recommendations

- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)*
- *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years) and 30-Day Follow-Up—Total (13+ Years)*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)*
- *Follow-Up Care for Children Prescribed ADHD Medication (ECDS)—Initiation Phase (6–12 Years) and Continuation and Maintenance Phase (6–12 Years)*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)*

In the Pediatric Health measure group, DCS CHP's rates for these performance measures were at or above the 90th percentile **[Quality, Access]**:

- *Child and Adolescent Well-Care Visits—Total (3–21 Years)*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)*
- *Immunizations for Adolescents (ECDS)—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)*

In the Oral Health measure group, DCS CHP's rate for the *Oral Evaluation, Dental Services—Total (0–20 Years)* performance measure was at or above the 90th percentile. **[Access]**

Opportunities for Improvement and Recommendations

In the Behavioral Health measure group, DCS CHP's performance measure rates for *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* remained below the 25th percentile, indicating that not all members were following the engagement period for SUD treatments. **[Quality, Timeliness, Access]**

Recommendation: HSAG recommends that DCS CHP continue all efforts to conduct a root cause analysis or focus study to determine why some members were not accessing SUD services or MAT following their initiation visit. HSAG recommends that DCS CHP review patient data for any patterns present by ZIP Code and other demographics for case management prioritization. One study suggests that male members who have a schizophrenia spectrum disorder diagnosis are less likely to initiate treatment, while current drug dependence and recent arrest were associated with lowered odds of engaging in treatment. Current drug dependence is associated with factors

Strengths, Opportunities for Improvement, and Recommendations

that make scheduling and attending treatment appointments difficult, such as severe symptoms, chaotic living situations, and self-care and life functioning issues.¹⁴⁶

While DCS CHP was successful in reporting valid rates for all AHCCCS-required performance measures for its DCH CHP population, the audit identified the following recommendations for future years' reporting [**Quality**]:

Recommendations: HSAG recommends that DCS CHP/Mercy Care continue to ensure compliance with AHCCCS requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes AHCCCS requirements for members for whom DCS CHP does not hold the primary insurance contract. In addition, HSAG recommends that DCS CHP continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES.

Validation of Performance Improvement Projects

In CY 2025, DCS CHP continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 3, PIP validation activities focused on improvement from the baseline results. DCS CHP submitted Remeasurement 3 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes or discontinuation of the interventions.

HSAG conducted an annual validation of the third remeasurement year reflective of CY 2024 (January 1, 2024, through December 31, 2024) using AHCCCS-calculated and validated indicator rates. HSAG evaluated DCS CHP's performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of [Appendix A. Methodology](#).

Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG's confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG's confidence that the PIP's performance indicator results

¹⁴⁶ National Committee for Quality Assurance. Initiation and Engagement of Substance Use Disorder (IET). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/initiation-and-engagement-of-substance-use-disorder-treatment-iet/>. Accessed on: Feb 11, 2026.

demonstrated evidence of significant improvement. Table 8-5 displays the overall confidence levels for the DCS CHP *Back to Basics* PIP.

Table 8-5—DCS CHP *Back to Basics* PIP Overall Confidence Levels for Remeasurement 3

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
DCS CHP	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>	100%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Measure Results

Table 8-6 provides the *Back to Basics* PIP baseline, Remeasurement Year 1, Remeasurement 2, and Remeasurement Year 3 rates for the indicator for DCS CHP.

Table 8-6—DCS CHP Program *Back to Basics* PIP Rates

Contractor	PIP Indicator: <i>Child and Adolescent Well-Care Visits (WCV)</i>			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
DCS CHP	72.58%	71.02%	77.14%	78.91%

Interventions

Table 8-7 presents PIP interventions for the DCS CHP Program. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 8-7—DCS CHP Program *Back to Basics* PIP Interventions

Contractor	Interventions
DCS CHP	- Integrated care management outreach members focused on the provision of preventive EPSDT services. - HPV educational mailing to members turning 11 years of age. - Mailing to parents/guardians of 1-month-olds that included a well-child magnet listing the ages that children need well visits and a booklet on immunizations and debunking immunization myths. - EPSDT reminder cards, including information consistent with the AHCCCS periodicity schedule. - EPSDT second reminder cards. - Written reminders: member handbook, member newsletters, and newborn booklets to promote well-child visits, EPSDT reminder cards, and well-child reminder letters. - Written provider outreach process which included mailings to PCPs for members in need of an EPSDT visit; members 0–24 months of age in need of immunizations; adolescents in need of immunizations; a reminder on the requirement to conduct a developmental screening at the 9-, 18-, and 24-month visits; and information pertaining to the member’s historical dental care and whether or not the member is due for dental care. - Virtual or face-to-face contacts between the Mercy Care DCS CHP coordinators and providers encouraging outreach efforts to members lacking childhood immunizations and/or well-child visits. - Providers pay for performance to VBS groups for improving performance in the measure. - Adolescent immunization reminder card mailed to the parents/guardians of members during the month of the member’s 12th birthday, reminding them of the importance of obtaining immunizations. - Mailing to the Native American members in need of a well visit a cover letter and CDC brochure specific to the health of Native Americans. - Follow-up calls to members who were referred for dental screening or services via an EPSDT visit. - Care Management personnel monitor gaps in care for all youth enrolled in Peds Care Management. - Partnership and collaboration with pediatric providers to promote EPSDT awareness. - Referred new members to pediatric providers for comprehensive EPSDT services and care.

Contractor	Interventions
	- Resource liaisons outreached to caregivers to ensure understanding of the importance of preventive (EPSDT) visits. - Pilot project to address adolescent well visit adherence. - The total population of adolescents, ages 12–17 in Arizona foster care eligible for the EPSDT. sampled 200 youth for random distribution to control and intervention groups: - Scripted telephonic outreach to caregiver and adolescent dyads. - Outreach of foster caregivers and other placements upon a child’s entry into DCS care (Onboarding team). - Written provider outreach process which includes mailings to PCPs for members in need of an EPSDT visit; members 0–24 months of age in need of immunizations; adolescents in need of immunizations; a reminder on the requirement to conduct developmental screenings at the 9-, 18-, and 24-month visits. - Leverage tribal liaisons to engage members who might be difficult to engage or find, provide health information, offer referral, assist with navigation, etc., to assist in addressing health disparities. - Mercy Care Health Assistant—a platform where members can monitor their health actions and redeem awards for completing health actions. Mercy Care DCS CHP also has the ability to send education and gap closure reminders to members via short message service (SMS), email, and mail.

Strengths, Opportunities for Improvement, and Recommendations

Table 8-8 presents strengths, opportunities for improvement, and recommendations for DCS CHP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 8-8—DCS CHP Program Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: - The Contractor adhered to acceptable methodology through all phases of the <i>Back to Basics</i> PIP. [Quality, Access] - The Contractor achieved statistically significant improvement between the baseline rate and the Remeasurement 2 rate and sustained that statistically significant improvement at Remeasurement 3 for the <i>Child and Adolescent Well-Care Visits (WCV)</i> performance indicator. [Quality, Access]

Strengths, Opportunities for Improvement, and Recommendations

Opportunities for Improvement and Recommendations

HSAG identified no opportunities for improvement related to the *Back to Basics* PIP.

Recommendation: HSAG recommends that the Contractor consider the following for future PIPs:

- Apply lessons learned from the *Back to Basics* PIP.
- Seek technical assistance from HSAG to understand the CMS EQR Protocol 1 requirements.
- Implement interventions with clearly defined intervention effectiveness measures.

Compliance Reviews

Results

For the CYE 2025 compliance review activity, AHCCCS continued its monitoring of DCS CHP’s CAPs from the CYE 2022 compliance review. On September 29, 2025, AHCCCS reviewed DCS CHP’s CAP status and determined that all CAPs had been completed and approved for closure. HSAG will conduct a compliance review of DCS CHP in 2026, which starts a new three-year compliance review cycle. Table 8-9 presents the compliance review results and CAP updates for DCS CHP.

Table 8-9—DCS CHP Program Compliance Review Results

AHCCCS Compliance Focus Areas	CYE 2024 DCS CHP CAP Update	CYE 2025 DCS CHP CAP Update
Corporate Compliance	NA	NA
Claims and Information Standards	NA	NA
Delivery Systems	Partially Met	Met
General Administration	Met	NA
Grievance Systems	NA	NA
Adult; EPSDT; and Maternal Child Health	Partially Met	Met
Medical Management	Met	NA
Member Information	Met	NA
Quality Management	Partially Met	Met
Quality Improvement	Partially Met	Met
Reinsurance	NA	NA
Third-Party Liability	NA	NA
Integrated Systems of Care	NA	NA

NA = Not applicable. A CAP was not required as the CYE 2022 score was 95% or above or the CAP was closed by AHCCCS in CYE 2024.

Partially Met = AHCCCS approved the Contractor’s proposed CAP. The Contractor must submit evidence of compliance.

Met = AHCCCS accepted and closed the Contractor’s CAP.

Strengths, Opportunities for Improvement, and Recommendations

Table 8-10 presents strengths, opportunities for improvement, and recommendations for DCS CHP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 8-10—DCS CHP Program Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
DCS CHP successfully closed CAPs in the following focus areas: • Delivery Systems (DS) [Timeliness, Access] • Adult, EPSDT, and Maternal Child Health (MCH) [Quality, Timeliness, Access] • Quality Management (QM) [Quality] • Quality Improvement (QI) [Quality, Access]
Opportunities for Improvement and Recommendations
As a result of its CAP interventions implemented in CYE 2025, DCS CHP was found to be fully compliant within all focus areas and had no continuing corrective actions or recommendations.

Network Adequacy Validation

ISCA Results

HSAG completed an ISCA for the DCS CHP subcontracted health plan, Mercy Care, which is contracted to deliver services to Medicaid managed care members in Arizona, and this report presents findings and validation ratings based on Mercy Care DCS CHP’s ISCA and live system demonstrations. HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data systems. Additionally, HSAG determined that Mercy Care DCS CHP’s data collection procedures were acceptable. Mercy Care DCS CHP used external delegated entities to complete network adequacy indicator reporting during the reporting period, and no issues were identified.

Based on the results of the ISCA’s combined with the detailed validation of each NAV indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and whether Mercy Care DCS CHP’s interpretation of data was accurate.

Table 8-11 summarizes HSAG’s validation ratings for the DCS CHP subcontracted health plan by indicator type.

Table 8-11—Summary of Mercy Care DCS CHP Validation Ratings by Indicator Type

Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Appointment Availability	100%	0%	0%	0%
Time/Distance	100%	0%	0%	0%

Of the network adequacy indicators assessed, Mercy Care DCS CHP received *High Confidence* for both appointment availability and time/distance indicator types.

NAV Results

HSAG’s validation of Mercy Care DCS CHP’s results showed minor discrepancies between its self-reported ACOM 436 results and HSAG’s time/distance calculations in each quarter that data could be compared. While minor differences (i.e., less than 1 percentage point) between HSAG’s time/distance calculation results and Mercy Care DCS CHP’s time/distance calculation results were common, these findings may be attributable to the timing of the input data or software versions used by Mercy Care DCS CHP, or due to a small number of members eligible for inclusion in time/distance calculations for the standard and county.

Table 8-12 summarizes HSAG’s assessment of Mercy Care DCS CHP’s compliance with AHCCCS’ minimum time/distance network standards. A check mark indicates that Mercy Care DCS CHP met the minimum network standard for all assigned counties during the CYE 2024 S2 assessment, and an “X” indicates that Mercy Care DCS CHP did not meet one or more minimum network standards in any assigned county.

Table 8-12—Summary of CYE 2024 S2 Compliance With Minimum Time/Distance Network Requirements for Mercy Care DCS CHP

Minimum Network Requirement	Mercy Care DCS CHP
Behavioral Health Outpatient and Integrated Clinic, Pediatric	✓
BHRF	X
Cardiologist, Pediatric	✓
Dentist, Pediatric	X
Hospital	✓
OB/GYN	✓
PCP, Pediatric	✓
Pharmacy	X

Mercy Care DCS CHP consistently met the Behavioral Health Outpatient and Integrated Clinic, Pediatric; Cardiologist, Pediatric; Hospital; OB/GYN; and PCP, Pediatric standards. Overall, Mercy Care DCS CHP met all minimum time/distance network standards in Cochise, Gila, Graham, Maricopa, Mohave, Navajo, Pinal, Santa Cruz, Yavapai, and Yuma counties.

No isolated data issues were identified affecting Mercy Care DCS CHP’s compliance with time/distance standards.

As part of the NAV, AHCCCS maintained its feedback process for Mercy Care DCS CHP to review and improve the accuracy of its data submissions. Specifically, AHCCCS supplied Mercy Care DCS CHP with copies of HSAG’s network adequacy analysis, the PAT file that HSAG used to conduct the analysis, and HSAG’s saturation analysis results. When issues were identified, Mercy Care DCS CHP was expected to research the instances and make corrections for future PAT data and/or ACOM 436 submissions.

Mercy Care DCS CHP should continue to monitor and maintain its existing provider network as of CYE 2024 S2, with specific attention to ensuring the availability of the following provider categories:

- BHRF in Pima County
- Dentist, Pediatric in Apache, Greenlee, and La Paz counties
- Pharmacy in Coconino and La Paz counties

HSAG evaluated Mercy Care DCS CHP’s compliance results with AHCCCS’ time/distance standards by GSA and county. This section presents CYE 2024 S2 validation findings specific to the DCS CHP Program, with one results table for each of the following GSAs:

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

Each region-specific table summarizes validation results containing the percentage of members meeting each time/distance standard by county, with color coding to identify whether the time/distance standard was *Met* or *Not Met*.

Table 8-13—Time/Distance Validation Results for Mercy Care DCS CHP Central GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0 [^]	99.0 ^{^Y}	100.0 [^]
BHRF	NA	99.6	NA
Cardiologist, Pediatric	100.0 [^]	100.0 [^]	100.0 [^]
Dentist, Pediatric	93.9 ^Y	99.6 ^Y	100.0

Provider Category	Gila	Maricopa	Pinal
Hospital	100.0	100.0 ^Y	100.0
OB/GYN	100.0*	100.0	100.0
Pharmacy	100.0 ^Y	99.2 ^Y	100.0
PCP, Pediatric	100.0 [^]	99.7 [^]	100.0 [^]

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

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

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

NA indicates results are not applicable to the county.

Table 8-14—Time/Distance Validation Results for Mercy Care DCS CHP North GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Apache	Coconino	Mohave	Navajo	Yavapai
Behavioral Health Outpatient and Integrated Clinic, Pediatric	89.7 ^{^Y}	98.8 ^{^Y}	100.0 [^]	93.3 ^{^Y}	100.0 [^]
BHRF	NA	NA	NA	NA	NA
Cardiologist, Pediatric	94.9 ^{^Y}	100.0 [^]	98.7 ^{^Y}	100.0 [^]	100.0 [^]
Dentist, Pediatric	89.7 ^R	100.0	98.1 ^Y	100.0	99.4 ^Y
Hospital	100.0 ^Y	100.0	100.0	100.0	100.0
OB/GYN	100.0*	100.0	100.0	100.0*	100.0
Pharmacy	97.4 ^Y	89.4 ^R	98.7 ^Y	92.1 ^Y	99.4 ^Y
PCP, Pediatric	94.9 ^{^Y}	98.8 ^{^Y}	98.1 ^{^Y}	93.3 ^{^Y}	100.0 [^]

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

R represents time/distance standard results that do not meet the compliance standard based on HSAG's results.

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

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

NA indicates results are not applicable to the county.

Table 8-15—Time/Distance Validation Results for Mercy Care DCS CHP South GSA—Percentage of Members Meeting Minimum Network Requirements

Provider Category	Cochise	Graham	Greenlee	La Paz	Pima	Santa Cruz	Yuma
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0 [^]	100.0 [^]	100.0 ^{*^}	100.0 ^{*^}	94.9 ^{^Y}	100.0 [^]	100.0 [^]
BHRF	NA	NA	NA	NA	86.1 ^R	NA	NA

Provider Category	Cochise	Graham	Greenlee	La Paz	Pima	Santa Cruz	Yuma
Cardiologist, Pediatric	100.0 [^]	100.0 [^]	100.0 ^{*^}	100.0 ^{*^}	99.8 ^{^Y}	100.0 [^]	100.0 [^]
Dentist, Pediatric	100.0 ^Y	100.0	88.9 ^{*R}	66.7 ^{*R}	98.1 ^Y	100.0	100.0
Hospital	100.0	100.0	100.0 [*]	100.0 [*]	99.6 ^Y	100.0	100.0
OB/GYN	100.0	100.0 [*]	100.0 ^{*Y}	NR	100.0	100.0 [*]	100.0
Pharmacy	100.0	100.0 ^Y	100.0 [*]	66.7 ^{*R}	96.9 ^Y	100.0	100.0
PCP, Pediatric	100.0 [^]	100.0 ^{^Y}	100.0 ^{*^}	100.0 ^{*^}	99.1 ^{^Y}	100.0 [^]	100.0 [^]

Y	represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
R	represents time/distance standard results that do not meet the compliance standard based on HSAG's results.
NR	represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.
* indicates that fewer than 10 members were included in the denominator of HSAG's results.	
[^] indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.	
NA indicates results are not applicable to the county.	

Strengths, Opportunities for Improvement, and Recommendations

Table 8-16 presents strengths, opportunities for improvement, and recommendations for DCS CHP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 8-16—DCS CHP Program Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: - Mercy Care DCS CHP received <i>High Confidence</i> for both appointment availability and time/distance indicators. [Access] - Mercy Care DCS CHP met all minimum network requirements for all assigned counties except Apache, Coconino, Greenlee, La Paz, and Pima counties. [Access] - Mercy Care DCS CHP met all minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Pediatric; Cardiologist, Pediatric; Hospital; OB/GYN; and PCP, Pediatric. [Access] Note: DCS CHP provides coverage statewide in the following counties: Apache, Cochise, Coconino, Gila, Graham, Greenlee, La Paz, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma.

Strengths, Opportunities for Improvement, and Recommendations

Opportunities for Improvement and Recommendations

HSAG identified the following opportunities for improvement:

- Mercy Care DCS CHP did not meet the minimum network requirements for BHRF; Dentist, Pediatric; and Pharmacy. [Access]

Recommendation: HSAG recommends that Mercy Care DCS CHP maintain current compliance with network standards and continue to address network gaps, as applicable.

Consumer Assessment of Healthcare Providers and Systems Results

DCS CHP Results

HSAG administered member experience surveys on AHCCCS' behalf to members enrolled in the AHCCCS' DCS CHP. DCS CHP is Arizona's CHIP for eligible children (under age 18 years) who do not qualify for other AHCCCS health insurance.

Table 8-17 shows the 2024 and 2025 scores, including the overall members' experience ratings, trend analysis, and national average comparison results for each CAHPS measure for both the general child and CCC DCS CHP Medicaid populations.

Table 8-17—DCS CHP CAHPS Comparative Analyses

Measure	General Child Medicaid		CCC Medicaid	
	2024	2025	2024	2025
Global Ratings				
<i>Rating of Health Plan</i>	★ 68.7%	★★ 70.2%	★ 61.5%	★★ 65.5%
<i>Rating of All Health Care</i>	★★★★★ 73.8%	★★★★★ 76.3%	★★★★ 65.6%	★★★★ 68.8%
<i>Rating of Personal Doctor</i>	★★★★★ 79.9%	★★★★★ 81.5%	★★★★ 75.4%	★★★ 75.3%
<i>Rating of Specialist Seen Most Often</i>	★ 66.2% ⁺	★★ 68.7% ⁺	★ 62.1% ⁺	★★★★ 72.7% ⁺
Composite Measures				
<i>Getting Needed Care</i>	★★ 82.4%	★★★★★ 88.1%	★ 79.3% ⁺	★★★★ 85.1%

Measure	General Child Medicaid		CCC Medicaid	
	2024	2025	2024	2025
<i>Getting Care Quickly</i>	★★★★★ 89.6%	★★★★★ 96.1% ▲H	★ 85.3% ⁺	★★★★★ 93.9% ▲H
<i>How Well Doctors Communicate</i>	★★★ 94.3%	★★★★★ 95.8%	★★ 92.7%	★★★ 95.3%
<i>Customer Service</i>	★★★★★ 93.3% ⁺	★★★★★ 96.6% ⁺ H	★★★★★ 95.3% ⁺	★★★★★ 92.1% ⁺
Individual Item Measure				
<i>Coordination of Care</i>	★★ 83.7%	★★ 82.6% ⁺	★ 77.0% ⁺	★ 76.0%
CCC Composite Measures and Items				
<i>Access to Specialized Services</i>	NA	NA	★ 64.5% ⁺	★★★★★ 83.8% ⁺ ▲H
<i>FCC: Personal Doctor Who Knows Child</i>	NA	NA	★ 81.2%	★ 88.8% ▲
<i>Coordination of Care for Children with Chronic Conditions</i>	NA	NA	★ 74.2% ⁺	★ 72.5% ⁺
<i>Access to Prescription Medicines</i>	NA	NA	★ 84.5%	★★★★★ 92.9% ▲
<i>FCC: Getting Needed Information</i>	NA	NA	★ 87.7%	★★★★★ 94.2%

Star Assignments Based on Percentiles:

★★★★★ 90th or Above ★★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

▲ Indicates the 2025 score is statistically significantly higher than the 2024 score.

▼ Indicates the 2025 score is statistically significantly lower than the 2024 score.

H Indicates the 2025 score is statistically significantly higher than the NCQA national average.

L Indicates the 2025 score is statistically significantly lower than the NCQA national average.

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

NA Indicates that this measure is not applicable for the population.

Strengths, Opportunities for Improvement, and Recommendations

Table 8-18 presents program-level strengths, opportunities for improvement, and recommendations for DCS CHP related to the 2025 DCS CHP program-level CAHPS results.

**Table 8-18—DCS CHP Strengths, Opportunities for Improvement, and Recommendations
Related to CAHPS**

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • DCS CHP’s member experience ratings for <i>Rating of All Health Care</i>, <i>Getting Care Quickly</i>, and <i>Customer Service</i> were at or above the 90th percentiles for the general child population. [Quality, Timeliness] • DCS CHP’s member experience ratings for <i>Getting Care Quickly</i> and <i>Access to Specialized Services</i> were at or above the 90th percentiles for the CCC population. [Quality, Timeliness, Access] • DCS CHP’s member experience ratings for <i>Rating of Personal Doctor</i>, <i>Getting Needed Care</i>, and <i>How Well Doctors Communicate</i> were at or between the 75th and 89th percentiles for the general child population. [Quality, Access] • DCS CHP’s member experience rating for <i>Customer Service</i> was at or between the 75th and 89th percentiles for the CCC population. [Quality] • DCS CHP’s 2025 scores for <i>Getting Care Quickly</i> and <i>Customer Service</i> were statistically significantly higher than the NCQA national averages for the general child population. [Quality, Timeliness] • DCS CHP’s 2025 scores for <i>Getting Care Quickly</i> and <i>Access to Specialized Services</i> were statistically significantly higher than the NCQA national averages for the CCC population. [Quality, Timeliness, Access] • DCS CHP’s 2025 score for <i>Getting Care Quickly</i> was statistically significantly higher than the 2024 score for the general child population. [Quality, Timeliness] • DCS CHP’s 2025 scores for <i>Getting Care Quickly</i>, <i>Access to Specialized Services</i>, <i>FCC: Personal Doctor Who Knows Child</i>, and <i>Access to Prescription Medicines</i> were statistically significantly higher than the 2024 scores for the CCC population. [Quality, Timeliness, Access]
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: • DCS CHP’s member experience ratings for <i>Coordination of Care</i>, <i>FCC: Personal Doctor Who Knows Child</i>, and <i>Coordination of Care for Children with Chronic Conditions</i> were below the 25th percentiles for the CCC population. [Quality] • DCS CHP’s member experience ratings for <i>Rating of Health Plan</i>, <i>Rating of Specialist Seen Most Often</i>, and <i>Coordination of Care</i> were at or between the 25th and 49th percentiles for the general child population. [Quality] • DCS CHP’s member experience ratings for <i>Rating of Health Plan</i> and <i>Rating of Personal Doctor</i> were at or between the 25th and 49th percentiles for the CCC population. [Quality]

Strengths, Opportunities for Improvement, and Recommendations

Recommendations: HSAG recommends that DCS CHP explore what may be driving lower experience scores and develop initiatives designed to improve the quality of care, including a focus on improving parents'/caretakers' overall experiences with the health plan, the specialist their child sees most often, access to care in a timely manner, and coordination of care for child members.

9. ALTCS-EPD Program-Level Comparative Results

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

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

Performance Measure Validation

During CYE 2025, HSAG evaluated each ALTCS-EPD Program Contractor’s data system for processing of each data type used for reporting the Contractor’s CY 2024 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. A summary of these findings by ALTCS-EPD Program Contractor is provided in Table 9-1. Table 9-1 also displays whether or not each ALTCS-EPD Program Contractor met the assessed IS standards, which demonstrates whether or not the Contractor has effective IS practices and control procedures for data reporting. Additional information about each ALTCS-EPD Program Contractor’s general findings for each data type reviewed can be found in [Section 10. ALTCS-EPD Program Contractor-Specific Results](#). Additional information regarding the CMS EQR Protocol 2 audit requirements, including additional information about the levels of scoring, can be found in the Validation of Performance Measures section of [Appendix A. Methodology](#).

**Table 9-1—Performance Measures Validation Contractor Comparison:
CMS EQR Protocol 2 Validation Results for ALTCS-EPD Program Contractors**

Data Type	BUFC LTC	Mercy Care LTC	UHCCP LTC
Medical Services Data	<i>Met</i>	<i>Met</i>	<i>Met</i>
Enrollment Data	<i>Met</i>	<i>Met</i>	<i>Met</i>
Provider Data	<i>Met</i>	<i>Met</i>	<i>Met</i>
Medical Record Review Processes	<i>Met</i>	<i>Met</i>	<i>Met</i>
Supplemental Data	<i>Met</i>	<i>Met</i>	<i>Met</i>
Data Preproduction Processing	<i>Met</i>	<i>Met</i>	<i>Met</i>
Data Integration and Reporting	<i>Met</i>	<i>Met</i>	<i>Met</i>

ALTCS-EPD Program-Level Results

Table 9-2 presents the CY 2024 aggregate performance measure results for the ALTCS-EPD Program Contractors. Performance measure rate cells shaded green indicate that the Contractor met or exceeded

the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the national Medicaid mean are shaded green. Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 9-2—CY 2024 Performance Measure Results for ALTCS-EPD Program Contractors

Performance Measure	BUFC LTC	Mercy Care LTC	UHCCP LTC	Aggregate
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	77.24%^	83.03%^	83.89%^	81.97%^
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	74.07%^	72.22%^	83.84%^	77.23%^
Effective Continuation Phase Treatment—Total (18+ Years)	66.36%^	62.22%^	75.21%^	68.52%^
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18—64 Years	92.56%^	98.05%^	93.06%^	95.28%^
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	NA ⁺⁺	NA ⁺⁺	30.30%^	27.63%^
30-Day Follow-Up—Total (13+ Years)	NA ⁺⁺	NA ⁺⁺	36.36%	36.84%
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ years)	35.29%	53.66%^	35.00%	41.74%^
30-Day Follow-Up—Total (6+ Years)	52.94%	70.73%^	52.50%	59.13%
Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	48.56%^	45.87%	48.00%^	47.31%^
Engagement of SUD Treatment—Total—Total (13+ Years)	6.58%	7.57%	5.05%	6.33%
Use of Opioids at High Dosage				
18+ Years*	9.53%	11.08%	9.50%	10.10%
Care of Acute and Chronic Conditions				
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status <8.0%—Total (18–75 Years)	58.88% ⁺⁺	66.67% ⁺⁺	68.61% ⁺⁺	65.31% ⁺⁺

Performance Measure	BUFC LTC	Mercy Care LTC	UHCCP LTC	Aggregate
<i>Glycemic Status >9.0%*—Total (18–75 Years)</i>	34.31% ⁺	26.28% ⁺⁺	22.14% ⁺⁺	26.99% ⁺⁺
Pediatric Health				
Child and Adolescent Well-Care Visits				
<i>Total (3–21 Years)</i>	48.25%	51.72%	54.55%	51.68%
Preventive Screening				
Breast Cancer Screening				
<i>Total (50–74 Years)^N</i>	49.84%	43.88%	39.56%	44.04%
Breast Cancer Screening (ECDS)				
<i>Total (50–74 Years)</i>	49.42%	43.88%	39.10%	43.73%
Cervical Cancer Screening				
<i>21–64 Years</i>	24.09% ⁺	32.60% ⁺	34.55% ⁺	31.25% ⁺
Cervical Cancer Screening (ECDS)				
<i>21–64 Years</i>	22.22%	28.88%	32.30%	28.37%
Colorectal Cancer Screening (ECDS)				
<i>Total (45–75 Years)</i>	38.76%	44.58% [^]	49.01% [^]	44.54% [^]
Appropriate Utilization of Services				
Plan All-Cause Readmissions				
<i>Observed/Expected (O/E) Ratio—Total (18–64 Years)*</i>	1.0274 [^]	1.0865 [^]	0.8872 [^]	1.0259 [^]
Oral Health				
Oral Evaluation, Dental Services				
<i>Total</i>	33.61%	47.15% [^]	37.12%	41.20% [^]

* A lower rate indicates better performance for this measure.

** Table A-2 in [Appendix A. Methodology](#) outlines which immunizations are included within each combination.

+ Indicates the measure was reported using hybrid methodology.

NA⁺⁺ indicates the denominator was too small to report a valid rate, based on the applicable measure specification.

^N Measure has no NCQA Medicaid mean for comparison.

 and [^] indicates that the rate met or exceeded the MY 2024 national Medicaid mean.

While the following measures were included as part of the PMV activity, they are not included in the performance measure results tables because their denominators were too small: PPC, FUM, DEV, IMA, IMA-E, APM, and W30.

Table 9-3 presents the CY 2023 and CY 2024 ALTCS-EPD Program Aggregate for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and/or MY 2024. Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus

sign (+) were reported using administrative methodology. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*).

**Table 9-3—CY 2023 and CY 2024 Performance Measure Aggregate Results
for ALTCES-EPD Program Contractors**

Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	81.06%^	81.97%^	→	★★★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	79.13%^	77.23%^	→	★★★★★
Effective Continuation Phase Treatment—Total (18+ years)	69.12%^	68.52%^	→	★★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	93.88%^	95.28%^	→	★★★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	55.36%^	42.86%^	→	★★★
30-Day Follow-Up—Total (6+ Years)	71.43%^	57.14%	→	★★★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	38.10%^	27.63%^	→	★★★
30-Day Follow-Up—Total (13+ Years)	51.19%^	36.84%	→	★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	35.94%	41.74%^	→	★★★
30-Day Follow-Up—Total (6+ Years)	57.81%	59.13%	→	★★
Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	49.05%^	47.31%^	→	★★★
Engagement of SUD Treatment—Total—Total (13+ years)	6.76%	6.33%	→	★
Use of Opioids at High Dosage				
18+ Years*	11.14%	10.10%	→	★

Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Care of Acute and Chronic Conditions				
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status <8.0%—Total (18–75 Years)	69.98% [^]	65.31% ^{+^}	↓	★★★★★
Glycemic Status >9.0%*—Total (18–75 Years)	23.93% [^]	26.99% ^{+^}	↓	★★★
Pediatric Health				
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	46.68%	51.68%	→	★★
Immunizations for Adolescents**				
Combination 1 (Meningococcal, Tdap)	NA ⁺⁺	88.89% [^]	—	★★★★★
Combination 2 (Meningococcal, Tdap, HPV)	NA ⁺⁺	41.67% [^]	—	★★★
Immunizations for Adolescents (ECDS)**				
Combination 1 (Meningococcal, Tdap)	—	88.89% [^]	—	★★★★★
Combination 2 (Meningococcal, Tdap, HPV)	—	38.89% [^]	—	★★★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	40.29%	44.04%	↑	NC [±]
Breast Cancer Screening (ECDS)				
Total (50–74 Years)	—	43.73%	—	★
Cervical Cancer Screening				
21–64 Years	29.93%	31.25% ⁺	→	★
Cervical Cancer Screening (ECDS)				
21–64 Years	—	28.37%	—	★
Colorectal Cancer Screening (ECDS)				
Total (45–75 Years)	—	44.54% [^]	—	★★★
Appropriate Utilization of Services				
Plan All-Cause Readmissions				
Observed/Expected (O/E) Ratio—Total (18–64 Years)*	—	1.0259 [^]	—	★★★★★
Oral Health				
Oral Evaluation, Dental Services				
Total	—	41.20% [^]	—	★★

* A lower rate indicates better performance for this measure.

** Table A-2 in [Appendix A. Methodology](#) outlines which immunizations are included within each combination.

NC± indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

+ Indicates the measure was reported using hybrid methodology.

NA⁺⁺ indicates that the ALTCS-EPD Program Contractor was not required to report the measure (i.e., small denominator).

 and ^ indicates that the rate met or exceeded the MY 2024 national Medicaid mean.

¹ Aggregated rates were calculated and compared from MY 2023 to MY 2024, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.

² Performance Levels for CY 2024 were based on comparisons of the HEDIS MY 2024 measure rates to NCQA Quality Compass national Medicaid HEDIS MY 2024 benchmarks.

— Indicates a 2023–2024 comparison is not presented in the CYE 2025 Annual Technical Report because either there was a break in trending, the CY 2023 rate was not presented in the CYE 2024 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

↑ Indicates statistically significant improvement of measure rates.

↓ Indicates statistically significant decline of measure rates.

→ Indicates no statistically significant change in measure rates.

Performance Levels for 2024 represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Table 9-4 highlights the ALTCS-EPD Program Contractors' performance for the current year by measure group. The table illustrates the Contractors' CY 2024 measure rates and their performance relative to the NCQA national Medicaid Quality Compass HEDIS MY 2024 percentiles, where applicable. The performance level star ratings are defined as follows:

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

Table 9-4—CY 2024 National Percentiles Comparison for ALTCS-EPD Program Contractors

Performance Measure	BUFC LTC	Mercy Care LTC	UHCCP LTC	Aggregate
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	★★★★★	★★★★★	★★★★★	★★★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	★★★★	★★★★	★★★★★	★★★★★
Effective Continuation Phase Treatment—Total (18+ Years)	★★★★★	★★★★★	★★★★★	★★★★★

Performance Measure	BUFC LTC	Mercy Care LTC	UHCCP LTC	Aggregate
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	★★★★★	★★★★★	★★★★★	★★★★★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	NC±	NC±	★★★	★★★
30-Day Follow-Up—Total (13+ Years)	NC±	NC±	★★	★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	★★	★★★★	★★	★★★
30-Day Follow-Up—Total (6+ Years)	★	★★★★	★	★★
Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	★★★	★★★	★★★	★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	★	★	★	★
Use of Opioids at High Dosage				
18+ Years*	★	★	★	★
Care of Acute and Chronic Conditions				
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status <8.0%—Total (18–75 Years)	★★	★★★★	★★★★★	★★★★
Glycemic Status >9.0%—Total (18–75 Years)*	★★	★★★★	★★★★★	★★★
Pediatric Health				
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	★	★★	★★	★★
Preventive Screening				
Breast Cancer Screening (ECDS)				
Total (50–74 Years)	★	★	★	★
Cervical Cancer Screening				
21–64 Years	★	★	★	★
Cervical Cancer Screening (ECDS)				
21–64 Years	★	★	★	★
Colorectal Cancer Screening (ECDS)				
Total (45–75 Years)	★★	★★★	★★★★	★★★

Performance Measure	BUFC LTC	Mercy Care LTC	UHCCP LTC	Aggregate
Appropriate Utilization of Services				
Plan All-Cause Readmissions				
Observed/Expected (O/E) Ratio—Total (18–64 Years)*	★★★★	★★★	★★★★★	★★★★
Oral Health				
Oral Evaluation, Dental Services				
Total	★★	★★★	★★	★★

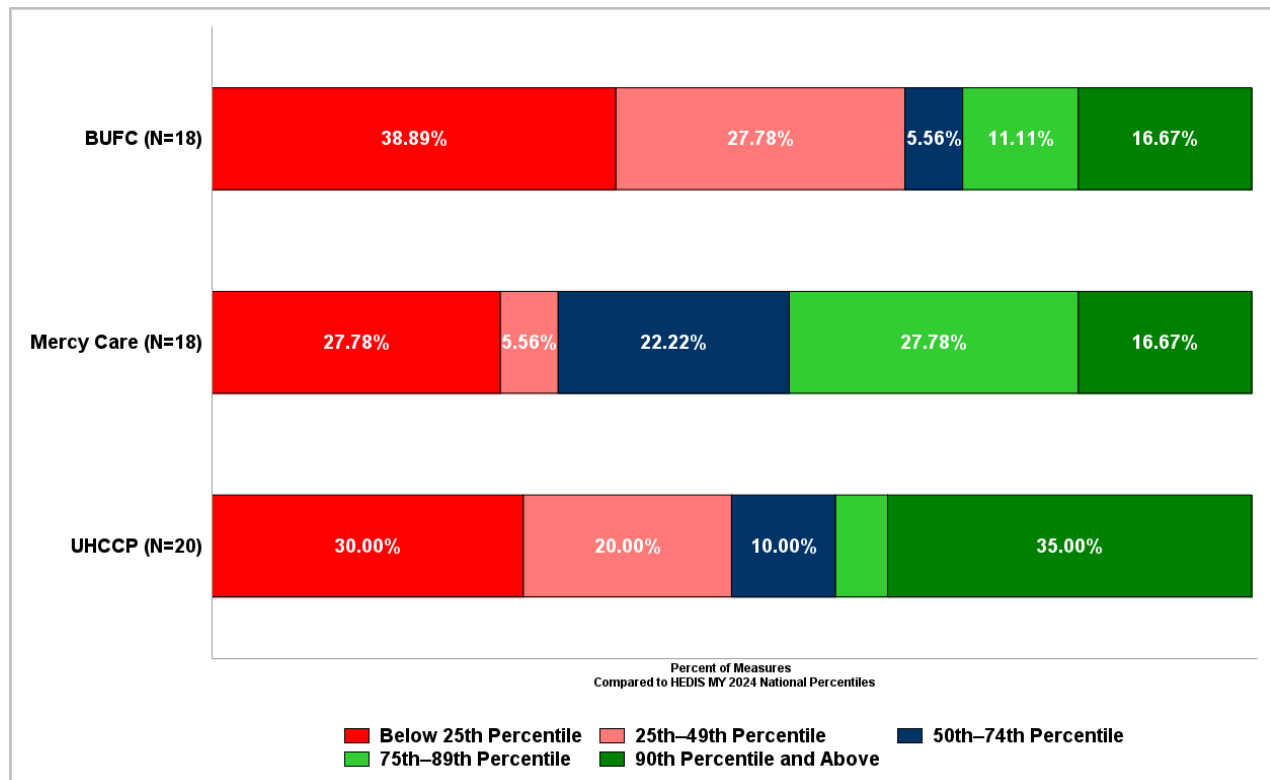
* A lower rate indicates better performance for this measure.

** Table A-2 in [Appendix A. Methodology](#) outlines which immunizations are included within each combination.

NC± indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

Figure 9-1 displays the ALTCS-EPD Program Contractors' HEDIS CY 2024 performance compared to NCQA CY 2024 National Percentiles. HSAG analyzed results from 15 performance measures for HEDIS CY 2024 for a total of 20 measure rates. Percentages in the figure may not total 100 percent due to rounding.

Figure 9-1—Comparison of Measure Indicators to HEDIS Medicaid National Percentiles for ALTCS-EPD Contractors



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

Table 9-5 presents program-level strengths, opportunities for improvement, and recommendations (as applicable) for the ALTCS-EPD Program related to performance measures.

Table 9-5—ALTCS-EPD Program Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group: - The <i>Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)</i> and <i>Effective Continuation Phase Treatment—Total (18+ Years)</i> measure rates for all ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean and the 75th percentile for HEDIS MY 2024. These results may indicate that members with a diagnosis of major depression who were enrolled with the three ALTCS-EPD Program Contractors may be receiving continuous medication treatment. Effective medication treatment of major depression can improve a person’s daily functioning and well-being and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated as well.¹⁴⁷ [Quality] - The <i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years</i> measure rate for all ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean and the 90th percentile for HEDIS MY 2024. These results may indicate that members with a diagnosis of schizophrenia who are enrolled with the three ALTCS-EPD Program Contractors may be receiving continuous medication treatment. [Quality, Timeliness, Access] - The <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years</i> measure rate for all ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean and the 90th percentile for HEDIS MY 2024, indicating members are receiving adequate diabetes screenings for those members diagnosed appropriately and using antipsychotics. [Quality] In the Care of Acute and Chronic Conditions measure group, the <i>Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total (18–75 Years)</i> measure rate for all ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024, indicating that

¹⁴⁷ National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/antidepressant-medication-management-amm/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

members enrolled with the three ALTCS-EPD Program Contractors who had a hypertension diagnosis may have controlled diabetes. **[Quality]**

In the Appropriate Utilization of Services measure group, the *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total (18–64 Years)* measure rate for all ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024, indicating that most members who were admitted to an acute inpatient and observation stay may not have had a subsequent unplanned acute readmission for any diagnosis within 30 days. **[Quality]**

Opportunities for Improvement and Recommendations

In the Behavioral Health measure group:

- The rates for all three ALTCS-EPD Program Contractors and the ALTCS-EPD Program Aggregate rate for *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* fell below the NCQA Quality Compass national Medicaid HMO mean and HEDIS MY 2024 25th percentile, indicating that members who initiated SUD treatment may not have had two or more additional SUD treatment services or MAT in the 34 days following their initiation visit. Treatment, including MAT, in conjunction with counseling or other behavioral therapies, has been shown to reduce SUD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.¹⁴⁸ **[Quality, Timeliness, Access]**

Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors continue all efforts to conduct a root cause analysis or focus study to determine why some members were not accessing SUD services or MAT following their initiation visit. HSAG recommends that the ALTCS-EPD Program Contractors review patient data for any patterns present by ZIP Code and other demographics for case management prioritization. One study suggests that male members who have a schizophrenia spectrum disorder diagnosis are less likely to initiate treatment, while current drug dependence and recent arrest were associated with lowered odds of engaging in treatment. Current drug dependence is associated with factors that make scheduling and attending treatment appointments difficult, such as severe symptoms, chaotic living situations, and self-care and life functioning issues.¹⁴⁹

- Rates for all three ALTCS-EPD Program Contractors and the ALTCS-EPD Program Aggregate rate for *Use of Opioids at High Dosage—18+ Years* did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024, and rates remained below the 25th

¹⁴⁸ National Committee for Quality Assurance. Initiation and Engagement of Substance Use Disorder Treatment (IET). Available at: <https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-substance-use-disorder-treatment/>. Accessed on: Feb 11, 2026.

¹⁴⁹ Brown CH, Bennett ME, Li L, Bellack AS. Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders. *Addictive Behaviors*. 2010;36(5):439–47.

Strengths, Opportunities for Improvement, and Recommendations

percentile. These results indicate that there is an opportunity for the ALTCS-EPD Program Contractors to better monitor prescribing and utilization data and implement interventions to improve care and services around opioid prescribing. The CDC guidelines on opioid prescribing for chronic, nonmalignant pain recommend the use of “additional precautions” when prescribing dosages ≥ 50 MED and that providers avoid or “carefully justify” increasing dosages ≥ 90 mg MED.¹⁵⁰ [Quality]

Recommendations: HSAG recommends that the ALTCS-EPD Program Contractors continue to evaluate their opioid prescription monitoring efforts to identify opportunities to enhance oversight of prescription opioids at a high dosage. Through this process, each ALTCS-EPD Program Contractor should determine if it is necessary to deploy additional mechanisms to identify members who may be at high risk for opioid overuse and misuse, as literature suggests there is a correlation between high dosages of prescription opioids and the risk of both fatal and nonfatal overdoses.¹⁵¹ Each ALTCS-EPD Program Contractor should continue to report any completed prescription opioid monitoring effort enhancements to AHCCCS. HSAG also recommends that ALTCS-EPD Program Contractors identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts.

In the Preventive Screening measure group:

- The rates for all three ALTCS-EPD Program Contractors and the ALTCS-EPD Program Aggregate rate for *Breast Cancer Screening (ECDS)—Total (50–74 Years)* did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024, and rates fell below the 25th percentile, indicating that some women may not be receiving timely screening for breast cancer. Early detection reduces the risk of dying from this type of cancer and can lead to a greater range of treatment options and lower healthcare costs.¹⁵² [Quality]

Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors conduct a root cause analysis or focus study to determine why some female members were not receiving timely breast cancer screenings and implement targeted interventions.

- Rates for all three ALTCS-EPD Program Contractors and the ALTCS-EPD Program Aggregate rate for *Cervical Cancer Screening—21–64 Years* and *Cervical Cancer Screening (ECDS)—21–64 Years* did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and fell below the 25th percentile, indicating that some women may not be

¹⁵⁰ National Committee for Quality Assurance. Use of Opioids at High Dosage (HDO). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/use-of-opioids-at-high-dosage-hdo/>. Accessed on: Feb 11, 2026.

¹⁵¹ Ibid.

¹⁵² National Committee for Quality Assurance. Breast Cancer Screening (BCS-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/breast-cancer-screening-bcs-e/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

receiving timely screening for cervical cancer. Effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate.¹⁵³ **[Quality]**

Recommendations: HSAG recommends that ALTCS-EPD Program Contractors consider utilizing one-on-one interactions with health care professionals, such as CHWs, which have been shown to improve cervical cancer screening rates. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that ALTCS-EPD Program Contractors provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge.

Starting as part of MY 2022 performance measure reporting, RES is required based on NCQA HEDIS specifications. While HSAG noted that two of the three ALTCS-EPD Contractors could benefit from improvement in performance measure reporting using RES, all ALTCS-EPD Contractors could benefit from continuing to focus on refining RES reporting when required in keeping with measure specifications. **[Quality]**

Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors continue to explore data sources for the capture of race and ethnicity data to support performance measure reporting that requires stratifications related to RES. The ALTCS-EPD Program Contractors should continue to collaborate with AHCCCS to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information.

Performance Improvement Projects

Breast Cancer Screening PIP

Breast cancer is the most common cancer in women in the United States except for skin cancers and is the second most common cause of cancer death in women.¹⁵⁴ It accounts for about 30 percent (or one in three) of all new female cancers each year.¹⁵⁵ Ensuring that all women receive regular breast cancer screening is critically important in disease prevention, early detection, and treatment. Breast cancer screening for women is aimed at identifying breast abnormalities as early as possible, and ideally before warning signs or symptoms are present, when the chances of survival are the highest. Even if breast cancer incidences

¹⁵³ National Committee for Quality Assurance. Cervical Cancer Screening (CCS-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/cervical-cancer-screening-ccs-e/>. Accessed on: Feb 11, 2026.

¹⁵⁴ American Cancer Society. Key Statistics for Breast Cancer (2025). Available at: <https://www.cancer.org/cancer/types/breast-cancer/about/how-common-is-breast-cancer.html>. Accessed on: Feb 12, 2026.

¹⁵⁵ Ibid.

cannot be substantially reduced for some women who are at high risk for developing the disease, the risk of death from breast cancer can be reduced by regular screenings.

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

ALTCS-EPD Program-Level Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG’s confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG’s confidence that the PIP’s performance indicator results demonstrated evidence of significant improvement. Table 9-6 presents the ALTCS-EPD program-level overall validation results for each Contractor for the *Breast Cancer Screening* PIP.

Table 9-6—ALTCS-EPD Program Contactors’ *Breast Cancer Screening* PIP Overall Confidence Levels for Remeasurement 3

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
BUFC LTC	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>	100%	100%
Mercy Care LTC	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>	100%	100%
UHCCP LTC	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>	100%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

ALTCS-EPD Program-Level Measure Results

Table 9-7 presents the indicator rate for each Contractor during the baseline, Remeasurement Year 1, Remeasurement Year 2, and Remeasurement Year 3 rates.

Table 9-7—ALTCS-EPD Program Contractors’ Breast Cancer Screening PIP Comparative Rates

Contractor	PIP Indicator: <i>Breast Cancer Screening</i>			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
BUFC LTC	38.45%^	40.99%	48.93%	49.84%
Mercy Care LTC	37.76%	35.22%	38.40%	43.88%
UHCCP LTC	34.07%	41.62%	37.27%	39.56%

^In CYE 2019, the BUFC LTC indicator rate had a small denominator, which did not allow for reporting of the measure. As such, the CY 2020 rate of 38.5 percent served as the baseline for BUFC LTC.

ALTCS-EPD Program-Level Interventions

For the *Breast Cancer Screening* PIP, all Contractors provided lists of interventions that were in place for this validation cycle. These lists detailed the identified population, the intervention(s) in place, and whether or not the intervention(s) will be continued. The most common interventions across the ALTCS-EPD Program Contractors included targeting members and providers for outreach and education related to breast cancer screenings. Outreach methods included IVR, person-to-person, and automated phone calls; text message campaigns; events; mobile units; emails; and letters and other physical mailers. Provider and member incentives were also used as well as provider gap reports. For further descriptions of each Contractor’s interventions, see [Section 10. ALTCS-EPD Program Contractor-Specific Results](#).

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

Table 9-8 presents program-level strengths, opportunities for improvement, and recommendations (as applicable) for the ALTCS-EPD Program related to PIPs.

Table 9-8—ALTCS-EPD Program Strengths, Opportunities for Improvement, and Recommendations Related to the Breast Cancer Screening PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths:

Strengths, Opportunities for Improvement, and Recommendations
- All ALTCS-EPD Program Contractors adhered to acceptable methodology through all phases of the PIP. [Quality, Access] - All ALTCS-EPD Program Contractors were able to achieve statistically significant improvement when comparing the baseline rate to Remeasurement 3 rate. [Quality, Access] - Two ALTCS-EPD Program Contractors achieved statistically significant improvement at Remeasurement 3 when compared to the baseline rate, sustaining the statistically significant improvement achieved at Remeasurement 2. [Quality, Access]
Opportunities for Improvement and Recommendations
HSAG did not identify any program-level opportunities for improvement. Recommendations: Although there were no opportunities for improvement identified, HSAG recommends that the ALTCS-EPD Program Contractors consider the following for the future PIP selected to replace the <i>Breast Cancer Screening</i> PIP. - Apply lessons learned from the <i>Breast Cancer Screening</i> PIP. - Seek technical assistance from HSAG to understand the CMS EQR Protocol 1 requirements. - Implement interventions with clearly defined intervention effectiveness measures that are directly linked to the intervention to assess the effectiveness of each intervention.

Compliance Reviews

AHCCCS contracted with HSAG to conduct compliance reviews of the ALTCS-EPD Program Contractors. CYE 2025 began a new three-year cycle of compliance reviews, referred to as ORs, for two of the three ALTCS-EPD Contractors.

For the CYE 2025 evaluation of the ALTCS-EPD program, HSAG performed two types of activities. First, HSAG conducted a review of 15 standard areas using monitoring tools to assess and document compliance with federal and State requirements. The 15 standards for review were related to the federal Medicaid managed care regulations and associated State requirements. The compliance review included completing a desk review of documents, a review of the Contractor's NCQA health plan accreditation reports and findings, file reviews, and an on-site review that included reviewing additional documents and conducting interviews with the Contractor. The second compliance review activity in CYE 2025 involved HSAG's and AHCCCS' evaluation of the ACC Contractor's CAPs related to findings from the CYE 2025 compliance review.

ALTCS-EPD Program-Level Results

Table 9-9 summarizes the results from the 2025 compliance reviews. This table contains high-level results of the ALTCS-EPD Contractors' performance on a set of requirements (federal Medicaid

managed care regulations and State contract provisions) for each of the 15 operational standard areas reviewed.

Table 9-9—Standards and Compliance Scores

Standard #	Standard Name*	BUFC LTC	UHCCP LTC
I	Disenrollment: Requirements and Limitations	67%	89%
II	Member Rights and Member Information	95%	91%
III	Emergency and Poststabilization Services	85%	92%
IV	Availability of Services	100%	100%
V	Assurances of Adequate Capacity and Services	100%	100%
VI	Coordination and Continuity of Care	100%	100%
VII	Coverage and Authorization of Services	90%	87%
VIII	Provider Selection	86%	100%
IX	Confidentiality	100%	100%
X	Grievance and Appeal Systems	84%	84%
XI	Subcontractual Relationships and Delegation	60%	80%
XII	Practice Guidelines	100%	100%
XIII	Health Information Systems	89%	100%
XIV	Quality Assessment and Performance Improvement Program	89%	89%
XV	Program Integrity	100%	100%
Totals		90%	92%
<i>Totals:</i> The compliance scores were calculated by adding the Deemed elements and the Met elements and then dividing by the total number of applicable elements.			

* Table A-7 in [Appendix A. Methodology](#) outlines the compliance review standards and associated federal citations.

The two ALTCS-EPD Contractors submitted their CAPs as required. HSAG and AHCCCS evaluated the sufficiency of the CAPs for implementation of proposed interventions.

Additionally, AHCCCS continued its monitoring of Mercy Care LTC’s CAPs from the CYE 2024 compliance review. On January 29, 2025, AHCCCS reviewed Mercy Care ACC-RBHA’s CAP status and determined that all CAPs had been completed and approved for closure.

HSAG will conduct a compliance review of Mercy Care LTC in 2026, which starts a new three-year compliance review cycle for this Contractor.

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

Table 9-10 presents program-level strengths, opportunities for improvement, and recommendations (as applicable) for the ALTCS-EPD Program related to compliance.

Table 9-10—ALTCS-EPD Program Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
Both ALTCS-EPD Contractors’ scores were at or above 95 percent in the following standards: - Assurances of Adequate Capacity and Services [Timeliness, Access] - Availability of Services [Timeliness, Access] - Confidentiality [Quality] - Coordination and Continuity of Care [Quality, Timeliness, Access] - Practice Guidelines [Quality] - Program Integrity [Quality]
Opportunities for Improvement and Recommendations
Both ALTCS-EPD Contractors’ scores were below 95 percent in the following standards: - Coverage and Authorization of Services [Quality, Timeliness, Access] - Disenrollment: Requirements and Limitations [Quality] - Emergency and Poststabilization Services [Quality, Timeliness, Access] - Grievance and Appeal Systems [Quality, Timeliness, Access] - Quality Assessment and Performance Improvement Program [Quality, Timeliness] - Subcontractual Relationships and Delegation [Quality] Recommendations: HSAG recommends that the ALTCS-EPD Program Contractors continue to work on any outstanding CAPs during CYE 2026.

Network Adequacy Validation

ALTCS-EPD Program-Level Results

ISCA Results

HSAG completed an ISCA for each of the ALTCS-EPD Program Contractors contracted to deliver services to Medicaid managed care members in Arizona, and this report presents findings and validation ratings based on the ALTCS-EPD Program Contractors’ ISCA and live system demonstrations. For each of the ALTCS-EPD Program Contractors assessed, HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data systems. Additionally, HSAG determined that each ALTCS-EPD Program Contractor’s data collection procedures were acceptable.

For the ALTCS-EPD Program Contractors that used external delegated entities to complete network adequacy indicator reporting during the reporting period, no issues were identified.

Based on the results of the ISCAs combined with the detailed validation of each NAV indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and whether the ALTCS-EPD Program Contractors’ interpretation of data was accurate. All ALTCS-EPD Program Contractors received *High Confidence* for both appointment availability and time/distance indicators. However, there were identified areas for improvement for some of the ALTCS-EPD Program Contractors; please refer to [Section 10: ALTCS-EPD Program Contractor-Specific Results](#).

NAV Results

HSAG’s validation of the ALTCS-EPD Program Contractors’ results showed minor discrepancies between the ALTCS-EPD Program Contractors’ self-reported ACOM 436 results and HSAG’s time/distance calculations for all ALTCS-EPD Program Contractors in each quarter for which data could be compared. While minor differences (i.e., less than 1 percentage point) between HSAG’s time/distance calculation results and each Contractor’s time/distance calculation results were common, these findings are most likely attributable to the timing of the input data or software versions used by each ALTCS-EPD Program Contractor, or due to a small number of members eligible for inclusion in time/distance calculations for the standard and county.

Table 9-11 summarizes HSAG’s assessment of each ALTCS-EPD Program Contractor’s compliance with AHCCCS’ minimum time/distance network standards. A check mark indicates that the ALTCS-EPD Program Contractor met the minimum network standard for all assigned counties during the CYE 2024 S2 assessment, and an “X” indicates that the ALTCS-EPD Program Contractor did not meet one or more minimum network standard in any assigned county. [Section 10: ALTCS-EPD Program Contractor-Specific Results](#) contains NAV results specific to each ALTCS-EPD Program Contractor.

Table 9-11—Summary of CYE 2024 S2 Compliance With Minimum Time/Distance Network Requirements for ALTCS-EPD Program Contractors

Minimum Network Requirement	BUFC LTC	Mercy Care LTC	UHCCP LTC
Behavioral Health Outpatient and Integrated Clinic, Adult	✓	✓	✓
Behavioral Health Outpatient and Integrated Clinic, Pediatric	✓	✓	✓
BHRF	✓	✓	✓
Cardiologist, Adult	✓	✓	✓
Cardiologist, Pediatric	✓	✓	✓
Dentist, Pediatric	✓	✓	✓
Hospital	✓	✓	✓

Minimum Network Requirement	BUFC LTC	Mercy Care LTC	UHCCP LTC
Nursing Facility	✓	✓	✓
OB/GYN	✓	✓	✓
PCP, Adult	✓	✓	✓
PCP, Pediatric	✓	✓	✓
Pharmacy	X	✓	✓

The ALTCS-EPD Program Contractors consistently met the Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; BHRF; Cardiologist, Adult and Pediatric; Dentist, Pediatric; Hospital; Nursing Facility; OB/GYN; and PCP, Adult and Pediatric standards.

No isolated data issues were identified affecting ALTCS-EPD Program Contractors' compliance with time/distance standards.

As part of the NAV, AHCCCS maintained its feedback process for the ALTCS-EPD Program Contractors to review and improve the accuracy of their data submissions. Specifically, AHCCCS supplied each ALTCS-EPD Program Contractor with copies of HSAG's network adequacy analysis, the PAT file that HSAG used to conduct the analysis, and HSAG's saturation analysis results. When issues were identified, the ALTCS-EPD Program Contractors were expected to research the instances and make corrections for future PAT data and/or ACOM 436 submissions.

Overall, the applicable ALTCS-EPD Program Contractor met all minimum time/distance network standards in Apache, Cochise, Coconino, Gila, Graham, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. Based on the CYE 2024 S2 NAV results, Mercy Care ALTCS-EPD and UHCCP ALTCS-EPD met all requirements for all standards in their respective counties.

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

Table 9-12 presents program-level strengths, opportunities for improvement, and recommendations (as applicable) for the ALTCS-EPD Program related to NAV.

Table 9-12—ALTCS-EPD Program Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths:

Strengths, Opportunities for Improvement, and Recommendations

- The ALTCS-EPD Program Contractors received *High Confidence* for both appointment availability and time/distance indicators. **[Access]**
- The applicable ALTCS-EPD Program Contractors met all minimum time/distance network standards in Apache, Cochise, Coconino, Gila, Graham, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. **[Access]**
- The ALTCS-EPD Program Contractors' performance consistently met the Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; BHRF; Cardiologist, Adult and Pediatric; Dentist, Pediatric; Hospital; Nursing Facility; OB/GYN; and PCP, Adult and Pediatric standards. **[Access]**

Opportunities for Improvement and Recommendations

HSAG identified the following opportunities for improvement:

- Based on the NAV results, one ALTCS-EPD Program Contractor did not meet the standard for Pharmacy in more than one county. **[Access]**

Recommendation: HSAG recommends that AHCCCS support the ALTCS-EPD Program Contractor in continuing to monitor and maintain its existing provider network coverage as of CYE 2024 S2, with specific attention to ensuring the availability of the following provider category where one ALTCS-EPD Program Contractor did not meet the network requirement in more than one county:

- Pharmacy in Greenlee and La Paz counties.

10. ALTCS-EPD Program Contractor-Specific Results

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

BUFC LTC

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2025, HSAG evaluated BUFC LTC’s data system for processing of each data type used for reporting the Contractor’s CY 2024 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that BUFC LTC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 10-1 displays HSAG’s PMV findings for each data type reviewed during CYE 2025 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 10-1—CYE 2025 PMV Findings

Data Type	HSAG Findings
Medical Services Data	<i>No identified concerns</i>
Enrollment Data	<i>No identified concerns</i>
Provider Data	<i>No identified concerns</i>
Medical Record Review Process	<i>No identified concerns</i>
Supplemental Data	<i>No identified concerns</i>
Data Integration	<i>Issues identified in rate review resulted in a DNR designation for hybrid measures that did not follow AHCCCS’ sampling methodology requirements. AHCCCS-required methodology was not followed for HPCMI-AD, which was reported as admin.</i>

Results for Performance Measures

Table 10-2 presents the CY 2023 and CY 2024 BUFC LTC performance measure results that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY

2024. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and/or MY 2024. Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*).

Table 10-2—CY 2023 and CY 2024 BUFC LTC Performance Measure Results

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	81.90%^	77.24%^	→	★★★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	78.37%^	74.07%^	→	★★★★★
Effective Continuation Phase Treatment—Total (18+ Years)	65.20%^	66.36%^	→	★★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	94.26%^	92.56%^	→	★★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	NA ⁺⁺	35.29%	—	★★
30-Day Follow-Up—Total (6+ Years)	NA ⁺⁺	52.94%	—	★
Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	51.21%^	48.56%^	→	★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	7.25%	6.58%	→	★
Use of Opioids at High Dosage				
18+ Years*	12.70%	9.53%	→	★
Care of Acute and Chronic Conditions				
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status <8.0%—Total (18–75 Years)	68.86%^	58.88%^+	↓	★★
Glycemic Status >9.0%—Total (18–75 Years)*	30.17%^	34.31% ⁺	→	★★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Pediatric Health				
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	48.70%	48.25%	→	★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	48.93%	49.84%	→	NC [±]
Breast Cancer Screening (ECDS)				
Total (50–74 Years)	—	49.42%	—	★
Cervical Cancer Screening				
21–64 Years	22.63%	24.09% ⁺	→	★
Cervical Cancer Screening (ECDS)				
21–64 Years	—	22.22%	—	★
Colorectal Cancer Screening (ECDS)				
Total (45–75 Years)	—	38.76%	—	★★
Appropriate Utilization of Services				
Plan All-Cause Readmissions				
Observed/Expected (O/E) Ratio—Total (18–64 Years)*	—	1.0274 [^]	—	★★★★
Oral Health				
Oral Evaluation, Dental Services				
Total	—	33.61%	—	★★

* A lower rate indicates better performance for this measure.

** Table A-2 in [Appendix A. Methodology](#) outlines which immunizations are included within each combination.

NA⁺⁺ indicates the denominator was too small to report a valid rate, based on the applicable measure specification.

NC[±] indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

+ Indicates the measure was reported using hybrid methodology.

■ and ^ indicates that the rate met or exceeded the MY 2023 and/or MY 2024 national Medicaid mean.

— Indicates a 2023–2024 comparison is not presented in the CYE 2025 Annual Technical Report because either the CY 2023 rate was not presented in the CYE 2024 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

¹ Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.

² Performance Levels for CY 2024 were based on comparisons of the HEDIS MY 2024 measure rates to NCQA Quality Compass national Medicaid HEDIS MY 2024 benchmarks.

↑ Indicates statistically significant improvement of measure rates.

↓ Indicates statistically significant decline of measure rates.

→ Indicates no statistically significant change in measure rates.

Performance Levels for 2024 represent the following percentile comparisons:

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

Strengths, Opportunities for Improvement, and Recommendations

Table 10-3 presents strengths, opportunities for improvement, and recommendations (as applicable) for BUFC LTC related to performance measures, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-3—BUFC LTC Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations	
Strengths	
In the Behavioral Health measure group, five of BUFC LTC’s measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. [Quality] <i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years</i> <i>Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years) and Effective Continuation Phase Treatment—Total (18+ Years)</i> <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years</i> <i>Use of Opioids at High Dosage—18+ Years</i>	
In the Appropriate Utilization of Services measure group, BUFC LTC’s performance measure rate for <i>Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total (18–64 Years)</i> was at or between the 75th and 89th percentile, indicating that most members who were admitted to an acute inpatient and observation stay may not have had a subsequent unplanned acute readmission for any diagnosis within 30 days. [Quality]	
Opportunities for Improvement and Recommendations	
In the Care of Acute and Chronic Conditions measure group, BUFC LTC’s performance measure rates for <i>Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total (18–75 Years)</i> and <i>Glycemic Status >9.0%—Total (18–75 Years)</i> were at or between the 25th and 49th percentile indicating poor control over diabetes. [Quality] Recommendation: Diabetes is a complex group of diseases marked by high blood glucose (blood sugar) due to the body’s inability to make or use insulin. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life. With support	

Strengths, Opportunities for Improvement, and Recommendations

from health care providers, patients can manage their diabetes with self-care, taking medications as instructed, eating a healthy diet, being physically active, and quitting smoking.¹⁵⁶

In the Pediatric Health measure group, BUFC LTC's performance measure rate for *Child and Adolescent Well-Care Visits—Total (3–21 Years)* fell below the 25th percentile, indicating that children and adolescents were not always receiving well-care visits at the recommended intervals. Assessing physical, emotional, and social development is important at every stage of life, particularly for children and adolescents. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.¹⁵⁷ **[Quality, Access]**

Recommendation: HSAG recommends that BUFC LTC continue implementing interventions as part of the *Back to Basics* PIP, which includes a root cause analysis and interventions to address the *Child and Adolescent Well-Care Visits—Total (3–21 Years)* measure. HSAG recommends that BUFC LTC draw as needed from other states' performance improvement initiatives. For instance, as part of a federal performance initiative to improve well-child care, California and Virginia have focused on reducing delays in newborn enrollment data, and Missouri and Texas focused on beneficiary barriers and implemented interventions such as utilizing patient portals and phone outreach. HSAG recommends that BUFC ACC identify other barriers to care and conduct a focus group on identifying ways to address barriers.¹⁵⁸

In the Preventive Screening measure group, all five of BUFC LTC's performance measure rates fell at or below the 25th to 49th percentile. **[Quality]**

- *Breast Cancer Screening—Total (50–74 Years)*
- *Breast Cancer Screening (ECDS)—Total (50–74 Years)*
- *Cervical Cancer Screening—21–64 Years*
- *Cervical Cancer Screening (ECDS)—21–64 Years*
- *Colorectal Cancer Screening (ECDS)—Total (45–75 Years)*

Recommendation: HSAG recommends that BUFC LTC identify disparities or SDOH within the plan's populations that contributed to the preventive screening rates. Upon identification of a root cause, HSAG recommends that BUFC LTC implement appropriate interventions to reduce barriers to care. Further, HSAG recommends that BUFC LTC provide scheduled reminders, direct providers to send messages to members, and utilize personalized outreach for overdue patients.

¹⁵⁶ National Committee for Quality Assurance. Glycemic Status Assessment for Patients with Diabetes (GSD). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/glycemic-status-assessment-for-patients-with-diabetes-gsd/>. Accessed on: Feb 11, 2026.

¹⁵⁷ National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (WCV). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/child-and-adolescent-well-care-visits-wcv/>. Accessed on: Feb 11, 2026

¹⁵⁸ Centers for Medicare & Medicaid Services. Well-Child Care. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations
Communication should be clear and concise and include information on the procedure time. Some of these interventions might include a mobile clinic to conduct the screening, transportation assistance, and adjusting hours for visits to accommodate those with job/childcare concerns.
In the Oral Health measure group, BUFC LTC’s performance measure rate for <i>Oral Evaluation, Dental Services—Total</i> fell at or between the 25th and 49th percentile. [Access] Recommendation: HSAG recommends that BUFC LTC identify disparities or SDOH within the plan’s populations under 21 years of age to identify barriers to receiving a comprehensive or periodic oral evaluation with a dental provider. Upon identification of a root cause, HSAG recommends that BUFC LTC implement appropriate interventions to reduce barriers to care. Research indicates that oral examinations include physical examination, review of appropriate images, and evaluation for risk of tooth decay. Dental caries is the most common chronic disease in children in the United States. From 2015–2016, prevalence of total (untreated and treated) caries-related tooth decay was 46 percent for children 2–19 years old. Identifying caries early on is important to reverse the disease process, prevent progression of caries, and reduce incidence of future lesions.¹⁵⁹

Validation of Performance Improvement Projects

In CYE 2025, BUFC LTC continued the *Breast Cancer Screening* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 3, PIP validation activities focused on improvement from the baseline results. BUFC LTC submitted Remeasurement 3 performance indicator results and interventions implemented during this validation cycle along with the status of interventions, focus, and rationale for changes to or discontinuation of the intervention.

HSAG conducted an annual validation of the third remeasurement year reflective of CY 2024 (January 1, 2024, through December 31, 2024) using AHCCCS-calculated and validated indicator rates. HSAG evaluated BUFC LTC’s performance indicator rates based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of [Appendix A. Methodology](#).

Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG’s confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data

¹⁵⁹ National Committee for Quality Assurance. Oral Evaluation, Dental Services. Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/oral-evaluation-dental-services-oed/>. Accessed on: Feb 11, 2026.

analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG’s confidence that the PIP’s performance indicator results demonstrated evidence of significant improvement. Table 10-4 displays the overall confidence levels for the BUFC LTC *Breast Cancer Screening* PIP.

Table 10-4—BUFC LTC *Breast Cancer Screening* PIP Overall Confidence Levels for Remeasurement 3

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
BUFC LTC	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>	100%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Measure Results

Table 10-5 provides the *Breast Cancer Screening* PIP baseline, Remeasurement Year 1, Remeasurement Year 2, and Remeasurement Year 3 rates for BUFC LTC.

Table 10-5—BUFC LTC *Breast Cancer Screening* PIP Rates

Contractor	PIP Indicator: <i>Breast Cancer Screening</i>			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2020*	CY 2022	CY 2023	CY 2024
BUFC LTC	38.45%	40.99%	48.93%	49.84%

*In CYE 2019, the BUFC LTC indicator rate had a small denominator, which did not allow for reporting of the measure.

As such, CY 2020 served as the baseline for BUFC LTC.

Interventions

Table 10-6 presents PIP interventions for BUFC LTC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 10-6—BUFC LTC Breast Cancer Screening PIP Interventions

Contractor	Interventions
BUFC LTC	• ALTCS case managers asked applicable female members if they have had a mammogram completed during the assessment with the member and provide the member with education on the importance of mammograms. • Implemented a PCP/practice-specific VBP/pay-for-performance program targeting breast cancer screening. • ALTCS case managers identified applicable members who needed a mammogram or will become overdue and attempt outreach calls to offer assistance with scheduling a mammogram appointment. • BUFC imaging collaborated with the ALTCS Care Management department to assist with scheduling members who need a mammogram in Maricopa County. • Quarterly gaps in care lists were generated and sent to the ALTCS case managers for outreach to members still needing a screening. • Initiated discussions for contracting with a mobile mammogram unit. • Annual breast cancer screening mailers and postings on social media in both English and Spanish. • Included educational materials in English and Spanish on the Banner Health website. • Reviewed and collected Non-Standard Supplemental Data (NSSD). • Text message campaigns deployed to members with open care gaps, offering educational information and assistance with scheduling appointments. • Promoted senior health and wellness fair events. • Utilization of Assurance Wireless outreached members and reminded them of regular screenings. • Incentive offering members a gift card for completing a mammogram. • Targeted outreach campaign to American Indian/Alaska Native members by the health plan's Tribal care coordinator to provide support, education, and resources.

Strengths, Opportunities for Improvement, and Recommendations

Table 10-7 presents strengths, opportunities for improvement, and recommendations (as applicable) for BUFC LTC related to the *Breast Cancer Screening* PIP, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-7—BUFC LTC Strengths, Opportunities for Improvement, and Recommendations Related to the Breast Cancer Screening PIP

Strengths, Opportunities for Improvement, and Recommendations	
Strengths	
HSAG identified the following strengths: - The Contractor adhered to acceptable methodology through all phases of the PIP. [Quality, Access] - The Contractor achieved statistically significant improvement between the baseline rate and Remeasurement 2 and sustained the statistically significant improvement at Remeasurement 3 for the <i>BCS</i> performance indicator. [Quality, Access]	
Opportunities for Improvement and Recommendations	
HSAG identified no opportunities for improvement related to the <i>Breast Cancer Screening</i> PIP: Recommendation: HSAG recommends that the Contractor consider the following for future PIPs: - Apply lessons learned from the <i>Breast Cancer Screening</i> PIP. - Seek technical assistance from HSAG to understand the CMS EQR Protocol 1 requirements. - Implement interventions with clearly defined intervention effectiveness measures that are directly linked to the intervention to assess the effectiveness of each intervention.	

Compliance Reviews

In CYE 2025, HSAG conducted a review of 15 standard areas using monitoring tools to assess and document BUFC LTC’s compliance with federal and State requirements. The 15 standards for review were related to the federal Medicaid managed care regulations and associated State requirements. The compliance review included completing a desk review of documents, a review of the Contractor’s NCQA health plan accreditation reports and findings, file reviews, and an on-site review that included reviewing additional documents and conducting interviews with the Contractor.

Results

Table 10-8 presents the compliance review scores for BUFC LTC.

Table 10-8—Standards and Compliance Review Scores

Standard #	Standard Name*	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				D	M	NM	NA	
I	Disenrollment: Requirements and Limitations	9	9	0	6	3	0	67%
II	Member Rights and Member Information	22	22	6	15	1	0	95%

Standard #	Standard Name*	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				D	M	NM	NA	
III	Emergency and Poststabilization Services	13	13	0	11	2	0	85%
IV	Availability of Services	12	12	7	5	0	0	100%
V	Assurances of Adequate Capacity and Services	3	3	0	3	0	0	100%
VI	Coordination and Continuity of Care	12	12	10	2	0	0	100%
VII	Coverage and Authorization of Services	30	30	7	20	3	0	90%
VIII	Provider Selection	7	7	2	4	1	0	86%
IX	Confidentiality	3	3	1	2	0	0	100%
X	Grievance and Appeal Systems	38	38	2	30	6	0	84%
XI	Subcontractual Relationships and Delegation	5	5	1	2	2	0	60%
XII	Practice Guidelines	6	6	5	1	0	0	100%
XIII	Health Information Systems	9	9	0	8	1	0	89%
XIV	Quality Assessment and Performance Improvement Program	9	9	2	6	1	0	89%
XV	Program Integrity	15	14	0	14	0	1	100%
Totals		193	192	43	129	20	1	90%

* Table A-7 in [Appendix A. Methodology](#) outlines the compliance review standards and associated federal citations.

D=Deemed, **M**=Met, **NM**=Not Met, **NA**=Not Applicable

Total Elements: The total number of applicable elements in each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that received a score of **NA**.

Total Compliance Score: The compliance scores were calculated by adding the **Deemed** elements and the **Met** elements and then dividing by the total number of applicable elements.

Strengths, Opportunities for Improvement, and Recommendations

Table 10-9 presents strengths, opportunities for improvement, and recommendations (as applicable) for BUFC LTC related to compliance activities, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-9—BUFC LTC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
BUFC LTC achieved full compliance in six of the 15 standards reviewed, demonstrating strengths and adherence to all requirements measured in the following areas:
Availability of Services [Timeliness, Access]

Strengths, Opportunities for Improvement, and Recommendations
- Assurances of Adequate Capacity and Services [Timeliness, Access] - Confidentiality [Quality] - Coordination and Continuity of Care [Quality, Timeliness, Access] - Practice Guidelines [Quality] - Program Integrity [Quality]
Opportunities for Improvement and Recommendations
The areas with the greatest opportunity for improvement were related to the following, as these areas received performance scores under 95 percent: - Coverage and Authorization of Services [Quality, Timeliness, Access] - Disenrollment: Requirements and Limitations [Quality] - Emergency and Poststabilization Services [Quality, Timeliness, Access] - Grievance and Appeal Systems [Quality, Timeliness, Access] - Health Information Systems [Quality] - Provider Selection [Timeliness, Access] - Quality Assessment and Performance Improvement Program [Quality, Timeliness] - Subcontractual Relationships and Delegation [Quality] Recommendation: HSAG recommends that BUFC LTC address the elements scored as <i>Not Met</i> through the CAP process during CYE 2026.

Network Adequacy Validation

ISCA Results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if BUFC LTC’s interpretation of data was accurate.

Table 10-10 summarizes HSAG’s validation ratings for BUFC LTC by indicator type.

Table 10-10—Summary of BUFC LTC’s Validation Ratings by Indicator Type

Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Appointment Availability	100%	0%	0%	0%
Time/Distance	100%	0%	0%	0%

Of the network adequacy indicators assessed, BUFC LTC received *High Confidence* for both appointment availability and time/distance indicators. However, there were identified areas for improvement; please refer to the Contractor-specific Strengths, Opportunities for Improvement, and Recommendations section below for more details.

NAV Results

HSAG evaluated BUFC LTC’s compliance results with AHCCCS’ time/distance standards by GSA and county. This section presents CYE 2024 S2 validation findings specific to the ALTCS-EPD Program, with one results table for each of the following GSAs:

- Central GSA: Gila, Maricopa, and Pinal counties
- South GSA: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma counties

Each region-specific table summarizes validation results containing the percentage of members meeting each time/distance standard by county, with color coding to identify whether the time/distance standard was *Met* or *Not Met*.

Table 10-11—Time/Distance Validation Results for BUFC LTC Central GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0 [^]	99.5 ^{^Y}	100.0 [^]
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR	97.4 ^{^Y}	100.0 ^{*^}
BHRF	NA	95.7 ^Y	NA
Cardiologist, Adult	100.0 [^]	99.9 ^{^Y}	100.0 [^]
Cardiologist, Pediatric	NR [^]	100.0 [^]	100.0 ^{*^}
Dentist, Pediatric	NR	97.9 ^Y	100.0 [*]
Hospital	100.0	100.0	100.0
Nursing Facility	100.0	99.8 ^Y	100.0
OB/GYN	100.0 [*]	100.0	100.0
Pharmacy	100.0	99.6 ^Y	100.0
PCP, Adult	100.0 [^]	99.9 [^]	100.0 [^]
PCP, Pediatric	NR	97.9 ^{^Y}	100.0 ^{*^}

- Y** represents Contractor-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.
- NR** represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.
- * indicates that fewer than 10 members were included in the denominator of HSAG’s results.
- [^] indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
- NA indicates results are not applicable to the county.

Table 10-12—Time/Distance Validation Results for BUFC LTC South GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Cochise	Graham	Greenlee	La Paz	Pima	Santa Cruz	Yuma
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0 [^]	100.0 [^]	100.0* [^]	100.0 [^]	98.6 ^{^Y}	100.0 [^]	100.0 [^]
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0* [^]	100.0* [^]	NR	NR	87.0 ^{^Y}	100.0* [^]	100.0* [^]
BHRF	NA	NA	NA	NA	91.7 ^Y	NA	NA
Cardiologist, Adult	100.0 ^{^Y}	100.0 [^]	100.0* [^]	100.0 [^]	99.5 ^{^Y}	100.0 [^]	100.0 [^]
Cardiologist, Pediatric	100.0* [^]	100.0* [^]	NR [^]	NR [^]	100.0 [^]	100.0* [^]	100.0 [^]
Dentist, Pediatric	100.0*	100.0*	NR	NR	96.6 ^Y	100.0*	100.0
Hospital	100.0	100.0	100.0*	100.0	99.8	100.0	100.0
Nursing Facility	100.0	100.0	100.0*	100.0	99.7 ^Y	100.0	100.0
OB/GYN	100.0	100.0*	100.0*	100.0*	100.0 ^Y	100.0*	100.0
Pharmacy	100.0 ^Y	100.0	88.9* ^R	85.7 ^R	98.9 ^Y	100.0	100.0
PCP, Adult	100.0 ^{^Y}	100.0 [^]	88.9* ^{^Y}	100.0 [^]	99.8 [^]	100.0 [^]	100.0 [^]
PCP, Pediatric	100.0* [^]	100.0* [^]	NR	NR	100.0 [^]	100.0* [^]	100.0 [^]

Y	represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
R	represents time/distance standard results that do not meet the compliance standard based on HSAG's results.
NR	represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.
* indicates that fewer than 10 members were included in the denominator of HSAG's results.	
[^] indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.	
NA indicates results are not applicable to the county.	

Strengths, Opportunities for Improvement, and Recommendations

Table 10-13 presents strengths, opportunities for improvement, and recommendations (as applicable) for BUFC LTC related to NAV, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-13—BUFC LTC Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths:

Strengths, Opportunities for Improvement, and Recommendations

- BUFC LTC used multiple methods to ensure provider data were complete and current, including daily data reports for each LOB, random audits on data entry, and maintaining clear expectations for providers to update changes. **[Access]**
- BUFC LTC met all minimum network requirements for all assigned counties except in Greenlee and La Paz counties. **[Access]**
- BUFC LTC met all minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; BHRF; Cardiologist, Adult and Pediatric; Dentist, Pediatric; Hospital; OB/GYN; and PCP, Adult and Pediatric. **[Access]**

Note: BUFC LTC provides coverage in the following counties: Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Santa Cruz, and Yuma.

Opportunities for Improvement and Recommendations

HSAG identified the following opportunities for improvement:

- HSAG identified an opportunity for BUFC LTC to strengthen its methods to calculate appointment availability indicator results. BUFC LTC's appointment availability survey script incorporated leading questions directed toward providers, accompanied by a predetermined response format designed to align with AHCCCS compliance requirements. **[Access]**

Recommendation: HSAG recommends that BUFC LTC revise its appointment availability survey script to use open-ended questions that solicit the earliest available appointment dates from each provider. The collected responses should then be independently evaluated to determine compliance with AHCCCS standards.

- BUFC LTC did not meet the minimum network requirements for Pharmacy. **[Access]**

Recommendation: HSAG recommends that BUFC LTC maintain current compliance with network standards and continue to address network gaps, as applicable.

Mercy Care LTC

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2025, HSAG evaluated Mercy Care LTC's data system for processing of each data type used for reporting the Contractor's CY 2024 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that Mercy Care LTC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 10-14 displays HSAG's PMV findings for each data type reviewed during CYE 2025 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 10-14—CYE 2025 PMV Findings

Data Type	HSAG Findings
Medical Services Data	<i>No identified concerns</i>
Enrollment Data	<i>No identified concerns</i>
Provider Data	<i>No identified concerns</i>
Medical Record Review Process	<i>No identified concerns</i>
Supplemental Data	<i>No identified concerns</i>
Data Integration	<i>No identified concerns</i>

Results for Performance Measures

Table 10-15 presents the CY 2023 and CY 2024 Mercy Care LTC performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and/or MY 2024. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 10-15—CY 2023 and CY 2024 Mercy Care LTC Performance Measure Results

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	80.30%^	83.03%^	→	★★★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	70.30%^	72.22%^	→	★★★★★
Effective Continuation Phase Treatment—Total (18+ Years)	64.69%^	62.22%^	→	★★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	96.05%^	98.05%^	→	★★★★★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	34.38%^	NA ⁺⁺	—	NC [±]
30-Day Follow-Up—Total (13+ Years)	50.00%^	NA ⁺⁺	—	NC [±]
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	48.15%^	53.66%^	→	★★★★★
30-Day Follow-Up—Total (6+ Years)	66.67%^	70.73%^	→	★★★★★
Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	48.31%^	45.87%	→	★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	6.49%	7.57%	→	★
Use of Opioids at High Dosage				
18+ Years*	10.89%	11.08%	→	★
Care of Acute and Chronic Conditions				
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status <8.0%—Total (18–75 Years)	70.32%^	66.67% ⁺⁺	→	★★★★★
Glycemic Status >9.0%—Total (18–75 Years)*	22.14%^	26.28% ⁺⁺	→	★★★★★
Pediatric Health				
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	46.12%	51.72%	→	★★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	38.40%	43.88%	↑	NC [±]
Breast Cancer Screening (ECDS)				
Total (50–74 Years)	—	43.88%	—	★
Cervical Cancer Screening				
21–64 Years	30.41%	32.60% ⁺	→	★
Cervical Cancer Screening (ECDS)				
21–64 Years	—	28.88%	—	★
Colorectal Cancer Screening (ECDS)				
Total (45–75 Years)	—	44.58% [^]	—	★★★★
Appropriate Utilization of Services				
Plan All-Cause Readmissions				
Observed/Expected (O/E) Ratio—Total (18–64 Years)*	—	1.0865 [^]	—	★★★★
Oral Health				
Oral Evaluation, Dental Services				
Total (0–20 Years)	—	47.15% [^]	—	★★★★

* A lower rate indicates better performance for this measure.

** Table A-2 in [Appendix A. Methodology](#) outlines which immunizations are included within each combination.

NC[±] indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

+ Indicates the measure was reported using hybrid methodology.

NA⁺⁺ indicates the denominator was too small to report a valid rate, based on the applicable measure specification.

■ and ^ indicates that the rate met or exceeded the MY 2023 and/or MY 2024 national Medicaid mean.

— Indicates a 2023–2024 comparison is not presented in the CYE 2025 Annual Technical Report because either the CY 2023 rate was not presented in the CYE 2024 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

¹ Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.

² Performance Levels for CY 2024 were based on comparisons of the HEDIS MY 2024 measure rates to NCQA Quality Compass national Medicaid HEDIS MY 2024 benchmarks.

↑ Indicates statistically significant improvement of measure rates.

↓ Indicates statistically significant decline of measure rates.

→ Indicates no statistically significant change in measure rates.

Performance Levels for 2024 represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 10-16 presents strengths, opportunities for improvement, and recommendations (as applicable) for Mercy Care LTC related to performance measures, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-16—Mercy Care LTC Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group, six of Mercy Care LTC’s performance measure rates were at or between the 75th and 89th percentile or above the 90th percentile, indicating strength in providing behavioral health follow-up care to members. [Quality, Timeliness, Access] <i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years</i> <i>Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)</i> <i>Antidepressant Medication Management—Effective Continuation Phase Treatment—Total (18+ Years)</i> <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years</i> <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)</i> <i>Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total (6+ Years)</i>
In the Care of Acute and Chronic Conditions measure group, Mercy Care LTC’s performance measure rates for <i>Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total (18–75 Years)</i> and <i>Glycemic Status >9.0%—Total (18–75 Years)</i> were at or between the 75th and 89th percentile, indicating strength in providing appropriate care of acute and chronic conditions to applicable members. [Quality]
Opportunities for Improvement and Recommendations
While Mercy Care LTC was successful in reporting valid rates for all AHCCCS-required performance measures, the audit identified the following recommendations for future years’ reporting [Quality]: Recommendations: HSAG recommends that Mercy Care LTC continue to work with AHCCCS to explore the use of additional data sources for capturing member race and ethnicity information from members to support performance measure reporting. This could involve investigating supplemental data sources and implementing new collection strategies to ensure more complete member profiles. Additionally, HSAG recommends that Mercy Care LTC continue to uphold its adherence to continuous enrollment criteria to maintain compliance with AHCCCS requirements for performance measure reporting. This includes accurately accounting for members who switch product lines, and those for whom Mercy Care LTC is the secondary payer.

Strengths, Opportunities for Improvement, and Recommendations

In the Behavioral Health measure group, Mercy Care LTC's performance measure rates for *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* fell below the 25th percentile. This result provides an opportunity for Mercy Care LTC to implement interventions to improve care and services around SUD treatments. **[Quality]**

Recommendations: HSAG recommends that Mercy Care LTC strengthen strategies to support ongoing engagement in SUD treatment following the initiation period. These efforts should focus on improving care coordination between inpatient, outpatient, and behavioral health providers; reducing barriers to follow-up visits; and enhancing member outreach and reminder processes to encourage continued participation in treatment. In addition, Mercy Care LTC should monitor engagement timeliness and appointment availability, and assess documentation and coding practices to ensure that qualifying services are accurately captured.

In the Preventive Screening measure group, Mercy Care LTC's performance measure rates for *Breast Cancer Screening (ECDS)—Total (50–74 Years)*, *Cervical Cancer Screening—21–64 Years*, and *Cervical Cancer Screening (ECDS)—21–64 Years* fell below the 25th percentile, indicating that not all women were receiving timely screening for breast or cervical cancer. Early detection reduces the risk of dying from these types of cancer and can lead to a greater range of treatment options and lower health care costs. **[Quality]**

Recommendations: While Mercy Care LTC conducted a root cause analysis and implemented interventions specific to the *Breast Cancer Screening (ECDS)—Total (50–74 Years)*, *Cervical Cancer Screening—21–64 Years*, and *Cervical Cancer Screening (ECDS)—21–64 Years* measures, these rates remained low in MY 2024. HSAG recommends that Mercy Care LTC identify disparities or SDOH within the plan's populations that contributed to breast and cervical cancer screening rates. Upon identification of a root cause, HSAG recommends that Mercy Care LTC implement appropriate interventions to reduce barriers to care. Further, HSAG recommends that Mercy Care LTC provide scheduled reminders, direct providers to send messages to members, and utilize personalized outreach for overdue patients. Communication should be clear and concise and include information on the procedure time. Some of these interventions might include a mobile clinic to conduct the screening, transportation assistance, and adjusting hours for visits to accommodate those with job/childcare concerns.

Validation of Performance Improvement Projects

In CYE 2025, Mercy Care LTC continued the *Breast Cancer Screening* PIP, which was initiated in CYE 2019. As this PIP has progressed through Remeasurement 3, PIP validation activities focused on improvement from the baseline results. Mercy Care LTC submitted Remeasurement 3 performance indicator results and interventions implemented during this validation cycle along with the status of interventions, focus, and rationale for changes to or discontinuation of the interventions.

HSAG conducted an annual validation of the third remeasurement year reflective of CY 2024 (January 1, 2024, through December 31, 2024) using AHCCCS-calculated and validated indicator rates. HSAG evaluated Mercy Care LTC’s performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of [Appendix A. Methodology](#).

Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG’s confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG’s confidence that the PIP’s performance indicator results demonstrated evidence of significant improvement. Table 10-17 displays the overall confidence levels for the Mercy Care LTC *Breast Cancer Screening* PIP.

Table 10-17—Mercy Care LTC *Breast Cancer Screening* PIP Overall Confidence Levels for Remeasurement 3

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
Mercy Care LTC	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>	100%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Measure Results

Table 10-18 provides the *Breast Cancer Screening* PIP baseline, Remeasurement Year 1, Remeasurement Year 2, and Remeasurement Year 3 rates for Mercy Care LTC.

Table 10-18—Mercy Care LTC Breast Cancer Screening PIP Rates

Contractor	PIP Indicator: <i>Breast Cancer Screening</i>			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
Mercy Care LTC	37.76%	35.22%	38.40%	43.88%

Interventions

Table 10-19 presents PIP interventions for Mercy Care LTC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 10-19—Mercy Care LTC Breast Cancer Screening PIP Interventions

Contractor	Intervention
Mercy Care LTC	- Additional provider education for those areas mentioned that are underutilized: - Worked with those providers to discuss how we can help utilize a mobile mammogram program to reach their members. - Worked with those providers to promote our incentive program for breast cancer screenings. - Partnered with a radiology group to outreach members specifically assigned to these providers. - Developed and implemented a written or multi-channel outreach (text/IVR/email) intervention for newly enrolled female members ages 50–74 years, as well as members ages 52–59 years. - Addition of <i>BCS</i> measure to value-based programs. - Surveyed providers that have a high compliance rate/have been successful in working with members with similar profiles to identify best practices and outreach to low-performing providers to share identified best practices; encourage member outreach to close gaps in care. - ACMO targeted provider outreach for PCPs identified with the largest volume of members in need of screening—share best practices and list of members with a gap in care for outreach and care coordination.

Strengths, Opportunities for Improvement, and Recommendations

Table 10-20 presents strengths, opportunities for improvement, and recommendations (as applicable) for Mercy Care LTC related to the *Breast Cancer Screening* PIP, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-20—Mercy Care LTC Strengths, Opportunities for Improvement, and Recommendations Related to the *Breast Cancer Screening* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: Mercy Care LTC adhered to acceptable methodology through all phases of the PIP. The Contractor achieved improvement between the baseline rate and the Remeasurement 3 rate for the <i>BCS</i> performance indicator. [Quality, Access]
Opportunities for Improvement and Recommendations
HSAG identified no opportunities for improvement related to the <i>Breast Cancer Screening</i> PIP: Recommendation: HSAG recommends that the Contractor consider the following for future PIPs: - Apply lessons learned from the <i>Breast Cancer Screening</i> PIP. - Seek technical assistance from HSAG to understand the CMS EQR Protocol 1 requirements. - Implement interventions with clearly defined intervention effectiveness measures.

Compliance Reviews

Results

AHCCCS conducted a compliance review of Mercy Care LTC in CYE 2023. On September 20, 2023, AHCCCS accepted Mercy Care LTC’s proposed CAPs and required the Contractor to submit updated policies, manuals, desktop procedures, and other vital documents to provide evidence of CAP completion. On January 29, 2025, AHCCCS reviewed Mercy Care ACC-RBHA’s CAP status and determined that all CAPs had been completed and approved for closure.

Table 10-21—Mercy Care LTC Compliance Review Results

AHCCCS Compliance Focus Areas	CYE 2024 Mercy Care LTC CAP Update	CYE 2025 Mercy Care LTC CAP Update
Corporate Compliance	NA	NA
Claims and Information Standards	NA	NA
Case Management	Met	NA
Delivery Systems	NA	NA
General Administration	NA	NA
Grievance Systems	NA	NA
Adult; EPSDT; and Maternal Child Health	Met	NA
Medical Management	NA	NA

AHCCCS Compliance Focus Areas	CYE 2024 Mercy Care LTC CAP Update	CYE 2025 Mercy Care LTC CAP Update
Member Information	NA	NA
Quality Management	Partially Met	Met
Quality Improvement	NA	NA
Reinsurance	NA	NA
Third-Party Liability	NA	NA
Integrated Systems of Care	NA	NA

NA = Not applicable. A CAP was not required as the CYE 2023 score was 95% or above.

Partially Met = AHCCCS approved the Contractor's proposed CAP. The Contractor must submit evidence of compliance.

Met = AHCCCS accepted and closed the Contractor's CAP.

Strengths, Opportunities for Improvement, and Recommendations

Table 10-22 presents strengths, opportunities for improvement, and recommendations (as applicable) for Mercy Care LTC related to compliance, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-22—Mercy Care LTC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
Mercy Care LTC successfully closed CAPs in the following focus areas: Quality Management (QM) [Quality]
Opportunities for Improvement and Recommendations
As a result of its CAP interventions implemented in CYE 2025, Mercy Care LTC was found to be fully compliant within all focus areas and had no continuing corrective actions or recommendations.

Network Adequacy Validation

ISCA Results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Mercy Care LTC's interpretation of data was accurate.

Table 10-23 summarizes HSAG's validation ratings for Mercy Care LTC by indicator type.

Table 10-23—Summary of Mercy Care LTC’s Validation Ratings by Indicator Type

Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Appointment Availability	100%	0%	0%	0%
Time/Distance	100%	0%	0%	0%

Of the network adequacy indicators assessed, Mercy Care LTC received *High Confidence* for both appointment availability and time/distance indicators.

NAV Results

HSAG evaluated Mercy Care LTC’s compliance results with AHCCCS’ time/distance standards by GSA and county. This section presents CYE 2024 S2 validation findings specific to the ALTCS-EPD Program, with one results table for the following GSA:

- Central GSA: Gila, Maricopa, and Pinal counties
- South GSA: Pima County

Each region-specific table summarizes validation results containing the percentage of members meeting each time/distance standard by county, with color coding to identify whether the time/distance standard was *Met* or *Not Met*.

Table 10-24—Time/Distance Validation Results for Mercy Care LTC Central GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0 [^]	99.5 ^{^Y}	100.0 [^]
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR [^]	98.7 [^]	100.0 [^]
BHRF	NA	99.8	NA
Cardiologist, Adult	100.0 [^]	100.0 [^]	100.0 [^]
Cardiologist, Pediatric	NR [^]	100.0 [^]	100.0 [^]
Dentist, Pediatric	NR	98.6 ^Y	100.0
Hospital	100.0	100.0 ^Y	100.0
Nursing Facility	100.0	99.9	100.0
OB/GYN	100.0*	99.8 ^Y	100.0
Pharmacy	100.0	99.6 ^Y	100.0
PCP, Adult	100.0 [^]	99.9 [^]	100.0 [^]
PCP, Pediatric	NR [^]	99.5 [^]	100.0 [^]

Y	represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
NR	represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.
	* indicates that fewer than 10 members were included in the denominator of HSAG's results.
	^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
	NA indicates results are not applicable to the county.

Table 10-25—Time/Distance Validation Results for Mercy Care LTC South GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Pima
Behavioral Health Outpatient and Integrated Clinic, Adult	99.1 ^{^Y}
Behavioral Health Outpatient and Integrated Clinic, Pediatric	90.5 ^{^Y}
BHRF	97.4 ^Y
Cardiologist, Adult	99.9 [^]
Cardiologist, Pediatric	100.0 [^]
Dentist, Pediatric	100.0
Hospital	99.8 ^Y
Nursing Facility	99.6 ^Y
OB/GYN	98.4 ^Y
Pharmacy	99.6 ^Y
PCP, Adult	99.6 [^]
PCP, Pediatric	100.0 [^]

Y	represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
	^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

Strengths, Opportunities for Improvement, and Recommendations

Table 10-26 presents strengths, opportunities for improvement, and recommendations (as applicable) for Mercy Care LTC related to NAV, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-26—Mercy Care LTC Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths:

Strengths, Opportunities for Improvement, and Recommendations

- Mercy Care LTC maintained a robust internal provider data management process supported by multiple data management platforms and applications. This system included weekly reconciliation between credentialing and operational systems, the application of USPS address standardization, and annual validations of the provider directory through direct provider attestations. These activities demonstrated a strong process for maintaining accurate and up-to-date provider information. [Access]
- Mercy Care LTC met all the minimum network requirements for all assigned counties. [Access]

Note: Mercy Care LTC provides coverage in the following counties: Gila, Maricopa, Pima, and Pinal

Opportunities for Improvement and Recommendations

HSAG identified no opportunities for improvement for Mercy Care LTC.

UHCCP LTC

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2025, HSAG evaluated UHCCP LTC’s data system for processing of each data type used for reporting the Contractor’s CY 2024 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that UHCCP LTC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 10-27 displays HSAG’s PMV findings for each data type reviewed during CYE 2025 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 10-27—CYE 2025 PMV Findings

Data Type	HSAG Findings
Medical Services Data	<i>No identified concerns</i>
Enrollment Data	<i>No identified concerns</i>
Provider Data	<i>No identified concerns</i>
Medical Record Review Process	<i>No identified concerns</i>
Supplemental Data	<i>No identified concerns</i>
Data Integration	<i>No identified concerns</i>

Results for Performance Measures

Table 10-28 presents the CY 2023 and CY 2024 UHCCP LTC performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and MY 2024. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and/or MY 2024. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 10-28—CY 2023 and CY 2024 UHCCP LTC Performance Measure Results

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	81.76%^	83.89%^	→	★★★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	88.33%^	83.84%^	→	★★★★★
Effective Continuation Phase Treatment—Total (18+ Years)	77.29%^	75.21%^	→	★★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	90.61%^	93.06%^	→	★★★★★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	48.65%^	30.30%^	→	★★★
30-Day Follow-Up—Total (13+ Years)	59.46%^	36.36%	→	★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	26.09%	35.00%	→	★★
30-Day Follow-Up—Total (6+ Years)	54.35%	52.50%	→	★
Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	48.69%^	48.00%^	→	★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	6.77%	5.05%	→	★
Use of Opioids at High Dosage				
18+ Years*	10.52%	9.50%	→	★
Care of Acute and Chronic Conditions				
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status <8.0%—Total (18–75 Years)	70.32%^	68.61% ⁺⁺	→	★★★★★
Glycemic Status >9.0%—Total (18–75 Years)*	21.90%^	22.14% ⁺⁺	→	★★★★★
Pediatric Health				
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	46.04%	54.55%	→	★★

Performance Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	37.27%	39.56%	→	NC [±]
Breast Cancer Screening (ECDS)				
Total (50–74 Years)	—	39.10%	—	★
Cervical Cancer Screening				
21–64 Years	34.55%	34.55% ⁺	→	★
Cervical Cancer Screening (ECDS)				
21–64 Years	—	32.30%	—	★
Colorectal Cancer Screening (ECDS)				
Total (45–75 Years)	—	49.01% [^]	—	★★★★★
Appropriate Utilization of Services				
Plan All-Cause Readmissions				
Observed/Expected (O/E) Ratio—Total (18–64 Years)*	—	0.8872 [^]	—	★★★★★
Oral Health				
Oral Evaluation, Dental Services				
Total (0–20 Years)	—	37.12%	—	★★

* A lower rate indicates better performance for this measure.

** Table A-2 in [Appendix A. Methodology](#) outlines which immunizations are included within each combination.

+ Indicates the measure was reported using hybrid methodology.

NA⁺⁺ indicates the denominator was too small to report a valid rate, based on the applicable measure specification.

NC[±] indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

■ and ^ indicates that the rate met or exceeded the MY 2023 and/or MY 2024 national Medicaid mean.

— Indicates a 2023–2024 comparison is not presented in the CYE 2025 Annual Technical Report because either the CY 2023 rate was not presented in the CYE 2024 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

¹ Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.

² Performance Levels for CY 2024 were based on comparisons of the HEDIS MY 2024 measure rates to NCQA Quality Compass national Medicaid HEDIS MY 2024 benchmarks.

↑ Indicates statistically significant improvement of measure rates.

↓ Indicates statistically significant decline of measure rates.

→ Indicates no statistically significant change in measure rates.

Performance Levels for 2024 represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 10-29 presents strengths, opportunities for improvement, and recommendations (as applicable) for UHCCP LTC related to performance measures, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-29—UHCCP LTC Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group, six of UHCCP LTC’s performance measures met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024, indicating strength in providing behavioral health care treatment to members. [Quality, Timeliness, Access] <i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years</i> <i>Antidepressant Medication Management—Effective Acute Phase Treatment (18+ Years) and Effective Continuation Phase Treatment (18+ Years)</i> <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years</i> <i>Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)</i> <i>Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)</i>
In the Care of Acute and Chronic Conditions measure group, UHCCP LTC’s <i>Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total (18–75 Years)</i> and <i>Glycemic Status >9.0%—Total (18–75 Years)</i> measure rates were at or above the 90th percentile. [Quality]
In the Appropriate Utilization of Services measure group, UHCCP LTC’s <i>Plan All-Cause Readmissions—O/E Ratio—Total (18–64 Years)</i> measure rate was at or above the 90th percentile, indicating that members were generally not experiencing unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay. [Quality]
Opportunities for Improvement and Recommendations
In the Behavioral Health measure group, UHCCP LTC’s performance measure rate for <i>Use of Opioids at High Dosage—18+ Years</i> fell below the 25th percentile. This result indicates an opportunity for UHCCP LTC to monitor prescribing and utilization data and to implement interventions to improve care and services around opioid prescribing. The CDC guidelines on opioid prescribing for chronic,

Strengths, Opportunities for Improvement, and Recommendations

nonmalignant pain recommend the use of “additional precautions” when prescribing dosages ≥ 50 MED and that providers avoid or “carefully justify” increasing dosages ≥ 90 mg MED.¹⁶⁰ **[Quality]**

Recommendations: HSAG recommends that UHCCP LTC implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid misuse. HSAG also recommends that UHCCP LTC monitor and expand on interventions currently in place to improve performance related to the *Use of Opioids at High Dosage—18+ Years* measure. HSAG also recommends that UHCCP LTC identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts.

In the Preventive Screening measure group, UHCCP LTC’s performance measure rates for *Breast Cancer Screening (ECDS)—Total (50–74 Years)*, *Cervical Cancer Screening—21–64 Years*, and *Cervical Cancer Screening—ECDS (21–64 Years)* fell below the 25th percentile, indicating that women were not always receiving timely screening for breast and cervical cancer. Early detection reduces the risk of dying from cancer and can lead to a greater range of treatment options and lower health care costs. **[Quality]**

Recommendations: While UHCCP LTC conducted a root cause analysis and implemented interventions specific to the *Breast Cancer Screening (ECDS)—Total (50–74 Years)*, *Cervical Cancer Screening—21–64 Years*, and *Cervical Cancer Screening—ECDS (21–64 Years)* measures, these rates remained low in MY 2024. HSAG recommends that UHCCP LTC identify disparities or SDOH within the plan’s populations that contributed to breast and cervical cancer screening rates. Upon identification of a root cause, HSAG recommends that UHCCP LTC implement appropriate interventions to reduce barriers to care. Further, HSAG recommends that UHCCP LTC provide scheduled reminders, direct providers to send messages to members, and utilize personalized outreach for overdue patients. Communication should be clear and concise and include information on the procedure time. Some of these interventions might include a mobile clinic to conduct the screening, transportation assistance, and adjusting hours for visits to accommodate those with job/childcare concerns.

In the Behavioral Health measure group, UHCCP LTC’s performance measure rates for *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)*, and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total (6+ Years)* fell below the 25th percentile. This result provides an opportunity for UHCCP LTC to monitor prescribing and utilization data and to implement interventions to improve care and services for behavioral health members. **[Quality]**

Recommendations:

¹⁶⁰ National Committee for Quality Assurance. Use of Opioids at High Dosage (HDO). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/use-of-opioids-at-high-dosage-hdo/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

- Regarding the *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* measure, HSAG recommends that UHCCP LTC review patient data for any patterns present by ZIP Code and other demographics for case management prioritization. One study suggests that male members who have a schizophrenia spectrum disorder diagnosis are less likely to initiate treatment, while current drug dependence and recent arrest were associated with lowered odds of engaging in treatment. Current drug dependence is associated with factors that make scheduling and attending treatment appointments difficult, such as severe symptoms, chaotic living situations, and self-care and life functioning issues.
- Regarding the *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total (6+ Years)* measure, HSAG recommends that UHCCP LTC consider utilizing effective interventions to reduce repeat hospitalizations for people with mental illness, such as Critical Time Intervention (CTI), Assertive Community Treatment (ACT), case management, and a focus on co-occurring SUDs.

Validation of Performance Improvement Projects

In CY 2025, UHCCP LTC continued the *Breast Cancer Screening* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 3, PIP validation activities focused on improvement from the baseline results. UHCCP LTC submitted Remeasurement 3 performance indicator results and interventions implemented during this validation year along with the status of interventions, focus, and rationale for changes to or discontinuation of the interventions.

HSAG conducted an annual validation of the third remeasurement year reflective of CY 2024 (January 1, 2024, through December 31, 2024) using AHCCCS-calculated and validated indicator rates. HSAG evaluated UHCCP LTC's performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of [Appendix A. Methodology](#).

Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG's confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed to the Outcomes stage and reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. Table 10-30 displays the overall confidence levels for the UHCCP LTC *Breast Cancer Screening* PIP.

Table 10-30—UHCCP LTC *Breast Cancer Screening* PIP Overall Confidence Levels for Remeasurement 3

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
UHCCP LTC	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>	100%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Measure Results

Table 10-31 provides the *Breast Cancer Screening* PIP baseline, Remeasurement Year 1, Remeasurement Year 2, and Remeasurement Year 3 rates for UHCCP LTC.

Table 10-31—UHCCP LTC *Breast Cancer Screening* PIP Rates

Contractor	PIP Indicator: <i>Breast Cancer Screening</i>			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
UHCCP LTC	34.07%	41.62%	37.27%	39.56%

Interventions

Table 10-32 presents PIP interventions for UHCCP LTC. Language in the PIP interventions section is minimally edited and generally reflective of the language provided by the Contractor.

Table 10-32—UHCCP LTC *Breast Cancer Screening* PIP Interventions

Contractor	Intervention
UHCCP LTC	Letter to SNFs and ALFs. The letter identified members with a BCS gap and provided BCS education information.

Contractor	Intervention
	- High risk nurse manager call outreach and survey to members with gaps in care in the HCBS to provide BCS education. - Case managers provided BCS education to members with gaps in care during their assessments. - Member gift card incentive/reward letter mailed to members with gaps in care. - LTC member newsletter with BCS education. - National Women’s Health Email Campaign. Email educates members on BCS importance, provider engagement, scheduling an appointment, and obtaining a BCS. - Practice Assist Initiative. UHCCP collaborates with providers to obtain and manually upload member BCS records for gap closure. - CM Education: BCS Education Series annually. - Member live calls. - QM mailings: BCS reminder letters (July) and follow-up letters (October) to Black or African American members with BCS gaps in care. - QM Calls: Health Disparities: BCS Black/African American members. - Advanced illness and frailty exclusion.

Strengths, Opportunities for Improvement, and Recommendations

Table 10-33 presents strengths, opportunities for improvement, and recommendations (as applicable) for UHCCP LTC related to the *Breast Cancer Screening* PIP, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-33—UHCCP LTC Strengths, Opportunities for Improvement, and Recommendations Related to the *Breast Cancer Screening* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: - The Contractor adhered to acceptable methodology through all phases of the PIP. [Quality, Access] - The Contractor achieved statistically significant improvement between the baseline rate and the Remeasurement 2 rate and sustained the statistically significant improvement at Remeasurement 3 for the <i>BCS</i> performance indicator. [Quality, Access]
Opportunities for Improvement and Recommendations
HSAG identified no opportunities for improvement related to the <i>Breast Cancer Screening</i> PIP:

Strengths, Opportunities for Improvement, and Recommendations

Recommendation: HSAG recommends that the Contractor consider the following for future PIPs:

- Apply lessons learned from the *Breast Cancer Screening* PIP.
- Seek technical assistance from HSAG to understand the CMS EQR Protocol 1 requirements.
- Implement interventions with clearly defined intervention effectiveness measures.

Compliance Reviews

In CYE 2025, HSAG conducted a review of 15 standard areas using monitoring tools to assess and document UHCCP LTC’s compliance with federal and State requirements. The 15 standards for review were related to the federal Medicaid managed care regulations and associated State requirements. The compliance review included completing a desk review of documents, a review of the Contractor’s NCQA health plan accreditation reports and findings, file reviews, and an on-site review that included reviewing additional documents and conducting interviews with the Contractor.

Results

Table 10-34 presents the compliance review scores for UHCCP LTC.

Table 10-34—Standards and Compliance Review Scores

Standard #	Standard Name*	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				D	M	NM	NA	
I	Disenrollment: Requirements and Limitations	9	9	0	8	1	0	89%
II	Member Rights and Member Information	22	22	5	15	2	0	91%
III	Emergency and Poststabilization Services	13	13	0	12	1	0	92%
IV	Availability of Services	12	12	7	5	0	0	100%
V	Assurances of Adequate Capacity and Services	3	3	0	3	0	0	100%
VI	Coordination and Continuity of Care	12	12	10	2	0	0	100%
VII	Coverage and Authorization of Services	30	30	7	19	4	0	87%
VIII	Provider Selection	7	7	2	5	0	0	100%
IX	Confidentiality	3	3	1	2	0	0	100%
X	Grievance and Appeal Systems	38	38	0	32	6	0	84%
XI	Subcontractual Relationships and Delegation	5	5	0	4	1	0	80%
XII	Practice Guidelines	6	6	5	1	0	0	100%
XIII	Health Information Systems	9	9	0	9	0	0	100%

Standard #	Standard Name*	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				D	M	NM	NA	
XIV	Quality Assessment and Performance Improvement Program	9	9	2	6	1	0	89%
XV	Program Integrity	15	14	0	14	0	1	100%
Totals		193	192	39	137	16	1	92%

* Table A-7 in [Appendix A. Methodology](#) outlines the compliance review standards and associated federal citations.

D=Deemed, **M**=Met, **NM**=Not Met, **NA**=Not Applicable

Total Elements: The total number of applicable elements in each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that received a score of **NA**.

Total Compliance Score: The compliance scores were calculated by adding the **Deemed** elements and the **Met** elements and then dividing by the total number of applicable elements.

Strengths, Opportunities for Improvement, and Recommendations

Table 10-35 presents strengths, opportunities for improvement, and recommendations (as applicable) for UHCCP LTC related to compliance, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-35—UHCCP LTC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
UHCCP LTC achieved full compliance in eight of the 15 standards reviewed, demonstrating strengths and adherence to all requirements measured in the following areas: - Assurances of Adequate Capacity and Services [Timeliness, Access] - Availability of Services [Timeliness, Access] - Confidentiality [Quality] - Coordination and Continuity of Care [Quality, Timeliness, Access] - Health Information Systems [Quality] - Practice Guidelines [Quality] - Program Integrity [Quality] - Provider Selection [Timeliness, Access]
Opportunities for Improvement and Recommendations
The areas with the greatest opportunity for improvement were related to the following, as these areas received performance scores under 95 percent: Coverage and Authorization of Services [Quality, Timeliness, Access]

Strengths, Opportunities for Improvement, and Recommendations

- Disenrollment: Requirements and Limitations [Quality]
- Emergency and Poststabilization Services [Quality, Timeliness, Access]
- Grievance and Appeal Systems [Quality, Timeliness, Access]
- Member Rights and Member Information [Quality, Timeliness, Access]
- Quality Assessment and Performance Improvement Program [Quality, Timeliness]
- Subcontractual Relationships and Delegation [Quality]

Recommendation: HSAG recommends that UHCCP LTC address the elements scored as *Not Met* through the CAP process during CYE 2026.

Network Adequacy Validation

ISCA Results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and whether UHCCP LTC's interpretation of data was accurate.

Table 10-36 summarizes HSAG's validation ratings for UHCCP LTC by indicator type.

Table 10-36—Summary of UHCCP LTC's Validation Ratings by Indicator Type

Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Appointment Availability	100%	0%	0%	0%
Time/Distance	100%	0%	0%	0%

Of the network adequacy indicators assessed, UHCCP LTC received *High Confidence* for both appointment availability and time/distance indicators. However, there were identified areas for improvement; please refer to the Contractor-specific Strengths, Opportunities for Improvement, and Recommendations section below for more details.

NAV Results

HSAG evaluated UHCCP LTC's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents CYE 2024 S2 validation findings specific to the ALTCS-EPD Program, with one results table for each of the following GSAs:

- Central GSA: Gila, Maricopa, and Pinal counties

- North GSA: Apache, Coconino, Mohave, Navajo, and Yavapai counties

Each region-specific table summarizes validation results containing the percentage of members meeting each time/distance standard by county, with color coding to identify whether the time/distance standard was *Met* or *Not Met*.

Table 10-37—Time/Distance Validation Results for UHCCP LTC Central GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0 [^]	97.5 ^{^Y}	100.0 [^]
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR [^]	97.5 ^{^Y}	100.0 ^{*^}
BHRF	NA	97.9 ^Y	NA
Cardiologist, Adult	100.0 [^]	99.9 ^{^Y}	100.0 [^]
Cardiologist, Pediatric	NR [^]	100.0 [^]	100.0 ^{*^}
Dentist, Pediatric	NR	100.0	100.0 [*]
Hospital	100.0	99.9	100.0
Nursing Facility	100.0	99.7 ^Y	100.0
OB/GYN	100.0 [*]	100.0	100.0
Pharmacy	100.0	99.5 ^Y	100.0
PCP, Adult	100.0 [^]	99.8 ^{^Y}	100.0 [^]
PCP, Pediatric	NR [^]	100.0 [^]	100.0 ^{*^}

Y represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.
* indicates that fewer than 10 members were included in the denominator of HSAG's results.
[^] indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.

Table 10-38—Time/Distance Validation Results for UHCCP LTC North GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Apache	Coconino	Mohave	Navajo	Yavapai
Behavioral Health Outpatient and Integrated Clinic, Adult	95.6 ^{^Y}	93.6 ^{^Y}	98.7 ^{^Y}	99.6 [^]	100.0 [^]
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0 ^{*^Y}	100.0 ^{*^}	100.0 ^{*^}	100.0 ^{*^}	100.0 [^]
BHRF	NA	NA	NA	NA	NA
Cardiologist, Adult	94.1 ^{^Y}	100.0 [^]	100.0 [^]	99.6 ^{^Y}	100.0 [^]
Cardiologist, Pediatric	100.0 ^{*^Y}	100.0 ^{*^}	100.0 ^{*^}	100.0 ^{*^}	100.0 [^]

Provider Category	Apache	Coconino	Mohave	Navajo	Yavapai
Dentist, Pediatric	100.0* ^Y	100.0*	100.0*	100.0*	100.0
Hospital	100.0	100.0	99.9	100.0	100.0
Nursing Facility	95.3 ^Y	91.2 ^Y	97.2 ^Y	99.3 ^Y	100.0
OB/GYN	100.0*	100.0*	100.0	100.0*	100.0
Pharmacy	97.1 ^Y	100.0 ^Y	99.8 ^Y	100.0	99.6 ^Y
PCP, Adult	97.1 ^{^Y}	100.0 ^{^Y}	99.8 ^{^Y}	100.0 [^]	100.0 [^]
PCP, Pediatric	100.0* ^{^Y}	100.0* [^]	100.0* [^]	100.0* [^]	100.0 [^]

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

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

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

NA indicates results are not applicable to the county.

Strengths, Opportunities for Improvement, and Recommendations

Table 10-39 presents strengths, opportunities for improvement, and recommendations (as applicable) for UHCCP LTC related to NAV, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-39—UHCCP LTC Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: - UHCCP LTC performed proactive outreach to maintain provider data accuracy. When providers did not attest or when business rules triggered a demographic verification request, outreach was completed via email or telephone, with up to three attempts. [Access] - UHCCP LTC met all minimum network requirements for all assigned counties. [Access] Note: UHCCP LTC provides coverage in the following counties: Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal, and Yavapai.
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: While UHCCP LTC had a strong outreach process in place, there is an opportunity to strengthen oversight by tracking and trending provider nonresponses to outreach and incorporate this into ongoing monitoring, which would help identify gaps and ensure timely resolution of provider data discrepancies. [Access]

Strengths, Opportunities for Improvement, and Recommendations

Recommendation: HSAG recommends that UHCCP LTC consider tracking and trending provider nonresponses to outreach attempts as part of its oversight process. Monitoring response rates and outcomes would allow UHCCP LTC to identify patterns (e.g., providers or groups with repeated nonresponses) and strengthen timeliness in updating provider records.

- HSAG identified an opportunity for UHCCP LTC to strengthen its methods to calculate appointment availability indicator results. UHCCP LTC's appointment availability survey script incorporated leading questions directed toward providers, accompanied by a predetermined response format designed to align with AHCCCS compliance requirements. **[Access]**

Recommendation: HSAG recommends that UHCCP LTC revise its appointment availability survey script to use open-ended questions that solicit the earliest available appointment dates from each provider. The collected responses should then be independently evaluated to determine compliance with AHCCCS standards.

11. ALTCS-DD Program Results

The **ALTCS-DD Program** Contractor, DES/DDD, provides integrated physical health and behavioral health services through two subcontracted health plans, Mercy Care DD and UHCCP DD.

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

ALTCS-DD Program

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2025, HSAG evaluated DES/DDD’s data system for processing of each data type used for reporting the Contractor’s CY 2024 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that DES/DDD followed the measure specifications and produced reportable rates for most measures in the scope of the validation of performance measures.

Table 11-1 displays HSAG’s PMV findings for each data type reviewed during CYE 2025 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 11-1—CYE 2025 PMV Findings

Data Type	HSAG Findings
Medical Services Data	<i>No identified concerns</i>
Enrollment Data	<i>No identified concerns</i>
Provider Data	<i>No identified concerns</i>
Medical Record Review Process	<i>No identified concerns</i>
Supplemental Data	<i>No identified concerns</i>
Data Integration	<i>Issues were identified in rate review with race and ethnicity stratifications not totaling correctly, which resulted in a DNR designation for these measures: PPC; Glycemic Status Assessment for Patients With Diabetes (GSD)—Glycemic Status <8.0%—Total (18–75 Years) and</i>

Data Type	HSAG Findings
	<i>Glycemic Status >9.0%—Total (18–75 Years); IMA-E—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV). PCR measure rates were calculated incorrectly, resulting in a DNR designation.</i>

Results for Performance Measures

Table 11-2 presents the CY 2024 performance measure results for ALTCS-DD. Performance measure rate cells shaded green indicate that DES/DDD met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 11-2—CY 2024 DES/DDD Performance Measure Results

Performance Measure	CY 2024 Performance
Maternal and Perinatal Care	
Prenatal and Postpartum Care	
<i>Timeliness of Prenatal Care</i>	DNR ^D
<i>Postpartum Care</i>	DNR ^D
Behavioral Health	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	
<i>18+ Years</i>	87.72% [^]
Antidepressant Medication Management	
<i>Effective Acute Phase Treatment—Total (18+ Years)</i>	78.03% [^]
<i>Effective Continuation Phase Treatment—Total (18+ Years)</i>	62.33% [^]
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	
<i>18–64 Years</i>	89.24% [^]
Follow-Up After ED Visit for Mental Illness	
<i>7-Day Follow-Up—Total (6+ Years)</i>	65.70% [^]
<i>30-Day Follow-Up—Total (6+ Years)</i>	81.23% [^]
Follow-Up After Hospitalization for Mental Illness	
<i>7-Day Follow-Up—Total (6+ Years)</i>	50.98% [^]
<i>30-Day Follow-Up—Total (6+ Years)</i>	86.45% [^]

Performance Measure	CY 2024 Performance
Follow-Up Care for Children Prescribed ADHD Medication (ECDS)	
Initiation Phase (6–12 Years)	50.55%^
Continuation and Maintenance Phase (6–12 Years)	53.66%
Initiation and Engagement of SUD Treatment	
Initiation of SUD Treatment—Total—Total (13+ Years)	39.46%
Engagement of SUD Treatment—Total—Total (13+ Years)	23.78%^
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	
Total (1–17 Years)	22.03%
Use of Opioids at High Dosage	
18+ Years*	3.27%^
Care of Acute and Chronic Conditions	
Glycemic Status Assessment for Patients With Diabetes	
Glycemic Status <8.0%—Total (18–75 Years)	DNR ^D
Glycemic Status >9.0%—Total (18–75 Years)*	DNR ^D
Pediatric Health	
Child and Adolescent Well-Care Visits	
Total (3–21 Years)	60.79%^
Childhood Immunization Status**	
Combination 3	65.19% ⁺
Combination 7	29.63% ⁺
Combination 10	17.04% ⁺
Childhood Immunization Status (ECDS) **	
Combination 3	62.96%^
Combination 7	28.89%
Combination 10	17.04%
Developmental Screening in the First Three Years of Life	
Total (0–3 Years) ^N	24.04% ⁺
Immunizations for Adolescents**	
Combination 1 (Meningococcal, Tdap)	DNR ^D
Combination 2 (Meningococcal, Tdap, HPV)	DNR ^D

Performance Measure	CY 2024 Performance
Immunizations for Adolescents (ECDS)**	
Combination 1 (Meningococcal, Tdap)	80.17% ⁺ [^]
Combination 2 (Meningococcal, Tdap, HPV)	30.88% ⁺
Metabolic Monitoring for Children and Adolescents on Antipsychotics	
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	46.32% [^]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile—Total	84.67% ⁺ [^]
Counseling for Nutrition—Total	78.22% ⁺ [^]
Counseling for Physical Activity—Total	68.98% ⁺ [^]
Well-Child Visits in the First 30 Months of Life	
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	72.02%
Preventive Screening	
Breast Cancer Screening	
Total (50–74 Years) ^N	47.50%
Breast Cancer Screening (ECDS)	
Total (50–74 Years)	50.25%
Cervical Cancer Screening	
21–64 Years	21.90% ⁺
Cervical Cancer Screening (ECDS)	
21–64 Years	20.05%
Colorectal Cancer Screening (ECDS)	
Total (45–75 Years)	50.43% [^]
Appropriate Utilization of Services	
Plan All-Cause Readmissions	
O/E Ratio—18–64 Years*	DNR ^D
Oral Health	
Oral Evaluation, Dental Services	
Total (0–20 Years)	52.94% [^]

* A lower rate indicates better performance for this measure.

** Table A-2 in [Appendix A. Methodology](#) outlines which immunizations are included within each combination.

+ Indicates the measure was reported using hybrid methodology.

NA⁺⁺ indicates the denominator was too small to report a valid rate, based on the applicable measure specification.

^N Measure has no NCQA Medicaid mean for comparison.

DNR^D indicates the measure received a *Do Not Report* designation for CY 2024.

and [^] indicate that the rate met or exceeded the MY 2024 national Medicaid mean.

Table 11-3 presents the CY 2023 and CY 2024 DES/DDD results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 11-3—CY 2023 and CY 2024 DES/DDD Performance Measure Results

Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	NA ⁺⁺	DNR ^D	—	NC [±]
Postpartum Care	NA ⁺⁺	DNR ^D	—	NC [±]
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	87.93% [^]	87.72% [^]	→	★★★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	65.07% [^]	78.03% [^]	↑	★★★★★
Effective Continuation Phase Treatment—Total (18+ Years)	53.28% [^]	62.33% [^]	→	★★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	90.27% [^]	89.24% [^]	→	★★★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	63.45% [^]	65.70% [^]	→	★★★★★
30-Day Follow-Up—Total (6+ Years)	74.83% [^]	81.23% [^]	→	★★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	69.90% [^]	50.98% [^]	↓	★★★★★
30-Day Follow-Up—Total (6+ Years)	87.10% [^]	86.45% [^]	→	★★★★★
Follow-Up Care for Children Prescribed ADHD Medication (ECDS)				
Initiation Phase (6–12 Years)	—	50.55% [^]	—	★★★
Continuation and Maintenance Phase (6–12 Years)	—	53.66%	—	★★

Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	40.96%	39.46%	→	★
Engagement of SUD Treatment—Total—Total (13+ Years)	10.11%	23.78%^	↑	★★★★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Total (1–17 Years)	18.52%	22.03%	→	★
Use of Opioids at High Dosage				
18+ Years*	4.49%^	3.27%^	→	★★★
Care of Acute and Chronic Conditions				
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status <8.0%—Total (18–75 Years)	75.55%^	DNR ^D	—	NC [±]
Glycemic Status >9.0%—Total (18–75 Years)*	18.98%^	DNR ^D	—	NC [±]
Pediatric Health				
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	57.09%^	60.79%^	↑	★★★
Childhood Immunization Status**				
Combination 3	66.67%^	65.19% ⁺	→	★★
Combination 7	33.33%	29.63% ⁺	→	★
Combination 10	24.79%	17.04% ⁺	→	★
Childhood Immunization Status (ECDS) **				
Combination 3	—	62.96%^	—	★★★
Combination 7	—	28.89%	—	★
Combination 10	—	17.04%	—	★
Developmental Screening in the First Three Years of Life				
Total (0–3 Years) ^N	18.54%	24.04% ⁺	→	NC [±]
Immunizations for Adolescents**				
Combination 1 (Meningococcal, Tdap)	83.94%^	80.29% ^{+^}	→	★★
Combination 2 (Meningococcal, Tdap, HPV)	30.17%	32.36% ⁺	→	★★

Measure	CY 2023 Performance	CY 2024 Performance	2023–2024 Comparison ¹	2024 Performance Level ²
Immunizations for Adolescents (ECDS)**				
Combination 1 (Meningococcal, Tdap)	—	DNR ^D	—	NC [±]
Combination 2 (Meningococcal, Tdap, HPV)	—	DNR ^D	—	NC [±]
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	—	46.32% [^]	—	★★★★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	78.35%	84.67% ^{+^}	↑	★★★★
Counseling for Nutrition—Total	65.09%	78.22% ^{+^}	↑	★★★★
Counseling for Physical Activity—Total	52.80%	68.98% ^{+^}	↑	★★★
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	69.93% [^]	72.02%	→	★★★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	50.83%	47.50%	→	NC [±]
Breast Cancer Screening (ECDS)				
Total (50–74 Years)	—	50.25%	—	★
Cervical Cancer Screening				
21–64 Years	23.84%	21.90% ⁺	→	★
Cervical Cancer Screening (ECDS)				
21–64 Years	—	20.05%	—	★
Colorectal Cancer Screening (ECDS)				
Total (45–75 Years)	—	50.43% [^]	—	★★★★★
Appropriate Utilization of Services				
Plan All-Cause Readmissions				
O/E Ratio—18–64 Years*	—	DNR ^D	—	NC [±]
Oral Health				
Oral Evaluation, Dental Services				
Total (0–20 Years)	—	52.94% [^]	—	★★★★★

* A lower rate indicates better performance for this measure.

** Table A-2 in [Appendix A. Methodology](#) outlines which immunizations are included within each combination.

+ Indicates the measure was reported using hybrid methodology.

NA⁺⁺ indicates the denominator was too small to report a valid rate, based on the applicable measure.

NC[±] indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

■ and ^ indicates that the rate met or exceeded the MY 2023 and/or MY 2024 national Medicaid mean.

— Indicates a 2022–2023 comparison is not presented in the CYE 2024 Annual Technical Report because either there was a break in trending, the CY 2022 rate was not presented in the CYE 2023 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

¹ Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.

² Performance Levels for CY 2024 were based on comparisons of the HEDIS MY 2024 measure rates to NCQA Quality Compass national Medicaid HEDIS MY 2024 benchmarks.

DNR^D indicates the measure received a *Do Not Report* designation for CY 2024.

↑ Indicates statistically significant improvement of measure rates.

↓ Indicates statistically significant decline of measure rates.

→ Indicates no statistically significant change in measure rates.

Performance Levels for 2022 represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Table 11-4 highlights DES/DDD’s performance for the current year by measure group. The table illustrates the Contractor’s CY 2024 measure rates and their performance relative to the NCQA national Medicaid Quality Compass HEDIS MY 2024 percentiles, where applicable. The performance level star ratings are defined as follows:

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

Table 11-4—CY 2024 National Percentiles Comparison for DES/DDD

Performance Measure	CY 2024 Performance
Behavioral Health	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	
18+ Years	★★★★★
Antidepressant Medication Management	
Effective Acute Phase Treatment—Total (18+ Years)	★★★★★
Effective Continuation Phase Treatment—Total (18+ Years)	★★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	
18–64 Years	★★★★★

Performance Measure	CY 2024 Performance
Follow-Up After ED Visit for Mental Illness	
7-Day Follow-Up—Total (6+ Years)	★★★★★
30-Day Follow-Up—Total (6+ Years)	★★★★★
Follow-Up After Hospitalization for Mental Illness	
7-Day Follow-Up—Total (6+ Years)	★★★★★
30-Day Follow-Up—Total (6+ Years)	★★★★★
Follow-Up Care for Children Prescribed ADHD Medication (ECDS)	
Initiation Phase (6–12 Years)	★★★
Continuation and Maintenance Phase (6–12 Years)	★★
Initiation and Engagement of SUD Treatment	
Initiation of SUD Treatment—Total—Total (13+ Years)	★
Engagement of SUD Treatment—Total—Total (13+ Years)	★★★★★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	
Total (1–17 Years)	★
Use of Opioids at High Dosage	
18+ Years*	★★★
Pediatric Health	
Child and Adolescent Well-Care Visits	
Total (3–21 Years)	★★★
Childhood Immunization Status**	
Combination 3	★★
Combination 7	★
Combination 10	★
Childhood Immunization Status (ECDS)**	
Combination 3	★★★
Combination 7	★
Combination 10	★
Immunizations for Adolescents**	
Combination 1 (Meningococcal, Tdap)	★★
Combination 2 (Meningococcal, Tdap, HPV)	★★

Performance Measure	CY 2024 Performance
Metabolic Monitoring for Children and Adolescents on Antipsychotics	
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	★★★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile—Total	★★★
Counseling for Nutrition—Total	★★★
Counseling for Physical Activity—Total	★★
Well-Child Visits in the First 30 Months of Life	
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	★★
Preventive Screening	
Breast Cancer Screening (ECDS)	
Total (50–74 Years)	★
Cervical Cancer Screening	
21–64 Years	★
Cervical Cancer Screening (ECDS)	
21–64 Years	★
Colorectal Cancer Screening (ECDS)	
Total (45–75 Years)	★★★★
Oral Health	
Oral Evaluation, Dental Services	
Total (0–20 Years)	★★★★

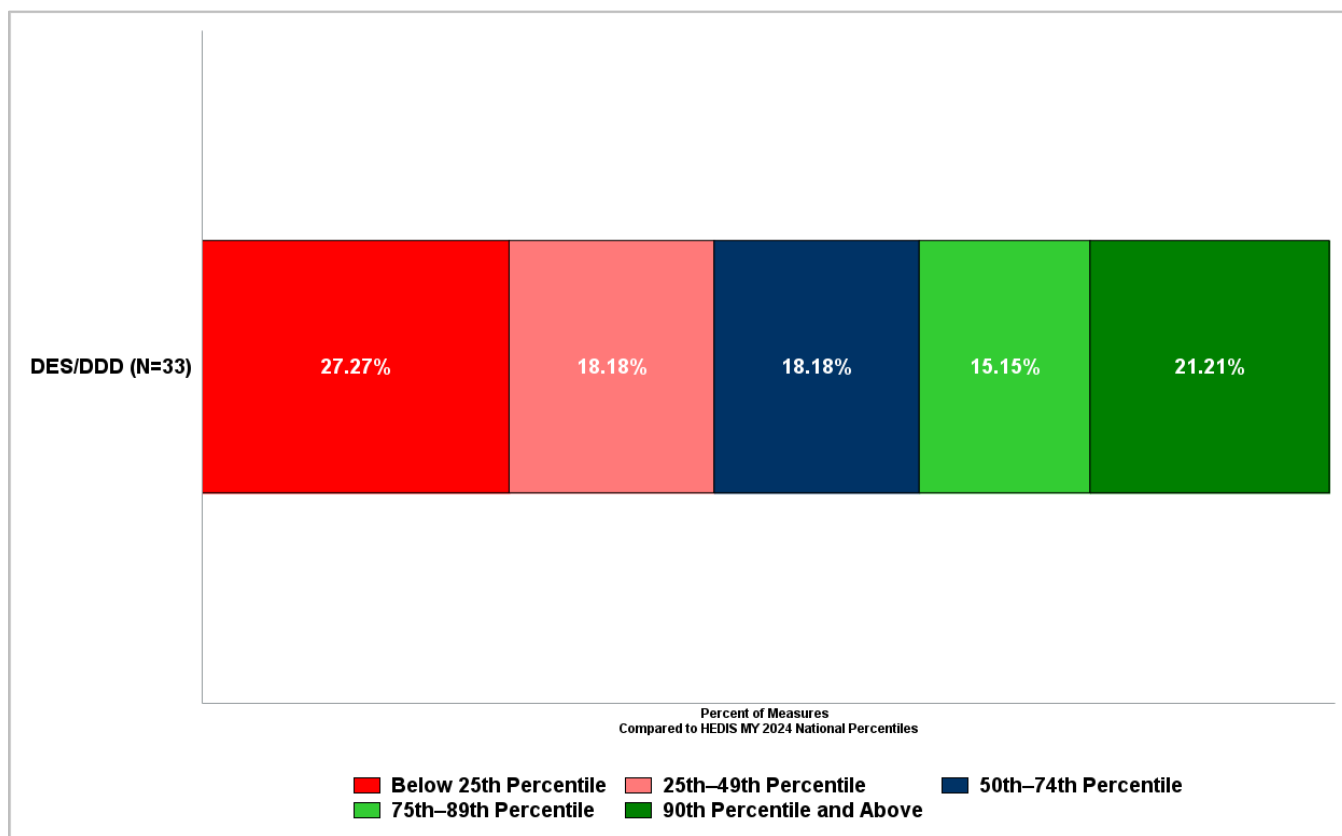
* A lower rate indicates better performance for this measure.

** Table A-2 in [Appendix A. Methodology](#) outlines which immunizations are included within each combination.

NC[±] indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

Figure 11-1 displays DES/DDD's HEDIS MY 2024 performance compared to benchmarks. HSAG analyzed results from 21 performance measures for HEDIS MY 2024 for a total of 33 measure rates. Percentages in the figure may not total 100 percent due to rounding.

Figure 11-1—Comparison of Measure Indicators to HEDIS Medicaid National Percentiles for DES/DDD



Strengths, Opportunities for Improvement, and Recommendations

Table 11-5 presents strengths, opportunities for improvement, and recommendations for DES/DDD, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 11-5—DES/DDD Strengths, Opportunities for Improvement, and Recommendations for Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group: - DES/DDD’s rates for the following measures met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and were at or above the 90th percentile [Quality, Timeliness, Access]: <i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years</i> <i>Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years) and Effective Continuation Phase Treatment—Total (18+ Years)</i>

Strengths, Opportunities for Improvement, and Recommendations

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total (6+ Years)*
- DES/DDD’s performance measure rates for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)*, and *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and were at or between the 75th and 89th percentile. **[Quality, Timeliness, Access]**

In the Pediatric Health measure group, DES/DDD’s performance measure rate for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)* met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and were at or between the 75th and 89th percentile, indicating that members taking antipsychotic medication had metabolic monitoring most of the time. Proper diabetes monitoring is essential to identify blood glucose concerns, reduce risks for complications, and prolong life.¹⁶¹ **[Quality]**

In the Preventive Screening measure group, DES/DDD’s performance measure rate for *Colorectal Cancer Screening (ECDS)—Total (45–75 Years)* met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and was at or between the 75th and 89th percentile, indicating that members were receiving timely screening for colorectal cancer. Early detection reduces the risk of dying from these types of cancer and can lead to a greater range of treatment options and lower healthcare costs. **[Quality]**

In the Oral Health measure group, DES/DDD’s performance measure rate for *Oral Evaluation, Dental Services—Total (0–20 Years)* met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and was at or between the 75th and 89th percentile. **[Access]**

Opportunities for Improvement and Recommendations

While DES/DDD was successful in reporting valid rates for most AHCCCS-required performance measures for its ALTCS-DD population, and HSAG did not identify specific opportunities for DES/DDD to improve RES, DES/DDD could benefit from continuing to focus on refining RES reporting where required in keeping with measure specifications. **[Quality]**

¹⁶¹ National Committee for Quality Assurance. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/metabolic-monitoring-for-children-and-adolescents-on-antipsychotics-apm-e/>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

Recommendation: HSAG recommends that DES/DDD collaborate with AHCCCS to improve the completion and accuracy of race/ethnicity data and explore other methods to augment enrollment data information. HSAG also recommends that DES/DDD explore other potential data sources for the capture of race/ethnicity data to support future performance measure reporting that may require stratification related to RES. To ensure data reporting accuracy, HSAG recommends that DES/DDD investigate conducting sample reviews on the subcontractor's reported rates prior to submission as a component of its ongoing quality review process, along with benchmark reviews of the individual subcontractor rates.

In the Behavioral Health measure group:

- DES/DDD's performance measure rate for *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and the 25th percentile. These results provide an opportunity for DES/DDD to implement interventions to improve care and services around SUD treatments. **[Quality]**

Recommendation: HSAG recommends that DES/DDD conduct a root cause analysis or focus study to determine why some members are not accessing SUD treatment services. HSAG recommends that DES/DDD review patient data for any patterns present by ZIP Code and other demographics for case management prioritization. One study suggests that male members who have a schizophrenia spectrum disorder diagnosis are less likely to initiate treatment, while current drug dependence and recent arrest were associated with lowered odds of engaging in treatment. Current drug dependence is associated with factors that make scheduling and attending treatment appointments difficult, such as severe symptoms, chaotic living situations, and self-care and life functioning issues.¹⁶²

- DES/DDD's performance measure rate for *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)* fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and the 25th percentile, indicating that clinicians may be underutilizing safer first-line psychosocial interventions and using antipsychotics for nonprimary indications in children and adolescents.¹⁶³ **[Quality]**

Recommendation: HSAG recommends that DES/DDD identify providers who may be overprescribing antipsychotics to children and adolescents. DES/DDD can collaborate with its

¹⁶² National Committee for Quality Assurance. Initiation and Engagement of Substance Use Disorder (IET). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/initiation-and-engagement-of-substance-use-disorder-treatment-iet/>. Accessed on: Feb 11, 2026.

¹⁶³ National Committee for Quality Assurance. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/use-of-first-line-psychosocial-care-for-children-and-adolescents-on-antipsychotics-app/>. Accessed on: Feb 18, 2026.

Strengths, Opportunities for Improvement, and Recommendations

PBM in conducting drug utilization reviews and then educate providers to ensure that members are receiving timely psychosocial care which includes a comprehensive treatment plan and behavioral and psychological therapies, in addition to medication management.¹⁶⁴

In the Preventive Screening measure group, DES/DDD's performance measure rates for *Breast Cancer Screening (ECDS)—Total (50–74 Years)*, *Cervical Cancer Screening—21–64 Years*, and *Cervical Cancer Screening (ECDS)—21–64 Years* fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and the 25th percentile, suggesting that female members were not always receiving timely access to screening for breast and cervical cancer. **[Quality]**

Recommendations: HSAG recommends that DES/DDD consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended cancer screenings and make appropriate health decisions. HSAG recommends that DES/DDD consider utilizing one-on-one interactions with health care professionals, such as CHWs, which have been shown to improve cervical cancer screening rates. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that DES/DDD provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge. In addition, HSAG recommends that DES/DDD work with its subcontracted health plans to analyze their data and consider whether there are disparities within DES/DDD's populations that contributed to lower screening rates.

In the Pediatric Health measure group, DES/DDD's performance measure rates for *Childhood Immunization Status—Combination 7* and *Combination 10* and *Childhood Immunization Status (ECDS)—Combination 7* and *Combination 10* fell below the 25th percentile, suggesting that some children were not receiving these immunizations, which are a critical aspect of preventive care for children. Childhood vaccines protect children from many serious and potentially life-threatening diseases, such as diphtheria, measles, meningitis, polio, tetanus, and whooping cough, at a time in their lives when they are most vulnerable to disease.¹⁶⁵ Continued coordinated efforts between health care providers and public health officials at the local, state, and federal levels will be necessary to achieve rapid catch-up vaccination.¹⁶⁶ **[Quality]**

Recommendation: HSAG continues to recommend that DES/DDD identify best practices to support children in receiving preventive vaccinations according to recommended schedules.

¹⁶⁴ Substance Abuse and Mental Health Services Administration (SAMHSA). Guidance on Strategies to Promote Best Practice in Antipsychotic Prescribing for Children and Adolescents. Available at: <https://library.samhsa.gov/sites/default/files/promote-best-practice-pep19-antipsychotic-bp.pdf>. Accessed on: Feb 18, 2026.

¹⁶⁵ National Committee for Quality Assurance. Childhood Immunization Status. Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/childhood-immunization-status-cis-c/>. Accessed on: Feb 11, 2026.

¹⁶⁶ The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: <https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.html>. Accessed on: Feb 11, 2026.

Strengths, Opportunities for Improvement, and Recommendations

HSAG recommends that DES/DDD provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.

Validation of Performance Improvement Projects

Well-care visits for children and adolescents aim to promote optimal health and development. Ensuring that children and adolescents receive regular well-care visits is critical in disease prevention, early detection, and treatment. There are many benefits of well-child/well-care visits, including disease prevention, tracking growth and development, raising concerns, and establishing a team approach to assist with the development of optimal physical, mental, and social health of a child.¹⁶⁷ Adolescence is a critical stage of development during which physical, intellectual, emotional, and psychological changes occur.¹⁶⁸ Adolescent well-care visits assist with promoting healthy choices and behaviors, preventing risky behaviors, and detecting early the conditions that can inhibit an adolescent's development.

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

As this PIP had progressed through Remeasurement 3, PIP validation activities focused on improvement from the baseline results. DES/DDD submitted Remeasurement 3 performance indicator results and interventions implemented during this validation cycle along with the status of interventions, focus, and rationale for changes to or discontinuation of the interventions. HSAG conducted an annual validation of the third remeasurement year reflective of CY 2024 (January 1, 2024, through December 31, 2024) using AHCCCS-calculated and validated indicator rates. HSAG evaluated DES/DDD's performance indicator rates based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of [Appendix A. Methodology](#).

Validation Results

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. Validation Rating 1 reflects HSAG's confidence that the Contractor adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Validation Rating 2 is assigned for PIPs that have progressed

¹⁶⁷ American Academy of Pediatrics. AAP Schedule of Well-Child Care Visits. Available at: <https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx>. Accessed on: Feb 11, 2026.

¹⁶⁸ Centers for Disease Control and Prevention. Adolescence: Preparing for Lifelong Health and Wellness. Available at: <https://archive.cdc.gov/#/details?url=https://www.cdc.gov/grand-rounds/pp/2015/20150818-adolescent-wellness.html>. Accessed on: Feb 11, 2026.

to the Outcomes stage and reflects HSAG’s confidence that the PIP’s performance indicator results demonstrated evidence of significant improvement. Table 11-6 displays the overall confidence levels for the DES/DDD *Back to Basics* PIP.

Table 11-6—DES/DDD *Back to Basics* PIP Overall Confidence Levels for Remeasurement 3

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³
DES/DDD	<i>Low Confidence</i>	73%	78%	<i>High Confidence</i>	100%	100%

¹ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

² **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Measure Results

Table 11-7 provides the *Back to Basics* PIP baseline, Remeasurement 1, Remeasurement 2, and Remeasurement 3 rates for DES/DDD.

Table 11-7—DES/DDD *Back to Basics* PIP Rates

Contractor	PIP Indicator: <i>Child and Adolescent Well-Care Visits (WCV)</i>			
	Baseline Year	Remeasurement 1	Remeasurement 2	Remeasurement 3
	CYE 2019	CY 2022	CY 2023	CY 2024
DES/DDD	50.72%	54.43%	57.09%	60.79%

Interventions

Table 11-8 presents PIP interventions for DES/DDD. Language in the PIP interventions section is minimally edited and generally reflective of the language provided by the Contractor.

Table 11-8—DES/DDD Program *Back to Basics* PIP Interventions

Contractor	Intervention
DES/DDD	- Collaborated with health plans to ensure best practices and continue member engagement outreach. - QMPI committee addressed health plan issues, questions, and concerns. - Initiated a new DDD Performance Improvement and Monitoring Workgroup. - Initiated a process for health plans to send target lists of members with gaps in care to DDD. - Initiated a process of distributing gap target lists provided by health plans to support coordinators in order to engage members and their families/healthcare decision makers in receipt of recommended services. - Initiated and coordinated member newsletter articles with health plans to increase member awareness of preventive services to optimize impact.

Strengths, Opportunities for Improvement, and Recommendations

Table 11-9 presents strengths, opportunities for improvement, and recommendations for DES/DDD, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 11-9—DES/DDD Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: The DES/DDD Contractor was able to achieve statistically significant improvement at Remeasurement 3 when compared to the baseline rate, sustaining the statistically significant improvement achieved at Remeasurement 2. [Quality, Access]
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement for DES/DDD: - The Contractor added a recalculated baseline rate in the narrative and used it for statistical testing between the baseline and Remeasurement 3 without explanation or updating the performance indicator data table. [Quality] - Subcontractor statistical testing was conducted between the Intervention Year and Remeasurement 3 instead of between the baseline and Remeasurement 3 for one subcontracted health plan. [Quality] - The Contractor did not report intervention effectiveness data for ongoing Mercy Care interventions. [Quality]

Strengths, Opportunities for Improvement, and Recommendations

Recommendations: To address the issues identified during this year’s validation, HSAG recommends that for future PIPs, DES/DDD:

- Apply lessons learned from the *Back to Basics* PIP.
- Implement interventions with clearly defined intervention effectiveness measures.
- Use the same baseline for all remeasurement period statistical testing.
- Track intervention effectiveness data for all subcontractor interventions.
- Seek technical assistance from HSAG to understand the CMS EQR Protocol 1 requirements.

Compliance Reviews

AHCCCS conducts a full compliance review for DES/DDD every three years. The current three-year review cycle spans from CYE 2024 to CYE 2027.

Results

AHCCCS conducted a compliance review of DES/DDD from August 12, 2024, to August 15, 2024. On October 31, 2024, AHCCCS finalized the report findings, provided DES/DDD with a CAP submission matrix, and required a CAP for any standard with a total score of less than 95 percent. On January 17, 2025, AHCCCS accepted DES/DDD’s proposed CAPs and required the Contractor to submit updated policies, manuals, desktop procedures, and other vital documents to provide evidence of CAP completion.

Table 11-10 presents the compliance review scores and CAP status for DES/DDD.

Table 11-10—DES/DDD Compliance Review Results

AHCCCS Compliance Focus Areas	CYE 2024 DES/DDD Scores	CYE 2025 DES/DDD CAP Updates
Corporate Compliance	93%	Met
Claims and Information Standards	100%	NA
Case Management	77%	Partially Met
Delivery Systems	97%	NA
General Administration	94%	Partially Met
Grievance Systems	100%	NA
Adult; EPSDT; and Maternal Child Health	100%	NA
Medical Management	87%	Met
Member Information	89%	Partially Met
Quality Management	73%	Partially Met
Quality Improvement	88%	Partially Met

AHCCCS Compliance Focus Areas	CYE 2024 DES/DDD Scores	CYE 2025 DES/DDD CAP Updates
Reinsurance	100%	NA
Third-Party Liability	100%	NA
Integrated Systems of Care	96%	NA

NA = Not applicable. A CAP was not required as the CYE 2024 score was 95% or above.

Partially Met = AHCCCS approved the Contractor’s proposed CAP. The Contractor must submit evidence of compliance.

Met = AHCCCS accepted and closed the Contractor’s CAP.

Strengths, Opportunities for Improvement, and Recommendations

Table 11-11 presents strengths, opportunities for improvement, and recommendations (as applicable) for DES/DDD related to compliance, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 11-11—DES/DDD Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
DES/DDD achieved full compliance in five of the 14 focus areas reviewed, demonstrating strengths and adherence to all requirements measured in the following areas: - Claims and Information Standards [Access] - Grievance Systems [Quality, Timeliness, Access] - Adult; EPSDT; and Maternal Child Health [Timeliness, Access] - Reinsurance [Quality] - Third-Party Liability [Quality, Timeliness, Access]
Opportunities for Improvement and Recommendations
The areas with the greatest opportunity for improvement were related to the following, as these areas received performance scores under 95 percent: - Corporate Compliance [Quality, Access] - Case Management [Quality, Access] - General Administration [Timeliness, Access] - Medical Management [Quality, Timeliness, Access] - Member Information [Quality] - Quality Management [Quality] - Quality Improvement [Quality, Access]

Strengths, Opportunities for Improvement, and Recommendations

Recommendation: HSAG recommends that DES/DDD continue to work with AHCCCS on closing remaining CAPs.

Network Adequacy Validation

ISCA Results

HSAG completed an ISCA for the DES/DDD subcontracted health plans contracted to deliver services to Medicaid managed care members in Arizona, and this report presents findings and validation ratings based on the DES/DDD subcontracted health plans' ISCA and live system demonstrations. HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data systems. Additionally, HSAG determined that the DES/DDD subcontracted health plans' data collection procedures were acceptable. For the DES/DDD subcontracted health plans that used external delegated entities to complete network adequacy indicator reporting during the reporting period, no issues were identified.

Based on the results of the ISCA's combined with the detailed validation of each NAV indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and whether the DES/DDD subcontracted health plans' interpretation of data was accurate.

Table 11-12 and Table 11-13 summarize HSAG's validation ratings for each DES/DDD subcontracted health plan by indicator type.

Table 11-12—Summary of Mercy Care DD Validation Ratings by Indicator Type

Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Appointment Availability	100%	0%	0%	0%
Time/Distance	100%	0%	0%	0%

Table 11-13—Summary of UHCCP DD Validation Ratings by Indicator Type

Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Appointment Availability	100%	0%	0%	0%
Time/Distance	100%	0%	0%	0%

Of the network adequacy indicators assessed, the DES/DDD subcontracted health plans received *High Confidence* for both appointment availability and time/distance indicator types. However, there were

identified areas for improvement for some of the DES/DDD subcontracted health plans; please refer to the Contractor-specific Strengths, Opportunities for Improvement, and Recommendations section below for more details.

NAV Results

HSAG’s validation of the DES/DDD subcontracted health plans’ results showed minor discrepancies between the DES/DDD subcontracted health plans’ self-reported ACOM 436 results and HSAG’s time/distance calculations for which data could be compared. While minor differences (i.e., less than 1 percentage point) between HSAG’s time/distance calculation results and each DES/DDD subcontracted health plan’s time/distance calculation results were common, these findings are most likely attributable to the timing of the input data or software versions used by each DES/DDD subcontracted health plan, or due to a small number of members eligible for inclusion in time/distance calculations for the standard and county.

Table 11-14 summarizes HSAG’s assessment of each DES/DDD subcontracted health plan’s compliance with AHCCCS’ minimum time/distance network standards. A check mark indicates that the DES/DDD subcontracted health plan met the minimum network standard for all assigned counties during the CYE 2024 S2 assessment, and an “X” indicates that the DES/DDD subcontracted health plan did not meet one or more minimum network standards in any assigned county.

Table 11-14—Summary of CYE 2024 S2 Compliance With Minimum Time/Distance Network Requirements for DES/DDD Subcontracted Health Plans

Minimum Network Requirement	Mercy Care DD	UHCCP DD
Behavioral Health Outpatient and Integrated Clinic, Adult	X	X
Behavioral Health Outpatient and Integrated Clinic, Pediatric	✓	X
BHRF	✓	X
Cardiologist, Adult	X	X
Cardiologist, Pediatric	✓	✓
Dentist, Pediatric	X	X
Hospital	✓	✓
OB/GYN	✓	✓
PCP, Adult	✓	✓
PCP, Pediatric	✓	✓
Pharmacy	✓	X

The DES/DDD subcontracted health plans consistently met the Cardiologist, Pediatric; Hospital; OB/GYN; and PCP, Adult and Pediatric standards.

No isolated data issues were identified affecting ALTCS-DD Program Contractors' compliance with time/distance standards.

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

Overall, the DES/DDD subcontracted health plans met all minimum time/distance network standards in Cochise, Coconino, Graham, Maricopa, Mohave, Navajo, Pinal, Santa Cruz, Yavapai, and Yuma counties. Based on the CYE 2024 S2 NAV results, the DES/DDD subcontracted health plans did not meet all requirements for all standards in the applicable counties.

The DES/DDD subcontracted health plans should continue to monitor and maintain their existing provider network as of CYE 2024 S2 with specific attention to ensuring the availability of the following provider categories where both DES/DDD subcontracted health plans did not meet the network requirement:

- Behavioral Health Outpatient and Integrated Clinic, Adult in Apache County
- Cardiologist, Adult in Apache County
- Dentist, Pediatric in Greenlee County

HSAG evaluated the DES/DDD subcontracted health plans' compliance results with AHCCCS' time/distance standards by GSA and county. This section presents CYE 2024 S2 validation findings specific to the DES/DDD Program, with one results table for each of the following GSAs:

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

Each region-specific table summarizes validation results containing the percentage of members meeting each time/distance standard by county, with color coding to identify whether the time/distance standard was *Met* or *Not Met*.

Table 11-15—Time/Distance Validation Results for Mercy Care DD Central GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0 [^]	98.3 [^]	100.0 [^]
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0 [^]	98.6 ^{^Y}	100.0 [^]
BHRF	NA	99.3 ^Y	NA
Cardiologist, Adult	100.0 [^]	100.0 [^]	100.0 [^]
Cardiologist, Pediatric	100.0 [^]	100.0 [^]	100.0 [^]
Dentist, Pediatric	90.2 ^Y	99.5 ^Y	100.0 ^Y
Hospital	100.0	99.9	100.0
OB/GYN	100.0	100.0	100.0
Pharmacy	100.0	99.0 ^Y	100.0
PCP, Adult	100.0 [^]	99.7 ^{^Y}	100.0 [^]
PCP, Pediatric	98.0 ^{^Y}	99.8 ^{^Y}	100.0 [^]

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

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

NA indicates results are not applicable to the county.

Table 11-16—Time/Distance Validation Results for Mercy Care DD North GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Apache	Coconino	Mohave	Navajo	Yavapai
Behavioral Health Outpatient and Integrated Clinic, Adult	71.4 ^{*^R}	95.0 ^{^Y}	100.0 [^]	100.0 ^{*^}	100.0 [^]
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0 ^{*^Y}	97.9 ^{^Y}	100.0 [^]	90.9 ^{^Y}	100.0 [^]
BHRF	NA	NA	NA	NA	NA
Cardiologist, Adult	57.1 ^{*^R}	94.1 ^{^Y}	100.0 [^]	100.0 ^{*^}	100.0 [^]
Cardiologist, Pediatric	100.0 ^{*^Y}	100.0 [^]	100.0 [^]	100.0 [^]	100.0 [^]
Dentist, Pediatric	100.0 ^{*Y}	100.0 ^Y	97.0 ^Y	100.0	98.7 ^Y
Hospital	100.0	100.0	100.0	100.0	100.0
OB/GYN	100.0 ^{*Y}	100.0 [*]	100.0	100.0 [*]	100.0 [*]
Pharmacy	100.0 ^Y	98.5 ^Y	98.8	94.7 ^Y	100.0 ^Y
PCP, Adult	85.7 ^{*^Y}	100.0 ^{^Y}	100.0 [^]	100.0 ^{*^}	100.0 [^]
PCP, Pediatric	100.0 ^{*^Y}	98.0 [^]	98.5 ^{^Y}	90.9 ^{^Y}	100.0 [^]

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

Table 11-17—Time/Distance Validation Results for Mercy Care DD South GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Cochise	Graham	Greenlee	La Paz	Pima	Santa Cruz	Yuma
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^	100.0^	100.0^	100.0*^	97.2^Y	100.0^	100.0^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0^	100.0^	100.0*^	100.0*^	95.0^Y	100.0^	100.0^
BHRF	NA	NA	NA	NA	91.9^Y	NA	NA
Cardiologist, Adult	100.0^	100.0^	100.0^	100.0*^	100.0^Y	100.0^	100.0^
Cardiologist, Pediatric	100.0^	100.0^	100.0*^	100.0*^	100.0^Y	100.0^	100.0^
Dentist, Pediatric	100.0	100.0^Y	85.7*R	60.0*R	98.5^Y	100.0	100.0
Hospital	100.0	100.0	100.0	100.0*	99.7^Y	100.0	100.0
OB/GYN	100.0	100.0	100.0*	100.0*	99.6^Y	100.0	100.0
Pharmacy	100.0	98.9^Y	100.0	100.0*	98.1^Y	100.0	100.0
PCP, Adult	100.0^	100.0^	100.0^	100.0*^	99.1^Y	100.0^	100.0^
PCP, Pediatric	100.0^	97.5^Y	100.0*^	100.0*^	99.3^Y	100.0^	100.0^

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

Table 11-18—Time/Distance Validation Results for UHCCP DD Central GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^	99.2^Y	100.0^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0^	99.4^Y	100.0^
BHRF	NA	97.9^Y	NA

Provider Category	Gila	Maricopa	Pinal
Cardiologist, Adult	100.0 [^]	99.9 ^{^Y}	100.0 [^]
Cardiologist, Pediatric	100.0 [^]	100.0 [^]	100.0 [^]
Dentist, Pediatric	53.7 ^R	99.4 ^Y	100.0
Hospital	100.0	99.9	100.0
OB/GYN	100.0	99.9 ^Y	100.0
Pharmacy	95.7 ^Y	99.2 ^Y	100.0
PCP, Adult	100.0 [^]	99.6 ^{^Y}	100.0 [^]
PCP, Pediatric	95.1 ^{^Y}	99.8 [^]	100.0 [^]

Y
R

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

represents time/distance standard results that do not meet the compliance standard based on HSAG's results.

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

NA indicates results are not applicable to the county.

Table 11-19—Time/Distance Validation Results for UHCCP DD North GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Apache	Coconino	Mohave	Navajo	Yavapai
Behavioral Health Outpatient and Integrated Clinic, Adult	70.0 ^{^R}	80.7 ^{^Y}	96.3 ^{^Y}	94.5 ^{^Y}	99.9 ^{^Y}
Behavioral Health Outpatient and Integrated Clinic, Pediatric	71.1 ^{^R}	85.1 ^{^Y}	94.6 ^{^Y}	95.1 ^{^Y}	100.0 [^]
BHRF	NA	NA	NA	NA	NA
Cardiologist, Adult	66.7 ^{^R}	99.3 [^]	100.0 [^]	96.8 ^{^Y}	100.0 [^]
Cardiologist, Pediatric	81.6 ^{^Y}	100.0 [^]	100.0 [^]	100.0 [^]	100.0 [^]
Dentist, Pediatric	91.8 ^Y	95.3 ^Y	94.4 ^Y	96.8 ^Y	98.6 ^Y
Hospital	100.0	100.0	100.0	100.0	100.0
OB/GYN	95.7	100.0	100.0	100.0	100.0
Pharmacy	89.8 ^R	94.8 ^Y	99.5 ^Y	96.8	99.1 ^Y
PCP, Adult	85.5 ^{^Y}	96.9 ^{^Y}	99.5 ^{^Y}	100.0 ^{^Y}	100.0 [^]
PCP, Pediatric	87.8 ^{^Y}	91.3 ^{^Y}	99.5 ^{^Y}	100.0 ^{^Y}	100.0 [^]

Y
R

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

represents time/distance standard results that do not meet the compliance standard based on HSAG's results.

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

NA indicates results are not applicable to the county.

Table 11-20—Time/Distance Validation Results for UHCCP DD South GSA—Percentage of Members Meeting Minimum Network Requirements by Provider Category

Provider Category	Cochise	Graham	Greenlee	La Paz	Pima	Santa Cruz	Yuma
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0 [^]	100.0 [^]	100.0 [^]	97.7 ^{^Y}	100.0 [^]	100.0 [^]
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0 [^]	100.0 [^]	100.0 [^]	100.0 [^]	95.2 ^{^Y}	100.0 [^]	100.0 [^]
BHRF	NA	NA	NA	NA	89.4 ^R	NA	NA
Cardiologist, Adult	100.0 [^]	100.0 [^]	100.0 ^{*^}	100.0 [^]	99.9 [^]	100.0 [^]	100.0 [^]
Cardiologist, Pediatric	100.0 [^]	100.0 [^]	100.0 [^]	100.0 [^]	100.0 [^]	100.0 [^]	100.0 [^]
Dentist, Pediatric	97.4 ^Y	100.0 ^Y	61.9 ^R	95.5 ^Y	98.7 ^Y	100.0	99.8 ^Y
Hospital	100.0	100.0	100.0	100.0	99.8 ^Y	100.0	100.0
OB/GYN	100.0	100.0	100.0 [*]	100.0 [*]	100.0	100.0	100.0
Pharmacy	99.8 ^Y	100.0 ^Y	100.0	100.0	99.0 ^Y	100.0	99.9 ^Y
PCP, Adult	100.0 [^]	100.0 ^{^Y}	100.0 ^{*^}	100.0 [^]	99.9 [^]	100.0 [^]	100.0 ^{^Y}
PCP, Pediatric	100.0 [^]	100.0 [^]	100.0 [^]	100.0 [^]	99.5 ^{^Y}	100.0 [^]	99.8 ^{^Y}

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

R represents time/distance standard results that do not meet the compliance standard based on HSAG’s results.

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

^{*} indicates fewer than 10 members were included in the denominator of HSAG’s results.

NA indicates results are not applicable to the county.

Strengths, Opportunities for Improvement, and Recommendations

Table 11-21 presents strengths, opportunities for improvement, and recommendations for DES/DDD, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 11-21—DES/DDD Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: The DES/DDD subcontracted health plans received <i>High Confidence</i> for both appointment availability and time/distance indicators. [Access]

Strengths, Opportunities for Improvement, and Recommendations

- The DES/DDD subcontracted health plans met all minimum time/distance network standards for Cochise, Coconino, Graham, Maricopa, Mohave, Navajo, Pinal, Santa Cruz, Yavapai, and Yuma counties. **[Access]**
- The DES/DDD subcontracted health plans consistently met the Cardiologist, Pediatric; Hospital; OB/GYN; and PCP, Adult and Pediatric standards. **[Access]**
- Mercy Care DD maintained a robust internal provider data management process supported by multiple data management platforms and applications. This system included weekly reconciliation between credentialing and operational systems, the application of USPS address standardization, and annual validations of the provider directory through direct provider attestations. These activities demonstrated a strong process for maintaining accurate and up-to-date provider information. **[Access]**
- Mercy Care DD met all minimum network requirements for all assigned counties except in Apache, Greenlee, and La Paz counties. **[Access]**
- Mercy Care DD met all minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Pediatric; BHRF; Cardiologist, Pediatric; Hospital; OB/GYN; PCP, Adult and Pediatric; and Pharmacy. **[Access]**
- UHCCP DD performed proactive outreach to maintain provider data accuracy. When providers did not attest or when business rules triggered a demographic verification request, outreach was completed via email or telephone, with up to three attempts. **[Access]**
- UHCCP DD met all minimum network requirements for all assigned counties except in Apache, Gila, Greenlee, and Pima counties. **[Access]**
- UHCCP DD met all minimum network requirements for Cardiologist, Pediatric; Hospital; OB/GYN; and PCP, Adult and Pediatric. **[Access]**

Note: DES/DDD provides coverage statewide in the following counties: Apache, Cochise, Coconino, Gila, Graham, Greenlee, La Paz, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma.

Opportunities for Improvement and Recommendations

HSAG identified the following opportunities for improvement:

- Based on the NAV results, neither of the DES/DDD subcontracted health plans met the standards for Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult; and Dentist, Pediatric. **[Access]**

Recommendation: HSAG recommends that AHCCCS support each DES/DDD subcontracted health plan in continuing to monitor and maintain its existing provider network coverage as of CYE 2024 S2, with specific attention to ensuring the availability of the following provider categories for which neither DES/DDD subcontracted health plan met the network requirement:

- Behavioral Health Outpatient and Integrated Clinic, Adult in Apache County.
- Cardiologist, Adult in Apache County.

Strengths, Opportunities for Improvement, and Recommendations

- Dentist, Pediatric in Greenlee County.

- Mercy Care DD did not meet the minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult; and Dentist, Pediatric. [Access]

Recommendation: HSAG recommends that Mercy Care DD maintain current compliance with network standards and continue to address network gaps, as applicable.

- While UHCCP DD had a strong outreach process in place, there is an opportunity to strengthen oversight by tracking and trending provider nonresponses to outreach and incorporate this into ongoing monitoring, which would help identify gaps and ensure timely resolution of provider data discrepancies. [Access]

Recommendation: HSAG recommends that UHCCP DD consider tracking and trending provider nonresponses to outreach attempts as part of its oversight process. Monitoring response rates and outcomes would allow UHCCP DD to identify patterns (e.g., providers or groups with repeated nonresponses) and strengthen timeliness in updating provider records.

- HSAG identified an opportunity for UHCCP DD to strengthen its methods to calculate appointment availability indicator results. UHCCP DD's appointment availability survey script incorporated leading questions directed toward providers, accompanied by a predetermined response format designed to align with AHCCCS compliance requirements. [Access]

Recommendation: HSAG recommends that UHCCP DD revise its appointment availability survey script to use open-ended questions that solicit the earliest available appointment dates from each provider. The collected responses should then be independently evaluated to determine compliance with AHCCCS standards.

- UHCCP DD did not meet the minimum network requirements for Behavioral Health and Integrated Clinic, Adult and Pediatric; BHRF; Cardiologist, Adult; Dentist, Pediatric; and Pharmacy. [Access]

Recommendation: HSAG recommends that UHCCP DD maintain current compliance with network standards and continue to address network gaps, as applicable.

12. Assessment of Follow-Up on Prior Year's Recommendations

Introduction

Regulations under 42 CFR 438.364 require an assessment of the degree to which each MCO, PIHP, or PAHP has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. This section provides the Contractors' self-reported follow-up actions in response to HSAG's CYE 2024 recommendations. Contractor responses were minimally edited for grammatical and stylistic changes only.

Scoring

In accordance with CMS guidance, HSAG used a three-point rating system when evaluating Contractors' responses to each EQRO recommendation. The Contractors' responses to each EQRO recommendation was rated as *High*, *Medium*, or *Low* according to the criteria below.

High indicates *all* of the following:

1. The Contractor implemented new initiatives or revised current initiatives that were applicable to the recommendation.
2. Performance improvement directly attributable to the initiative was noted *or* if performance did not improve, the Contractor identified barriers that were specific to the initiative.
3. The Contractor included a viable strategy for continued improvement or overcoming identified barriers.

A rating of *high* is indicated by the following graphic:



Medium indicates one or more of the following:

1. The Contractor continued previous initiatives that were applicable to the recommendation.
2. Performance improvement was noted that may or may not be directly attributable to the initiative.
3. If performance did not improve, the Contractor identified barriers that may or may not be specific to the initiative.
4. The Contractor included a viable strategy for continued improvement or overcoming barriers.

A rating of *medium* is indicated by the following graphic:



Low indicates one or more the following:

1. The Contractor did not implement an initiative or the initiative was not applicable to the recommendation.
2. No performance improvement was noted *and* the Contractor did not identify barriers that were specific to the initiative.
3. The Contractor's strategy for continued improvement or overcoming identified barriers was not specific or viable.

A rating of *low* is indicated by the following graphic:



ACC Program Contractors' Follow-Up on Prior Year's Recommendations

The tables below present recommendations made to each ACC Program Contractor in the CYE 2024 Annual Technical Report¹⁶⁹ and the Contractors' follow-up to the recommendations, as well as an assessment of the degree to which each Contractor effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by each Contractor. Follow-up responses may be based on Contractor internal data and not EQR-validated rates.

AzCH-CCP ACC-RBHA

Performance Measure Validation

Opportunity for Improvement: While AzCH-CCP ACC-RBHA was successful in reporting valid rates for all AHCCCS-required performance measures for its ACC population, the audit identified some considerations and recommendations for future years' reporting. **[Quality]**

Recommendations:

- HSAG recommends that AzCH-CCP ACC-RBHA continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES.

¹⁶⁹ Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2024 External Quality Review Annual Technical Report*. Available at: <https://www.azahcccs.gov/Resources/Downloads/EQR/2024/CYE2024ExternalQualityReviewAnnualTechnicalReport.pdf>. Accessed on: Feb 10, 2026.

Performance Measure Validation

- HSAG recommends that AzCH-CCP ACC-RBHA continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes AHCCCS' requirements for MCO-enrolled members who switch product lines or MCOs and members for whom AzCH-CCP ACC-RBHA does not hold the primary insurance contract.

AzCH-CCP ACC-RBHA's Response:

- AzCH-CCP ACC-RBHA is continuing to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES.
- AzCH-CCP ACC-RBHA is continuing to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting, including AHCCCS' requirements for MCO-enrolled members who switch product lines or MCOs and members for whom AzCH-CCP ACC-RBHA does not hold the primary insurance contract.
- The AzCH-CCP HEDIS Stratification Dashboard provides an NCQA-directed race and ethnicity stratification of applicable HEDIS performance measures.
- The AzCH-CCP Health Literacy Workgroup, a cross-functional monthly committee, reviews measures by contract stratified by race and ethnicity to determine opportunities to close disparity gaps.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Maternal and Perinatal Care measure group, AzCH-CCP ACC-RBHA's performance measure rate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* fell below the 25th percentile, while the *Prenatal and Postpartum Care—Postpartum Care* rate fell at or between the 25th and 49th percentile, indicating an opportunity to increase access to timely prenatal and postpartum care. **[Quality, Timeliness, Access]**

Recommendations:

- HSAG recommends that AzCH-CCP ACC-RBHA continue to implement appropriate interventions to improve performance relative to prenatal and postpartum care.
- HSAG recommends that AzCH-CCP ACC-RBHA monitor and expand on interventions currently in place to improve performance related to *the Prenatal and Postpartum Care—Postpartum Care* measure indicator, while adding interventions as appropriate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care*.

AzCH-CCP ACC-RBHA's Response:

As of CY2024, AzCH-CCP had implemented the following interventions:

- A proprietary care management/coordination and member education program. The program attempts to engage members in care management or care coordination, based on their risk and

Performance Measures

medical, behavioral, or other needs. This intervention is considered effective because it solicits a Notice of Pregnancy (NOP) risk assessment from the member or provider as early as possible to establish a relationship between the member, their healthcare provider and their health plan care team. In addition, studies by other Centene health plans have found a positive correlation between participation in the program and positive birth outcomes.

- A digital care management program that provides specialized care plans for pregnant and postpartum members, with daily health check lists, providers alerts, care gap alerts, and progress tracking for case managers. It also allows for two-way video/text communication with care management, if the member prefers.
- An NCQA-accredited self-management tool to provide multiple resources, support, and education across a variety of topics inclusive of prenatal and postpartum care that is accessible through the member portal.
- A mobile application to address loneliness and social isolation, assist in developing a support system, and provide resources to address social determinants of health (SDOH). The program also offers the ability to connect with a care coordinator for personalized coordination and resource navigation, along with empathy-led coaching for behavior change and self-reliance. Overall, members participating had an overall 49% reduction in loneliness scores between their baseline and final screenings, indicating that the intervention is effective.
- The AzCH-CCP Prenatal and Postpartum Work Group, an internal workgroup that meets to identify additional opportunities, identify/address racial disparities, and increase prenatal/postpartum outcome measures, including developing specific strategies to enhance member outreach and pregnancy outcomes.
- A cross-functional monthly committee convened to review identified measures, including *Prenatal and Postpartum Care (PPC)*, by contract stratified by race and ethnicity to determine opportunities to close disparity gaps and implement focused interventions.
- The HEDIS Stratification Dashboard, which provides an NCQA-directed race and ethnicity stratification of applicable HEDIS performance measures.
- Outreach to birthing parents through weekly newborn calls to educate them and assist with making postpartum appointments.

The final CY2024 ACC combined rate, based on hybrid data collection, for *Postpartum Care* was 4.3% lower than the final rate for CY2023 ($p=0.1739$), showing no year-over-year (YOY) improvement. The final ACC combined hybrid rate for *Timeliness of Prenatal Care* was 7.3% higher than the rate for CY2023, showing a significant improvement ($p=0.0109$).

New/enhanced interventions in CY2025 include:

- Expanding provider outreach to Obstetrics/Gynecology (OB/GYN) specialty providers around PPC, including (but not limited to) measure specifications, NOP forms, practice-specific performance rates, and care gap lists.

Performance Measures

- Partnering with a CHW program to complete face-to-face outreach for high-risk OB members that the health plan has been unable to reach.
- Implementing a new member incentive for completing a prenatal visit within the first trimester or 42 days of joining the health plan.
- Enhancing its proprietary care management/care coordination program with improvements that include, but are not limited to: a streamlined NOP form to increase completion by members and providers, trimester-based assessments to continuously identify and address barriers to care, additional reminder calls to members to ensure they attend scheduled appointments, and care coordinator teams specializing in prenatal or postpartum outreach.
- Implementing a value-added program that will allow pregnant members to receive items such as a car seat or stroller at no cost to them upon submission of an NOP and completion of a prenatal appointment in the first trimester.

The overall ACC Medicaid rate for Postpartum Care as of Quarter 3 (Q3) of CY2025 was 2.4% higher than the rate for Q3 of CY2024, indicating YOY improvement. The overall rate for Timeliness of Prenatal Care was 1.3% lower than the rate for Q3 of CY2024. It should be noted that these rates are expected to improve significantly with the completion of hybrid data collection in the first half of 2026.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Behavioral Health measure group, AzCH-CCP ACC-RBHA's performance measure rate for *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (18+ Years)* fell below the 25th percentile and fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and MY 2023, indicating opportunities to improve psychotropic medication compliance for members. **[Quality]**

Recommendations:

- HSAG recommends that AzCH-CCP ACC-RBHA consider implementing interventions that have been associated with increased medication adherence for members with schizophrenia.
- HSAG recommends that AzCH-CCP ACC-RBHA consider utilizing financial incentives offered to patients with severe mental illness to improve treatment adherence.

AzCH-CCP ACC-RBHA's Response:

As of CY2024, AzCH-CCP had implemented the following interventions:

- Provider Quality Liaisons (PQLs), who work with providers through on-site or virtual visits and provide technical assistance on quality care gaps, accessing and utilizing available provider analytic tools, member experience, risk, and incentive programs.

Performance Measures

- A drug utilization review (DUR) program that reviews data against evidence-based clinical rules and outreaches providers through clinical alerts to increase adherence to medications, including antipsychotic drugs.
- A medication adherence reward program that incentivizes members to take their daily prescribed antipsychotic medications, with daily check-ins. In CY2024, the program had an average daily engagement rate of 81.0%. Members completing the program demonstrated a significant improvement (>10%) in antipsychotic medication adherence.
- A mobile application to address loneliness and social isolation, assist in developing a support system, and provide resources to address SDOH. The program also offers the ability to connect with a care coordinator for personalized coordination and resource navigation, along with empathy-led coaching for behavior change and self-reliance. Overall, members participating had an overall 49% reduction in loneliness scores between their baseline and final screenings, indicating that the intervention is effective.

In CY2024, AzCH-CCP ACC achieved an increase of 5.7% from CY2023 for *Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)*, demonstrating significant improvement ($p=0.0219$) YOY.

New/enhanced interventions in CY2025 include:

- Working more closely with the vendor offering the mobile application to address loneliness and social isolation to enhance engagement and referral of members who have expressed SDOH needs.
- In CY2025, a provider-facing tip sheet for SAA was deployed.

The Q3 CY2025 rate for SAA is at 15.7%. However, because numerator hits are based on members who remained on an antipsychotic medication for at least 80% of their treatment period (the time from the first medication fill date through the end of the year), the ability to accurately interpret the measure rate was still somewhat limited. The rate was 2.5% higher than the Q3 CY2024 rate, suggesting YOY improvement.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Pediatric Health measure group, AzCH-CCP ACC-RBHA's performance measure rate for *Well-Child Visits in the First 30 Months of Life—15 Months to 30 Months—Two or More Well-Child Visits* fell below the 25th percentile, indicating opportunities for children who turned 30 months old during the measurement year to have at least two well-child visits with a PCP in the prior 15 months. **[Quality, Access]**

Performance Measures

Recommendations:

- HSAG recommends that AzCH-CCP ACC-RBHA continue implementing interventions as part of the *Back to Basics* PIP, which includes a root cause analysis and interventions to address this measure.
- HSAG recommends that AzCH-CCP ACC-RBHA draw as needed from other states' performance improvement initiatives.
- HSAG recommends that plans identify other barriers to care and conduct a focus group on identifying ways to address barriers.¹⁷⁰

AzCH-CCP ACC-RBHA's Response:

During the CY2024 Remeasurement Year 3, AzCH-CCP reevaluated the barriers brainstormed during the baseline and subsequent remeasurement years to update its root cause analysis and interventions.

As of CY2024, AzCH-CCP had implemented the following interventions:

- Conduct blitz call campaigns that educate, encourage, and assist members to schedule necessary appointments.
- Automated calls to members in the denominator with no claims to encourage completion of well-child visits in the first 30 months of life.
- Provider Quality Liaisons (PQLs), who work with providers through on-site or virtual visits and provide technical assistance on quality care gaps, accessing and utilizing available provider analytic tools, member experience, risk, and incentive programs.
- Presenting at least annually at the Provider Forum about the importance of well visits and other EPSDT-related topics.
- Collaboration with a strategic partner to implement a multi-prong outreach campaign to reach members to close *Well-Child Visits in The First 30 Months of Life (W30)* care gaps through in-home visits or community events.
- Health Literacy Workgroup, a cross-functional monthly committee convened to review identified measures by contract stratified by race and ethnicity to determine opportunities to close disparity gaps.

CY2024 shows the AzCH-CCP ACC rate at 72.4%, which exceeds the MY2023 mean by 3.2%. The YOY change represents a significant improvement ($p < 0.0001$).

New/enhanced interventions in CY2025 include:

¹⁷⁰ Centers for Medicare & Medicaid Services. Well-Child Care. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html>. Accessed on: Feb 3, 2026.

Performance Measures

- Conducting a targeted “Unable to Reach” call campaign to research additional sources of data, identify alternate contact information, and attempt to engage members who were not reached in CY2024.
- Adding targeted calls to members younger than 30 months in Q1 2025, to encourage and assist members with gaps for these visits and provide education to parents/health care decision makers (HCDMs).
- Deploying Member Passports, which provide customized outreach to members in need of preventive screenings, anchored off of gaps for child/adolescent well visits. Mailed/mailed information includes reminders and catered information regarding current open care gaps, what each screening/test involves, and how to access member rewards applicable to any gaps.

As of Q3 CY2025, the rate for *Well-Child Visits in the First 30 Months of Life—15 Months to 30 Months—Two or More Well-Child Visits* is currently at 69.3%. While the Medicaid rate was 2.0% lower than the Q3 rate for CY2024, the KidsCare rate was 5.9% higher than the Q3 rate for CY2024, indicating YOY improvement.

AzCH-CCP ACC has identified the following barriers to implementing initiatives:

- Member demographic data may be incorrect or no longer applicable: Changed/disconnected numbers.
- Members or health care decision makers may be difficult to reach during the day due to school or work.
- Provider lack of awareness of gaps in care and best practices for improvement, as well as current information on AHCCCS requirements and tools/resources for quality improvement.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Appropriate Utilization of Services measure group, AzCH-CCP ACC-RBHA's performance measure rate for *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total (18–64 Years)* fell at or between the 25th and 49th percentile, indicating that members who were admitted for an acute inpatient and observation stay might have followed that stay with an unplanned acute readmission for any diagnosis within 30 days.¹⁷¹ **[Quality]**

Recommendations:

¹⁷¹ National Committee for Quality Assurance. Plan All-Cause Readmissions. Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/plan-all-cause-readmissions-pcr/>. Accessed on: Feb 11, 2026.

Performance Measures

- HSAG recommends that AzCH-CCP ACC-RBHA consider reviewing the Re-Engineered Discharge (RED), which has been shown to reduce readmissions and posthospital ED visits.¹⁷² Other interventions that might be effective include technology platforms, including AI or machine learning, that can assist the plan in identifying members more at risk of readmission.
- HSAG recommends that AzCH-CCP ACC-RBHA utilize case management strategies that focus on person-centered techniques, addressing barriers and/or SDOH as needed.

AzCH-CCP ACC-RBHA's Response:

As of CY2024, AzCH-CCP had implemented the following interventions:

- PQLs, who work with providers through on-site or virtual visits and provide technical assistance on quality care gaps, accessing and utilizing available provider analytic tools, member experience, risk, and incentive programs.
- A reward program that incentivizes members to take their daily medication, in order to better manage chronic disease and reduce inpatient utilization. This initiative focuses on members with chronic diseases who demonstrate <80% adherence to one or more prescribed medications.
- A mobile application to address loneliness and social isolation, assist in developing a support system, and provide resources to address SDOH. The program also offers the ability to connect with a care coordinator for personalized coordination and resource navigation, along with empathy-led coaching for behavior change and self-reliance. Overall, members participating had an overall 49% reduction in loneliness scores between their baseline and final screenings, indicating that the intervention is effective.
- Post-discharge follow-up calls within three business days of discharge to confirm the member's well-being and progress of the discharge plan according to assessed and anticipated clinical (behavioral and physical health) and social needs.
- A mobile app that provides specialized care plans for members with daily health check lists, provider alerts, care gaps alerts, and progress tracking to care managers. The app allows for two-way video/text communication with care managers, according to member preference.
- A telehealth provider for members with SUD, providing a specialized option to members who might not otherwise access care due to their condition and SDOH factors such as social isolation and lack of transportation. Telehealth has been shown to support increased access to care and member engagement for behavioral health needs.
- Utilizing a DUR program that uses an evidence-based clinical rules engine to identify gaps in care and alert providers to those gaps. The use of clinical decision support systems has been shown to facilitate evidence-based medicine, and therefore promises to substantially improve health care quality.

¹⁷² Agency for Healthcare Research and Quality. Re-Engineered Discharge (RED) Toolkit. Available at: <https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool1.html>. Accessed on: Feb 3, 2026.

Performance Measures

CY2024 shows the AzCH-CCP RBHA O/E ratio was 0.1442 above the final rate for CY2023. The YOY difference was significant ($p=0.0231$).

New/enhanced interventions in CY2025 include:

- Working more closely with the vendor offering the mobile application to address loneliness and social isolation to enhance engagement and referral of members who have expressed SDOH needs.
- Behavioral health (BH) and physical health (PH) utilization management (UM) teams are continuing to share data/trends and have been working to identify actionable interventions for improvement in post-discharge call turn around times (TATs). The PH UM team implemented a software application designed to perform automated repetitive tasks (bot) to improve efficiency in closing authorizations, and BH UM is exploring implementation of the bot.
- Identifying provider groups and health homes that have higher readmission rates and utilizing PQL visits to discuss activities and share best practices for improvement.
- Developing a text message to be sent to members post discharge, encouraging follow-up appointments with their providers.
- Convening the AzCH-CCP PCR Workgroup, a cross-functional workgroup that is analyzing data and trends, and identifying opportunities to deploy new or enhanced interventions.
- Incorporating components of the Case Management Transitions of Care Model.

The Q3 CY2025 rate was 0.1679 above the rate in Q3 of CY2024, showing no improvement to date. However, the new and enhanced interventions are expected to lower the rate.

HSAG Assessment:



Validation of Performance Improvement Projects - Back to Basics PIP

Opportunity for Improvement: HSAG identified no opportunities for improvement related to the Back to Basics PIP.

Recommendation: Although there were no opportunities for improvement identified, HSAG recommends that AzCH-CCP ACC-RBHA continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention as the PIP progresses.

AzCH-CCP ACC-RBHA's Response:

Interventions currently in place include:

- Outreach to members via SMS text messaging to encourage attendance for annual child and adolescent well visits. In CY2024, these SMS text messages resulted in a 17% gap closure rate

Validation of Performance Improvement Projects - *Back to Basics* PIP

within 90 days and 39.7% overall care gap closure rate. SMS text messages sent for Well-Child Visits in The First 30 Months of Life (W30), 0–15 months, resulted in a 6.3% gap closure rate within 90 days and 24.3%. The overall care gap closure rate for both adolescent well-child visits and well-child visits for the first 30 months of life deems this intervention as effective and the health plan will continue to use this method of outreach to encourage preventive visits.

- A Back to School initiative encouraging members to complete their well-child visits with provider groups. Of seven provider groups who participated in CY2024, the groups experienced a 16% positive increase on average in well-child visits during the campaign time frame.
- Collaboration with strategic partners to implement a multi-prong outreach campaign to reach members/health care decision makers (HCDMs) resulted in a 19.1% reach rate. New databases and third-party vendor solutions are being explored to update member contact information, reducing the impact of outdated data, improving outreach efforts, and enhancing the overall success of this intervention as it continues through CY2025.
- A Population Health Workgroup to advance the health of populations, improve member experience, and deliver system-wide transformation to better serve member population health needs. The goal of the workgroup is to continue to strengthen cross-departmental initiatives between care management and quality teams and implement new pilot projects that are focused on data-driven member outreach.
- Member Passports, which provide customized outreach to members in need of preventive screenings, anchored off of gaps for child/adolescent well visits. Information includes reminders and catered information regarding open care gaps, what each screening/test involves and how to access member rewards applicable to any gaps. The member passport deployment achieved an overall 28.2% gap closure rate for the W30 and *Child and Adolescent Well-Care Visits (WCV)* measures.
- A health plan member outreach team member embedded at two pediatric offices on-site to outreach ACC members and schedule them for a well visit. In CY2024, the intervention resulted in a reach rate of 23.0% and is considered effective due to the high reach rate.
- PQLs, who educate and provide support to providers by supplying a variety of tools and resources, including but not limited to gaps in care, provider performance data, an EPSDT Quarterly Report for non-compliance, AHCCCS Medical Policy manual (AMPM) Policy 430, and EPSDT Provider Resource Guide. Provider engagement for EPSDT increased from 85% in CY2023 to 96% in CY2024 and was deemed successful because of the high engagement rate.

AzCH-CCP had a statistically significant increase in performance across both indicators in CY2024. The increase can be attributed to the efforts made to educate members and the healthcare decision makers on the importance of seeing the doctor and completing preventive visits to ensure proper development and growth. Outreach efforts were successful in 2024 and allowed the opportunity to connect with our members to explain to them their healthcare preventative services needed, explain to them the benefits included in their health plan, as well as address their barriers to care such as transportation. The health plan has also improved on identifying members with open care gaps so that

Validation of Performance Improvement Projects - *Back to Basics* PIP

the outreach team can target members who have not completed well-child visits and outreach the family to educate and encourage completion of the well visit.

The CY2024 Medicaid rate for W30 exceeded the CY2023 rate of 66.2% by 3.8%, reflecting a significant improvement ($p < 0.0001$). The CY2024 KidsCare rate is 6.4% above the CY2023 rate of 72.3%; however, the difference was not significant ($p = 0.0885$). The CY2024 Medicaid rate for WCV exceeded the CY2023 rate of 52.7% by 5.1%. The CY2024 KidsCare rate exceeded the CY2023 rate of 60.2% by 6.7%. The difference in YOY rates is significant for both populations ($p < 0.0001$).

AzCH-CCP revisited the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. New/enhanced interventions in CY2025 include:

- Conducting a targeted “Unable to Reach” call campaign to research additional sources of data, identify alternate contact information, and attempt to engage members who were not reached in CY2024.
- Adding targeted calls to members younger than 30 months in Q1 2025, to encourage and assist members with gaps for these visits and provide education to parents/HCDMs.
- Deploying Member Passports, which provide customized outreach to members in need of preventive screenings, anchored off of gaps for child/adolescent well visits. Mailed/emailed information includes reminders and catered information regarding current open care gaps, what each screening/test involves, and how to access member rewards applicable to any gaps.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: AzCH-CCP ACC-RBHA did not meet the minimum network requirements for Dentist, Pediatric and Pharmacy. [Access]

Recommendation: HSAG recommends that AzCH-CCP ACC-RBHA maintain current compliance with network standards and continue to address network gaps, as applicable.

AzCH-CCP ACC-RBHA's Response:

Outlined below are AzCH-CCP's strategies, efforts, and exception requests as of October 2024, applicable to both the Medicaid and CHIP populations, to address the identified areas of non-compliance:

- *Dental—Pediatric—Apache County (North GSA):* 86% of AzCH-CCP pediatric members have access to a dental provider within the defined time and distance standards. AzCH-CCP utilized the AHCCCS Saturation Data Report and identified that there were no additional providers within adequacy guidelines to increase adequacy coverage or close the gap. AzCH-CCP will continue to

Network Adequacy Validation

search for pediatric dental providers in Apache County to add to the network. AzCH-CCP will be submitting an exception request.

- *Dental—Pediatric—Coconino County (North GSA):* 86.8% of AzCH-CCP pediatric members have access to a dental provider within the defined time and distance standards. On July 13, 2024, AHCCCS approved the Care1st Network Exception submitted for Dentist – Pediatric – Coconino County prior to integration. The plan will continue to closely monitor any changes to the network and identify potential recruitment opportunities to close this gap. AzCH-CCP will be resubmitting an exception request under AzCH-CCP.
- *Dental—Pediatric—Greenlee County (South GSA):* 69.9% of AzCH-CCP pediatric members have access to a dental provider within the defined time and distance standards. On July 17, 2024, AHCCCS approved the AzCH-CCP Network Exception submitted for Dentist—Pediatric—Greenlee County. AzCH-CCP will continue to closely monitor any changes to the network and identify potential recruitment opportunities to close this gap.
- *Dentist—Pediatric—La Paz County (South GSA):* 53.7% of AzCH-CCP pediatric members have access to a dental provider within the defined time and distance standards. On August 25, 2023, AHCCCS approved the AzCH-CCP Network Exception submitted for Dentist—Pediatric—La Paz County. AzCH-CCP will continue to closely monitor any changes to the network and identify potential recruitment opportunities to close this gap.
- *Pharmacy—La Paz County (South GSA):* 84.5% of AzCH-CCP members have access to a pharmacy provider within the defined time and distance standards. On February 19, 2025, AHCCCS approved the network exception submitted for Pharmacy—La Paz County. The plan continues to closely monitor any changes to the network and identify potential recruitment opportunities to close this gap.

Additionally, AzCH-CCP ACC does provide education and awareness of the available telehealth services for all members to utilize.

HSAG Assessment:



BUFC ACC

Performance Measure Validation

Opportunity for Improvement: While BUFC ACC was successful in reporting valid rates for all AHCCCS-required performance measures for its ACC population, the audit identified some considerations and recommendations for future years' reporting. **[Quality]**

Recommendations:

Performance Measure Validation

- HSAG recommends that BUFC ACC work to integrate race data that BUFC ACC noted it is receiving as of April 2024 for future stratification reporting to improve data completeness.
- The MRRV and case management medical record review validation (CMMRRV) processes found several criterial errors which impacted BUFC ACC's ability to report the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition* measure indicators using the hybrid methodology. In addition, the long-term services and supports (LTSS) measures required several measures with second samples and revisions to the final medical record compliant case counts. HSAG recommends that BUFC ACC incorporate the feedback provided during this year's validation process into its abstraction process to mitigate these issues in future years.

BUFC ACC's Response:

BUFC ACC identified key takeaways from this audit and have implemented process improvement activities as a result. Beginning in MY2024, overreads were increased to 100% for all numerator-positive chases. For LTSS, BUFC ACC better understands the measure specifications and follows the NCQA guidelines. The final LTSS fix will be implemented by the performance measure vendor) for MY2025 and will re-run the 2024-member sample to share during the LTSS resampling process. Additionally, 100% overreads are now completed for all selected members, instead of the previous 95% pass rate per employee and 10% overall.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Maternal and Perinatal Care measure group, BUFC ACC's performance measure rate for *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, and the performance measure rate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* was at or between the 25th and 49th percentile, indicating an opportunity to increase access to timely prenatal and postpartum care. **[Quality, Timeliness, Access]**

Recommendations:

- HSAG recommends that BUFC ACC monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Postpartum Care* measure indicators, measuring effectiveness of interventions when possible.
- HSAG recommends that BUFC ACC consider whether there are disparities/social determinants of health within BUFC ACC's population that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that BUFC ACC implement appropriate interventions to reduce barriers to care.

BUFC ACC's Response:

Performance Measures

BUFC ACC continues to monitor the interventions that have demonstrated positive impacts on both the *Timeliness of Prenatal Care* and *Postpartum Care* performance measures. Findings from root cause analysis indicate that geographic location may be influencing access to care, with Cochise and La Paz counties—rural areas—showing a lower performance across both PPC measures. Additionally, American Indian/Alaska Native members were found to be underrepresented in these measures; however, this population accounts for less than 2.0% of the total health plan population.

Previously implemented interventions have continued to be monitored for effectiveness and refined as needed. Planning is also underway for new strategies to be introduced in the upcoming year. Current and planned interventions include:

- Well-Women's Preventive Care text message campaign continued and increased to 2x annually. Text message includes education on the importance of prenatal and postpartum care as well as resources for engaging with providers.
- PPC measures have been incorporated into the Non-Standard Supplemental Data (NSSD) review process with additional staff being dedicated to these measures.
- MCH team conducts discharge outreach calls to members after delivery, outreach has been extended to continue up to 12 weeks to better facilitate and encourage communication.
- Collaborations with an outpatient behavioral health facility to further reduce stigma and increase awareness about the importance of prenatal and postpartum care amongst members who are also facing substance use and/or behavioral health diagnoses.
 - Teams have begun exploring a possible expansion into additional behavioral health facilities.
- MCH and QM teams collaborate to provide education to providers on measure specifications, best care practices, NOP reporting, family planning, and well-women's care during JOCs, provider newsletters, and Banner University Health Plan (BUHP) Provider Forums.
- A postpartum care incentive program is in the early planning stages providing a gift card to members for completing their postpartum visit, with planned implementation in CY2026.
- A digital platform is in final review stages for potential implementation, enhancing communication, accessibility, and education to members while also increasing data sharing and provider accessibility.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Behavioral Health measure group, BUFC ACC's performance measure rate for *Use of Opioids at High Dosage—18+ Years* was below the 25th percentile, indicating an opportunity to identify trends leading to higher opioid use. [Quality]

Recommendations:

Performance Measures

- HSAG recommends that BUFC ACC follow the CDC guidelines on opioid prescribing for chronic, nonmalignant pain, which recommend the use of “additional precautions” when prescribing dosages ≥ 50 morphine equivalent dose (MED) and that providers avoid or “carefully justify” increasing dosages ≥ 90 mg MED.
- The opioid dosage assessed in this measure is a reference point for health plans to identify members who may be at high risk for opioid overuse and misuse. HSAG recommends outreach to members who fall within this category to assess and schedule interventions as necessary.¹⁷³
- HSAG also recommends that BUFC ACC identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts.

BUFC ACC's Response:

Interventions that have been established or continue for implementation with planned enhancements are outlined below:

- Established the Opioid Strategic Planning committee which meets at a minimum of quarterly.
- Pharmacy Controls: Prior authorization requirements for long- and short-acting opioids and restrictions on multiple short-acting prescriptions within 30 days.
- Provider Education: Opioid prescribing best practices, alternative pain management education, and Drug Enforcement Administration (DEA)-mandated education.
- Interdisciplinary Care Team: A collaborative team reviews high-dose opioid patients, monitors opioid use trends, and educates patients on Narcan.
- Embed the routine use of the opioid prescription database into the standard workflow.
- Implement provider-level monitoring to identify and address providers with higher-than-expected prescribing rates.
- Mandated education sessions for providers involved in opioid prescribing, focusing on best practices, risk management, and alternative pain management options.
- Distribute “Narcan 101” materials to providers to support patient and family education on the importance and use of Narcan.
- Implemented tracking system to track Narcan prescription data, using it to assess the impact of provider education.
- Screening Tool Assessment: Identifying which validated opioid screening tools are currently available and being used within our organization and assessing their effectiveness.
- Provider Practice Evaluation: Identifying current provider practices to determine what types of screenings are being conducted and under what circumstances screenings are being overlooked.
- Continued pharmacy practices for Opioid Specific Data Extensive Program for monitoring and intervention:

¹⁷³ National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/use-of-opioids-at-high-dosage-hdo/>. Accessed on: Feb 11, 2026.

Performance Measures

- Members identified with high dose opioid use from pharmacy data are sent letters about the risks.
- Providers of members identified with high dose opioid use from pharmacy data are sent letters about the risks.
- These identified members are assigned a Care Manager.
- Outcomes are reviewed by the Opioid Strategic Planning Committee.
- Identified members with no change to the high rate of use are reviewed by the Medical Director to determine next steps.
 - Members may be enrolled in pharmacy restriction program.
 - Egregious cases may be sent to AHCCCS credentialing board.
- Ensure that opioid risk screening is a mandatory step for providers before prescribing opioids or managing chronic pain, ensuring consistency across the Banner Health systems.
- Establish protocols for joint care plans between physical health providers (PCPs and pain specialists) and behavioral health teams to ensure care coordination.
- Form dedicated care coordination teams that include physical health, behavioral health, and pharmacy professionals to manage the care of at-risk individuals, ensuring communication and follow-up between departments.
- A subpopulation analysis has been conducted to identify any areas of membership or subpopulations that are displaying a disparity.
 - This information will be reviewed with members of leadership and pharmacy to develop additional interventions to target these populations.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Pediatric Health measure group, BUFC ACC's performance measure rate for *Child and Adolescent Well-Care Visits—Total (3–21 Years)* was below the 25th percentile, indicating that children and adolescents were not always receiving well-care visits at the recommended intervals. BUFC ACC's performance measure rate for *Well-Child Visits in the First 30 Months of Life—15 Months to 30 Months—Two or More Well-Child Visits* fell below the 25th percentile, indicating opportunities for children who turned 30 months old during the measurement year to have at least two well-child visits with a PCP in the prior 15 months.¹⁷⁴ **[Quality, Access]**

Recommendations:

¹⁷⁴ National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/well-child-visits-in-the-first-30-months-of-life-w30/>. Accessed on: Feb 11, 2026.

Performance Measures

- HSAG recommends that BUFC ACC continue implementing interventions as part of the *Back to Basics* PIP, which includes a root cause analysis and interventions to address both the *Child and Adolescent Well-Care Visits—Total (3–21 Years)* and the *Well-Child Visits in the First 30 Months of Life—15 Months to 30 Months—Two or More Well-Child Visits* measures.
- HSAG recommends that BUFC ACC draw as needed from other states' performance improvement initiatives
- HSAG recommends that BUFC ACC identify other barriers to care and conduct a focus group on identifying ways to address barriers.¹⁷⁵

BUFC ACC's Response:

Child & Adolescent Well-Care Visits: Findings from root cause analysis indicate that geographic location may be influencing access to care, with several rural counties—including Gila, Graham, Greenlee and La Paz—showing lower performance. Additionally, the 18–21 year old age group continues to underperform; however, this group has demonstrated consistent YOY improvement, attributed to targeted incentive opportunities and text message outreach campaigns.

Interventions that have been established or continued for implementation with planned enhancements are outlined below:

- Back to School incentive campaign was redesigned to include the Back to School and the Fall incentives from CY2023.
 - The new Back to School incentive was run from July 1, 2024–December 31, 2024, offering a gift card incentive to members in subpopulations identified to have disparities who completed well-care visits during this time.
 - These subpopulations included 18–21 year olds, American Indian/Alaska Native members, Black/African American members, and rural areas including Graham, Greenlee and La Paz counties.
 - Back to School Incentive Campaign has continued through CY2025 with additional enhancements, including the utilization of a contracted vendor to provide over-the-counter (OTC) gift cards to eligible members in subpopulations identified to have disparities. These gift cards can be used in a wide variety of locations such as grocery stores. The CY2025 incentive is being run from June 1, 2025–December 31, 2025.
 - These subpopulations include 15–21 year olds, American Indian/Alaska Native members, Black/African American members, rural areas including Gila, Graham, Greenlee and La Paz Counties, and members who speak Russian or Vietnamese.
- Provider education on best practices, measure specifications, member barriers and tips on overcoming barriers has been routinely shared through JOCs, BUHP Provider Forums, Provider Advisory Councils, and provider newsletters.

¹⁷⁵ Centers for Medicare & Medicaid Services. Well-Child Care. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html>. Accessed on: Feb 5, 2026.

Performance Measures

- Collaborations with CRS clinics offering clinic-specific performance and education were provided quarterly along with member-specific information on open care gaps for member chasing efforts.
- Member outreach team routinely contacts guardians/care takers of members identified as past due or coming due for well-care visits to assist with scheduling, transportation, and/or identification of NSSD that may be available.
- Collaborations with the VBP team for enhanced data sharing and opportunities for provider-specific performance of those VBP providers allowing for increased education, support, and monitoring.

Well-Child Visits in the First 30 Months: 15–30 Months: Similar to the WCV performance measure, rural communities continue to show disparities, including those in Gila, Graham, Greenlee and La Paz counties.

Interventions that have been implemented or continued for enhancement are outlined below:

- Provider education on best practices, measure specifications, member barriers and tips on overcoming barriers has been routinely shared through JOCs, BUHP Provider Forums, Provider Advisory Councils, and provider newsletters.
- Collaborations with CRS clinics offering clinic-specific performance and education were provided quarterly along with member-specific information on open care gaps for member chasing efforts.
- Member outreach team routinely contacts guardians/care takers of members identified as past due or coming due for well-care visits to assist with scheduling, transportation, and/or identification of NSSD that may be available.
- Collaborations with the VBP team for enhanced data sharing and opportunities for provider-specific performance of those VBP providers allowing for increased education, support, and monitoring.
- Implementation in CY2025 of the AHCCCS mandated PIP “From the Start: Promoting Children’s Health” allows subject matter experts from the MCH Team and the QM Team to further assess national initiatives, evidence-based practices, root causes, and disparities to better target improvement within this performance measure.
- CY2026 planned incentive campaign for this performance measure providing incentives to members upon completion of both well-child visits within the 15–30 month age range.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Preventive Screening measure group, BUFC ACC’s performance measure rate for *Cervical Cancer Screening—21–64 Years* fell below the 25th

Performance Measures

percentile, indicating that women were not always receiving timely screening for cervical cancer.

[Quality]

Recommendations:

- HSAG recommends that BUFC ACC expand on its most successful interventions related to improving female members' receipt of timely screening for cervical cancer.
- HSAG recommends that BUFC ACC consider utilizing one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve cervical cancer screening rates.
- HSAG recommends that BUFC ACC provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge.

BUFC ACC's Response:

An analysis revealed that members aged 45–64 years continue to demonstrate lower screening rates. Rural counties—including Gila, Graham, Greenlee and La Paz—also demonstrated a disparity in performance, collectively representing 4.4% of the total eligible population. Additional findings indicated that Chinese and Russian speaking members each comprise less than 1.0% of the eligible population, while American Indian/Alaska Native members account for approximately 2.1% of the total membership.

The following interventions have been established or continue with planned enhancements for implementation in the upcoming year:

- Provider education on best practices, measure specifications, member barriers and tips on overcoming barriers has been routinely shared through JOCs, BUHP Provider Forums, Provider Advisory Councils, and provider newsletters.
- Incentive campaign was continued in CY2025 with an extended run-time, allowing eligible members in identified subpopulations with disparities to earn an OTC gift card incentive for completing their screening between July 1, 2025, through December 31, 2025.
 - These subpopulations include 55–64 year olds, American Indian/Alaska Native members, rural communities including Gila, Greenlee, and La Paz Counties, urban community Maricopa County, and members who speak Chinese or Somali.
- Well-Women's Preventive Care text message campaign continued and increased to 2x annually. Text message includes education on the importance of prenatal and postpartum care as well as resources for engaging with providers.
- Additional initiation of an internal PIP utilizing CY2025 as the baseline measurement year allows subject matter experts to further assess national initiatives, evidence-based practices, root causes, and disparities to better target improvement within this performance measure.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Appropriate Utilization of Services measure group, BUFC ACC's performance measure rate for *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total (18–64 Years)* fell below the 25th percentile, indicating that members who were admitted to an acute inpatient and observation stay might have been followed by an unplanned acute readmission for any diagnosis within 30 days.¹⁷⁶

Recommendations:

- HSAG recommends that BUFC ACC consider reviewing the Re-Engineered Discharge (RED), which has been shown to reduce readmissions and posthospital ED visits.¹⁷⁷ Other interventions that might be effective include technology platforms, including AI or machine learning, that can assist the plan in identifying members more at risk of re-admission.
- HSAG also recommends that BUFC ACC utilize case management strategies that focus on person-centered techniques, addressing barriers and/or social determinants of health as needed.

BUFC ACC's Response:

BUFC ACC launched an internal Plan All-Cause Readmission (PCR) PIP in CY2025 to address and reduce hospital readmissions.

The PIP Workgroup will convene as least quarterly, bringing together key leaders and data analysts to review outcomes, trends, and ongoing initiatives. These meetings enable subject matter experts to evaluate national best practices, root causes, and areas of disparity to better inform targeted improvement strategies.

Interventions and data analytic strategies discussed and planned during the early stages of the PIP include:

- Explore workforce development strategies in rural counties to assess for and/or address a lack of available post-discharge services.
- Reach out to a health care organization to inquire about mobile services and potential collaborations.
- Analyze correlations between readmissions and other performance measures to identify causes and opportunities for additional member outreach and support.
- Identify mobile health providers and evaluate services for potential integration into post-discharge care.
- Establish a high-risk algorithm to better identify members with high-risk conditions prior to emergency department (ED) and/or inpatient utilization.

¹⁷⁶ National Committee for Quality Assurance. Metabolic Monitoring for Children and Adolescents on Antipsychotics. Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/plan-all-cause-readmissions-pcr/>. Accessed on: Feb 11, 2026.

¹⁷⁷ Agency for Healthcare Research and Quality. Re-Engineered Discharge (RED) Toolkit. Available at: <https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool1.html>. Accessed on: Feb 5, 2026.

Performance Measures

- Those members identified as high risk will be contacted from the Utilization Management (UM) Team and then connected with Care Management if needed.
- Establish a dashboard to better complete analysis of those members with higher readmission rates, such as home health utilizers, etc.

HSAG Assessment:



Validation of Performance Improvement Projects - *Back to Basics* PIP

Opportunity for Improvement: For Indicator 2, BUFC ACC had a decline of 2.56 percentage points in the indicator rate between the baseline year and Remeasurement Year 2. **[Quality, Access]**

Recommendations:

- HSAG recommends that BUFC ACC revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.
- HSAG recommends that BUFC ACC continues to implement identified interventions with clearly defined measures to assess the effectiveness of each intervention. Assure that all interventions are evaluated for effectiveness through a measure directly linked to the intervention.

BUFC ACC's Response:

The Back to Basics PIP workgroup continues to meet at least quarterly. These meetings include key leaders from the Maternal and Child Health team to review data analysis, trends, and outcomes. The workgroup continues to focus on identifying subpopulations that experience disparities and developing targeting interventions for these groups. Interventions are prioritized for subpopulations with the most potential to impact overall rates. Indicator 2 demonstrates steady improvement from the baseline year (CY2019) through remeasurement year 3 (CY2024). After an initial decline in CY2020—largely attributed to the COVID-19 pandemic—rates consistently improved each subsequent year, surpassing baseline performance by CY2023 and achieving the highest level to date in CY2024. This upward trend reflects the effectiveness of targeted interventions, data-driven adjustments, and ongoing monitoring through Plan-Do-Study-Act (PDSA) cycles. Overall, the results indicate measurable and sustainable progress in improving *WCV* rates across the assessed population.

BUFC ACC also reviews and updates the Fishbone Diagram to analyze root causes during each PIP workgroup meeting. Additionally, BUFC ACC applies the PDSA cycles to monitor interventions, assess outcomes, and ensure long-term sustainability.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: In BUFC ACC's ISCAT responses and supporting documentation, BUFC ACC used multiple naming conventions for its database systems. [Access]

Recommendation: HSAG recommends that BUFC ACC identify one consistent naming convention for each relevant database system as part of reporting to help ensure clarity in references and mitigate potential confusion.

BUFC ACC's Response:

An ongoing initiative is in place to educate staff on the standardized naming convention to be used across all systems.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: BUFC ACC manually entered provider data updates from the Arizona Association of Health Plans (AzAHP) forms and provider rosters into the Provider Manager system. [Access]

Recommendation: Although BUFC ACC had quality assurance checks and validations in place, HSAG recommends that BUFC ACC explore options to automate data transfer from electronic versions of the AzAHP forms and rosters into the Provider Manager system.

BUFC ACC's Response:

An active initiative is underway to implement a new software solution. The implementation will be executed in phases over the course of 2026 and will encompass functionality for the automated ingestion of AzAHP forms and rosters data.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: HSAG identified concerns with BUFC ACC's network adequacy indicator reporting processes regarding the lack of data checks conducted on the member data extracts used for network adequacy indicator calculation sent to the provider network management vendor and the minimal data checks conducted on the provider data extracts used for network adequacy indicator calculation sent to the provider network management vendor. [Access]

Recommendation: HSAG recommends incorporating additional oversight through data reasonability checks and data quality checks. BUFC ACC may be able to mitigate the downstream impact of incorrect identification of member populations, provider classifications, and the results of network

Network Adequacy Validation

adequacy indicator calculation that would allow for better trending/comparison for additional oversight and monitoring activities. This would allow BUFC ACC to better identify gaps and monitor changes to members' access in its service areas.

BUFC ACC's Response:

BUFC ACC will incorporate additional oversight measures through enhanced data reasonableness and quality checks. These improvements will help mitigate potential inaccuracies related to members' identification, provider classification, and network adequacy indicator calculations. The updated process will include additional validation steps to support accurate trending, comparison, and monitoring activities. Membership data will continue to be retrieved directly from the source system, and once received by the IT team, data reasonableness checks will be performed to assess consistency and identify any anomalies. Any discrepancies identified will be promptly addressed in collaboration with the IT team to ensure risks are mitigated in a timely and effective manner.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: BUFC ACC did not meet the minimum network requirements for Dentist, Pediatric and Pharmacy. [Access]

Recommendation: HSAG recommends that BUFC ACC maintain current compliance with network standards and continue to address network gaps, as applicable.

BUFC ACC's Response:

BUFC ACC will continue to maintain compliance with current network adequacy standards and address all identified network gaps as needed. AHCCCS approved exceptions for Dental and Pharmacy services in La Paz County remain in effect, and ongoing monitoring efforts will ensure continued adherence to network requirements.

HSAG Assessment:



HCA ACC

Performance Measure Validation

Opportunity for Improvement: While HCA ACC was successful in reporting valid rates for all AHCCCS-required performance measures for its ACC populations, the PMV audit identified some considerations and recommendations for future years' reporting. [Quality]

Performance Measure Validation

Recommendations:

- HSAG recommends that HCA ACC continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES.
- HSAG recommends that HCA ACC continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes AHCCCS requirements for MCO-enrolled members who switch product lines or MCOs and members for whom HCA ACC does not hold the primary insurance contract.

HCA ACC's Response:

- HCA ACC works to address healthcare disparities for the subpopulations we serve. Addressing healthcare disparities for marginalized communities is essential because these groups often face unique barriers to accessing quality care, including socioeconomic challenges, geographic isolation, language differences, and systemic bias. When disparities go unrecognized, they can lead to poorer health outcomes, higher rates of chronic disease, and increased mortality. By actively identifying and addressing these gaps, healthcare organizations can promote improve overall population health, and ensure that every individual receives the care and support they need to thrive. This commitment not only fulfills ethical and legal obligations but also strengthens the effectiveness and sustainability of the healthcare system as a whole.
- HCA ACC has worked in CY2025 to identify sources of demographic information to gain a better understanding of healthcare disparities within our system of care. We uncovered a previously unknown barrier where demographic information was being automatically overwritten in our tables. This occurred even when the currently held information was accurate, and the new information was either not specified or blank. After fixing this issue, HCA ACC resumed gathering this kind of demographic information and updating our member records to reflect it. The Health Risk Assessment (HRA) contains such information and in CY2025, we updated the workflow related to HRAs so that the workflow includes matching the race/ethnicity data with our system information and updating our information as necessary.
- HCA ACC continues to comply with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes AHCCCS requirements for MCO-enrolled members who switch product lines or MCOs and members for whom HCA ACC does not hold the primary insurance contract. We track continuous enrollment across our internal lines of business. We are working to streamline this kind of data between the Blue Cross Blue Shield of Arizona commercial and ACC lines of business as well. At the moment, this process is a manual process, however we are working to automate and streamline the process.
- HCA ACC works with partners and vendors to ensure that completed services are captured and included in AHCCCS performance measure data. This includes lab results from lab partners , which may have been paid for by other primary insurance, immunization data from the Arizona State Immunization Information System, and other services which providers may have documented in the HIE.

Performance Measure Validation

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Behavioral Health measure group, HCA ACC's performance measure rate for *Adherence to Antipsychotic Medications for Individuals with Schizophrenia—18+ Years* fell below the 25th percentile, indicating adults 18 years of age and older who have schizophrenia or schizoaffective disorder who were dispensed an antipsychotic medication did not remain on the medication for at least 80 percent of their treatment period. [Quality]

Recommendations:

- HSAG recommends that HCA ACC consider implementing one or more interventions that have been associated with increased medication adherence for members with schizophrenia.
- HSAG recommends that HCA ACC consider utilizing financial incentives offered to patients with severe mental illness to improve treatment adherence.

HCA ACC's Response:

- Supporting members with schizophrenia in adhering to their antipsychotic medication regimen is crucial because consistent medication use significantly reduces the risk of relapse, hospitalization, and worsening symptoms. By actively assisting members with reminders, education, and addressing barriers such as transportation or pharmacy issues, providers and health plans help ensure better treatment outcomes, improved quality of life, and greater stability for individuals living with schizophrenia.
- The pharmacy team monitors prescription fills for antipsychotic prescriptions that are not refilled after the number of days filled passes. The team then completes outreach to the member and assists in getting refills and securing appointments.
- Barriers the pharmacy team can assist with include: Out of refills, transportation issues, medication synchronization and conversion to 90–100 day fills to reduce trips to pharmacy, reminders and check-ins reinforce the importance of taking the medication every day, pharmacy supply or customer service issues, facilitation of prior authorization when needed, adverse reactions to medications, clinical questions from members about their medications, and pharmacy billing errors which may result in false assumptions about whether a member is adherent or not.
- The pharmacy team can make referrals to care management or providers if additional coordination of care is required. HCA ACC provides Care Management to members who require additional coordination of care. Care Managers conduct a thorough initial assessment of clinical needs and social determinants of health, utilizing the Health Appraisal and data from claims, pharmacy, authorizations, controlled substances prescription monitoring program (CSPMP), HIE, and provider records. They develop and regularly update a Care Management Plan based on the needs, preferences, and priorities of the member and their family. This plan is shared with the member's

Performance Measures

care team and includes pharmacy fill and diagnosis history, as well as care alerts for certain gaps or needs to assist in making calls as effective as possible.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Pediatric Health measure group, HCA ACC's performance measure rates for *Child and Adolescent Well-Care Visits—Total (3–21 Years)* and *Well-Child Visits in the First 30 Months of Life—15 Months to 30 Months—Two or More Well-Child Visits* fell below the 25th percentile, indicating that children and adolescents were not always receiving their well-care visits. HCA ACC's performance measure rates for *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10* fell below the 25th percentile, indicating that children were not always getting their immunizations by their second birthday. **[Quality, Access]**

Recommendations:

- HSAG recommends that HCA ACC monitor and expand on interventions currently in place to improve the performance related to well-care visits.
- HSAG recommends that HCA ACC draw as needed from other states' performance improvement initiatives.
- HSAG recommends that HCA ACC identify other barriers to care and conduct a focus group on identifying ways to address barriers.¹⁷⁸
- HSAG recommends that HCA ACC provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.

HCA ACC's Response:

- We have expanded our efforts detailed in the Back-to-Basics PIP to target the *Two or More Well-Child Visits* and *Child and Adolescent Well-Care Visits—Total (3–21 Years)* rate. The HCA ACC Quality Improvement Specialist (QIS) team worked diligently in the first part of MY2025 to educate providers on the measure and its specifications. The QIS team made child well-care an area of focus for the first two quarters of the year. During Q1, providers expressed difficulty discussing vaccines with resistant parents. Upon hearing this feedback, we provided resources for talking with parents about the risks and benefits of vaccines during Q2. The QIS team provided the updated MY2025 provider toolkit which provides resources for measure specifications and coding requirements. Deep dives and data mining were also completed to ensure that all completed visits are counted appropriately.

¹⁷⁸ Centers for Medicare & Medicaid Services. Well-Child Care. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html>. Accessed on: Feb 6, 2026.

Performance Measures

- Upon reviewing the successes other states have had in this area, HCA ACC has increased our electronic outreach to members in need of well-child visits. This effort is similar to the efforts described by HSAG which took place in Texas. On top of these efforts, we have also increased our live member events with things like health fairs and dental clinics. These live events provide an opportunity for the health plan to directly contact the members and educate those members on the importance of well-child visits.
- HCA ACC also implemented a provider portal where providers can quickly and easily access gap lists and updated, member-specific, measure information. Within the portal, providers have access to the most up-to-date gap lists. This makes their own member outreach more effective. Providers can also track members they have seen to ensure that the gaps are closed appropriately or they can submit NSSD to close gaps.
- Further, HCA ACC has increased our internal resources to better and more easily serve this population. Within our electronic system, we have implemented a tool called the “Member Stripe.” This stripe appears at the top of the data system and informs care managers or other points of contact that the member is in need of preventative services or has a gap in care related to one of our performance measures. We have also updated all of our member education materials and made those materials available within the same system. This way member points of contact can easily send necessary information at the click of a button.
- The efficacy of these interventions is already bearing fruit. This is evident in our MY2024 Year End rate for the measure. In MY2023, the HCA ACC rate was 58.9%. In MY2024, the rate increased by 4.9% to 63.8%. When the change is analyzed using a Chi-Squared Test with Yates’ Correction, the two-tailed P-value is less than 0.0001, indicating that the change is extremely statistically significant. In MY2025, our Q1 and Q2 results are even higher than the prior year results for the same time period. This improvement has positioned HCA ACC very well to meet the identified target by MY2025 year-end.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Preventive Screening measure group, HCA ACC’s performance measure rates for *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* fell below the 25th percentile, indicating that some women were not receiving timely screening for breast and cervical cancers. **[Quality]**

Recommendations:

- While HCA ACC implemented interventions specific to the MY 2022 *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* rates, these rates remained low in MY 2023; therefore, HSAG recommends that HCA ACC identify additional interventions to improve performance on these screening measures.

Performance Measures

- HSAG recommends that HCA ACC consider utilizing one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve screening rates. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness.

HCA ACC's Response:

- In discussions with members and providers, members experience a host of barriers in attending traditional appointments. Lack of transportation, lack of childcare, and physical disability or chronic pain can all prevent a member from being able to make a trip to a doctor's office. HCA ACC is partnering with a provider who can provide in-home services to families with barriers in attending traditional appointments, this provider is able to complete breast exams and assist in scheduling mammography. This provider is also able to complete pap smears and assist members in completing self-administered cervical cytology tests. This can all occur in the member's home, thus overcoming those barriers which prevent the member from attending a traditional appointment.
- The HCA ACC QIS Team will continue coordinating with providers to provide assistance, education, and gap lists related to the *Breast Cancer Screening (BCS)* and *Cervical Cancer Screening (CCS)* measures.
- HCA ACC has created a provider portal and updated it to ensure providers have ready access to measure information and reports. This portal can reduce responses for authorizations, provide the most updated gap information, and provide a method for providers to upload non-standard supplemental data.
- HCA ACC will continue data mining efforts to capture provided screenings.
- HCA ACC will continue to coordinate mobile mammography clinics.
- Our Healthy Rewards program has been expanded to include both CCS and BCS measures as this program has shown itself to be successful in increasing member participation in preventative care services.

HSAG Assessment:



Validation of Performance Improvement Projects - Back to Basics PIP

Opportunity for Improvement: For Indicator 2, HCA ACC had a decline of 0.4 percentage points in the indicator rate between the baseline year and Remeasurement Year 2. [Quality, Access]

Recommendations:

- HSAG recommends HCA ACC revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.
- HSAG recommends HCA ACC continue to implement identified interventions with clearly defined measures to assess the effectiveness of each intervention. Assure that all interventions are evaluated for effectiveness through a measure directly linked to the intervention.

Validation of Performance Improvement Projects - Back to Basics PIP**HCA ACC's Response:**

We revisited our root cause analysis related to the second intervention of this PIP. Previously, we had identified a need for member education and initiated several interventions to target this root cause. We reviewed a number of other projects where success was achieved in increasing well-care visits for other populations. It was determined that increased member outreach has been effective at targeting similar measures.

HCA ACC increased our member outreach by implementing a DRIP campaign. A DRIP campaign can significantly enhance patient attendance at well-child visits by leveraging targeted communication strategies. By utilizing data analytics, healthcare providers can identify and segment patients who are due for their well-child visits. Personalized messages can then be crafted to address the specific needs and concerns of each patient, making the communication more relevant and engaging. Regular reminders, educational content, and motivational messages can be sent through various channels such as emails, text messages, and phone calls, ensuring that the information reaches the patients effectively. This consistent and personalized approach not only keeps the importance of well-child visits at the forefront of patients' minds but also builds a stronger patient-provider relationship, ultimately leading to improved attendance rates and better health outcomes for children.

HCA ACC initiated this campaign with a goal to provide direct outreach to each member in the WCV denominator within MY2025 and will be considered successful if limitations do not prevent this goal from being achieved. This campaign was coordinated with our other efforts and ongoing interventions.

During CY2024, HCA ACC saw a statistically significant increase in this rate over the prior year, though the rate was still below the identified target. This PIP was closed successfully in CY 2025.

Summary:

The goal is to demonstrate a statistically significant increase in the number and percentage of child and adolescent well-child/well-care visits, as well as a statistically significant increase in the number and percentage of children and adolescents receiving an annual dental visit, followed by sustained improvement for one consecutive year.

CY2024

- Re-Measurement Year 3: HCA ACC experienced significant increases in all three rates in MY2024 over MY2023. Both Indicators 1 and 3 met the identified target. Indicator 2 fell below the target but still experienced a statistically significant increase.
- For Indicator 1—The rate from Re-Measurement Year One to Re-Measurement Year Two increased from 62.3% to 68.5%. When analyzed with a Chi Squared Test with Yates' Correction,

Validation of Performance Improvement Projects - *Back to Basics* PIP

the Chi squared equals 26.812 with 1 degree of freedom. The two-tailed P value equals 0.0001, indicating that the change was significant.

- For Indicator 2—The rate from Re-Measurement Year One to Re-Measurement Year Two decreased from 42.4% to 46.5%. When analyzed with a Chi Squared Test with Yates' Correction, the Chi squared equals 259.838 with 1 degree of freedom. The two-tailed P value equals 0.0001, indicating that the change was significant.
- For Indicator 3—The rate from Re-Measurement Year One to Re-Measurement Year Two decreased from 50.0% to 52.8%. When analyzed with a Chi Squared Test with Yates' Correction, the Chi squared equals 135.099 with 1 degree of freedom. The two-tailed P value equals 0.0001, indicating that the change was significant.

Overall Results to Date

- Overall—There were statistically significant increases in all three indicators between the Baseline Measurement and Re-Measurement Year 3. Indicators 1 and 3 remain above the identified target. Indicator 2 saw a statistically significant increase but remains below the identified target.

There were statistically significant increases in all three indicators between the Baseline Measurement and Re-Measurement Year 3. There were also statistically significant increases in all three indicators between Re-Measurement Year 2 and Re-Measurement Year 3. Indicators 1 and 3 remain above the identified target. Indicator 2 saw a statistically significant increase but remained below the identified target.

HCA ACC worked diligently to intervene in all three of the listed indicators and was pleased to see that hard work pays off both in better rates and in better care for our members. We largely attribute the success of these rates to our outreach to members and increased coordination with providers. Our QIS team worked closely with providers to ensure that visits were scheduled with members in accordance with the measure specifications and mined data for numerator hits that were not properly identified through claims.

We identified several healthcare disparities for rural populations and members identified as American Indian or Alaskan Native. HCA ACC worked diligently to address these disparities and was able to increase rates of well-child visits for these populations.

In conclusion, a key element in our success was outreaching members both telephonically and electronically but also meeting them in the community and assisting in overcoming the barriers preventing them from attending visits. Our dental fairs were evidence that these kinds of outreach are both effective and necessary for rural members in need of preventative care.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: Isolated data issues may have contributed to specific instances affecting HCA ACC's compliance with time/distance standards. [Access]

Recommendation: HSAG recommends that AHCCCS support HCA ACC in continuing to monitor the Contractor's processes for creating the PAT file and review this file for accuracy prior to submitting to AHCCCS.

HCA ACC's Response:

We submit the PAT file prior to the official due date to ensure its accuracy and completeness. Our process begins well in advance of the twice-yearly submission deadlines. We conduct thorough internal reporting and data reviews based on AHCCCS criteria to proactively identify and correct any issues. The PAT file is then uploaded to AHCCCS on the first business day of the designated delivery month. After submission, we typically receive an error report from AHCCCS within one business day, which we immediately review to address any outstanding errors that were not caught during our internal checks. We make the necessary corrections and resubmit the PAT file, often one or two more times, to ensure all errors are resolved and that the error rate remains well below the allowed threshold of 5%. This proactive approach has consistently resulted in exceptionally low error rates, under half a percent each submission:

PAT File Error Rate by Contract Year and Submission		
Contract Year Ending	Submission Number	Error Rate
CYE 2024	S1	0.22%
	S2	0.34%
CYE 2025	S1	0.30%
	S2	0.19%

This low error rate demonstrates the effectiveness of our collaboration with AHCCCS and our methodology in submitting the PAT file early and conducting multiple reviews before the final deadline.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: HCA ACC did not meet the minimum network requirements for Dentist, Pediatric. [Access]

Network Adequacy Validation

Recommendation: HSAG recommends that HCA ACC maintain current compliance with network standards and continue to address network gaps, as applicable.

HCA ACC's Response:

- We work diligently to ensure the provision of high quality and medically necessary covered services. Our provider network is robust, growing, accessible, specialized, culturally competent, and focused upon high quality member care and outcomes. Timely access to high quality clinical services is imperative in our healthcare delivery system and is a critical component of maximizing member healthcare outcomes. With this fundamental concept in mind, the HCA ACC Network Services department works collaboratively with our Clinical, Care Management, Medical Management, QM, Member Services, Reimbursement Services, Finance, and Business Intelligence (BI) departments to actively participate in ongoing network development and management activities.
- We have outreached to several providers who have previously declined participation with Medicaid. Our strategy includes annual outreach to provide opportunities for engaging in Medicaid participation.
- Additionally, we have contracted with a tribally operated 638 program in Ganado (Apache County), which offers dental care to tribal members, and providers are in the process of being credentialed.
- HCA ACC is hosting mobile events that include dental screenings throughout the year in counties with rural populations. In CY2025, this included an event at the public library in Eagar, Arizona, within Apache County. This was one of our highest attended events. The success of this event will lead to further events in the area.
- HCA ACC maintains a strong relationship with our existing network of pediatric dentists in and around Apache County.

HSAG Assessment:



Mercy Care ACC-RBHA

Performance Measure Validation

Opportunity for Improvement: While Mercy Care ACC-RBHA was successful in reporting valid rates for all AHCCCS-required performance measures for its ACC population, the audit identified recommendations for future years' reporting. **[Quality]**

Recommendations:

- HSAG recommends that Mercy Care ACC-RBHA continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes

Performance Measure Validation

AHCCCS' requirements for MCO-enrolled members who switch product lines or MCOs and members for whom Mercy Care ACC-RBHA does not hold the primary insurance contract.

- HSAG recommends that Mercy Care ACC-RBHA continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES.

Mercy Care ACC-RBHA's Response:

Mercy Care ACC-RBHA continues collaboration with the Aetna Medicaid Quality & Report team to update the 834 mapping to include all applicable data. Mercy Care ACC-RBHA is leveraging the CMS enrollment files and Case/Care Management data for capturing additional data for 2024. As part of this additional work, Mercy Care and Aetna Medicaid are collaborating to identify if indirect data sources can be captured to supplement the direct data sources. Mercy Care has been working with the HIE on receiving the A08 alerts for Race & Ethnicity data directly.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Behavioral Health measure group, Mercy Care ACC-RBHA's performance measure rate for *Use of Opioids at High Dosage—18+ Years* fell below the 25th percentile indicating an opportunity to identify trends leading to opioid use. **[Quality]**

Recommendations:

- HSAG recommends that Mercy Care ACC-RBHA follow the CDC guidelines on opioid prescribing for chronic, nonmalignant pain, which recommend the use of “additional precautions” when prescribing dosages ≥ 50 MED and that providers avoid or “carefully justify” increasing dosages ≥ 90 MED.
- The opioid dosage assessed in this measure is a reference point for health plans to identify members who may be at high risk for opioid overuse and misuse. HSAG recommends outreach to members who fall within this category to assess and schedule interventions as necessary.¹⁷⁹
- HSAG also recommends that Mercy Care ACC-RBHA identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts.

Mercy Care ACC-RBHA's Response:

Although the MY2024 rate of 8.68% remained unchanged from MY2023, Mercy Care ACC-RBHA has implemented several targeted interventions to drive improvement. These interventions include:

¹⁷⁹ National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/use-of-opioids-at-high-dosage-hdo/>. Accessed on: Feb 11, 2026.

Performance Measures

- Opioid Pharmacy Management Strategies at point of sale (POS) such as quantity level limits and professional codes required to be entered at POS.
- Exclusive Prescriber Program (EPP)—Members enrolled in the EPP are care managed to assist them in managing patterns of misuse. They provide education, care coordination, and offer necessary services and resources. Providers also receive education, care coordination, and support to better assist the members.
- Mercy Care ACC-RBHA case managers will outreach members in the *HDO* measure for care coordination.
- Educational Outreach Program (EOP) with provider fax including targeted member information for providers identified as having members on > 50 MME. This also includes an opioid prescriber report card. Program threshold was lowered from 90MME to 50MME in order raise awareness before member reaches 90MME.
- Data Review and Best Practice Identification—Presentation and distribution to Accountable Care Organizations and Clinically Integrated Networks regarding gaps in care (GIC)/QI HEDIS gap care closure and education.
- Pharmacy Risk Prevention Report including members at risk for adherence non-compliance and gap in care data—Report identifies members that are at risk of inpatient admission or ED visit with warning signs HEDIS Care Gaps, non-adherent to medications, gap in medication regimen, ambulatory care sensitive condition (ex: chronic condition) that needs to be closely managed.
- Pharmacy Benefit Manager (PBM) Integrated Fraud, Waste, and Abuse (iFWA) is a new program for 2025 and replaces the SMS (safety and monitoring solutions) program. iFWA is an integrated approach that provides safety oversight and addresses potential fraud, waste, and abuse at plan member, prescriber, pharmacy, and drug levels. This program targets high-risk drug classes, focusing on controlled substances, and inappropriate use- and misuse-related indicators such as polypharmacy, provider shopping, and high-total controlled substance claims volume. On a quarterly basis, clinical pharmacists evaluate controlled substance claims and available supporting medical data to identify potential medication misuse and inappropriate claims for appropriate intervention. During subsequent quarters, pharmacists conduct follow-up activities utilizing physician responses and current claim activity. Situations identified as being potentially inappropriate result in case referrals where extensive research is conducted along with a detailed course of action recommendation. Additionally, iFWA provides surveillance and lettering to prescribers for unusual claim activity, including hyperinflated medications, diabetic supplies, and Prior Authorization Fraud.
- Mercy Care ACC-RBHA launched a Quality Provider Liaison (QPL) program in Q4 2025 to connect providers with the Quality team for HEDIS education, performance updates, care gap identification, and support in addressing barriers to quality care.
- In Q1 of 2025, Mercy Care ACC-RBHA implemented a comprehensive HEDIS governance structure, assigning each priority measure to an accountable owner. We conduct monthly HEDIS workgroup meetings to review high-priority measures, escalate challenges, evaluate interventions and their effectiveness, and provide quarterly updates to executive leadership. To support this

Performance Measures

work, Mercy Care ACC-RBHA developed an internal tracking system that houses measure rates, goals, and intervention details. This system enables monthly intervention updates, identifies gaps to goal, and streamlines targeted strategies.

Mercy Care ACC-RBHA will continue to monitor the plan's performance with this measure through the additional phases of the PDSA cycle and modify existing interventions or implement additional interventions as necessary.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Behavioral Health measure group, Mercy Care ACC-RBHA's performance measure rates for *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total (18+ Years)* fell below the 25th percentile, indicating an opportunity to identify trends leading to antidepressant medication mismanagement. **[Quality]**

Recommendation: HSAG recommends that Mercy Care ACC-RBHA consider clinical recommendations shown to improve adherence to antidepressants, such as assessing depressive symptoms at baseline and each follow-up, as well as providing psychoeducation to the member and family.¹⁸⁰

Mercy Care ACC-RBHA's Response:

Mercy Care ACC-RBHA is pleased to report improvement in the *Acute Phase* submeasure, which achieved a rate of 53.52% in MY2024, as well as the *Continuation Phase* submeasure, which reached 38.43%. Although this measure will be retired in MY2025, Mercy Care ACC-RBHA remains committed to prioritizing depression medication adherence as a key component of member care and overall quality improvement.

HSAG Assessment:



Validation of Performance Improvement Projects - Back to Basics PIP

Opportunity for Improvement: Mercy Care ACC-RBHA did not update its resubmission narrative summary to reflect the revised statistical testing and did not provide CY 2023 intervention effectiveness data for two interventions. **[Quality, Access]**

¹⁸⁰ Solmi M, Miola A, Croatto G, et al. How can we improve antidepressant adherence in the management of depression? A targeted review and 10 clinical recommendations. *Brazilian Journal of Psychiatry*. 2021;43(2):189–202.

Validation of Performance Improvement Projects - *Back to Basics* PIP

Recommendations:

- HSAG recommends that Mercy Care ACC-RBHA seek technical assistance from HSAG to understand the requirements for statistical testing.
- HSAG recommends that Mercy Care ACC-RBHA continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.
- HSAG recommends that Mercy Care ACC-RBHA assure that all interventions are evaluated for effectiveness through a measure directly linked to the intervention.

Mercy Care ACC-RBHA's Response:

Mercy Care ACC-RBHA hired a Senior Manager in July 2025 to lead and manage PIPs, bringing extensive experience in PIP development and evaluation. This role ensures interventions are assessed for effectiveness using measures directly linked to the intervention, and that statistical testing requirements are understood and applied appropriately. Mercy Care is also hiring a new data analyst who will assist with the statistical testing process in Q4 of this year.

At the start of this year, Mercy Care ACC-RBHA implemented a comprehensive HEDIS governance structure, assigning each priority measure—including those within PIPs—to an accountable owner. We conduct monthly HEDIS workgroup meetings to review high-priority measures, escalate challenges, evaluate interventions and their effectiveness, and provide quarterly updates to executive leadership. To support this work, Mercy Care ACC-RBHA developed an internal tracking system that houses measure rates, goals, and intervention details. This system enables monthly intervention updates, identifies gaps to goal, and streamlines targeted strategies.

Mercy Care ACC-RBHA will continue to seek technical assistance from HSAG as needed and maintain rigorous evaluation of all interventions.

HSAG Assessment:



Compliance Reviews

Opportunity for Improvement: Mercy Care ACC-RBHA scored below 95 percent in the Member Information (MI) focus area. **[Quality]**

Recommendation: HSAG recommends that Mercy Care ACC-RBHA continue to work with AHCCCS on closing remaining CAPs.

Mercy Care ACC-RBHA's Response:

Mercy Care ACC-RBHA confirms that the CAP was successfully closed on May 19, 2025. The following actions were completed to address AHCCCS findings and ensure compliance:

Compliance Reviews

1. Policy and Procedure Updates:

- Mercy Care ACC-RBHA updated and resubmitted policies and procedures to clearly define how provider failure to report or late reporting is addressed when identified during incident triage or Quality of Care (QOC) investigations.

2. Alignment with AHCCCS Requirements:

- All updates ensure compliance with AHCCCS contract requirements and AMPM policies, including processes for addressing provider late or non-reporting during incident triage and QOC investigations.

3. Communication to AHCCCS:

- Updated documents were submitted to AHCCCS as part of the CAP closure process.

HSAG Assessment:



Network Adequacy Validation

Opportunities for Improvement: Isolated data issues may have contributed to specific instances affecting Mercy Care ACC-RBHA's compliance with time/distance standards. **[Access]**

HSAG identified an opportunity for Mercy Care ACC-RBHA to improve the results to calculate time/distance indicators. **[Access]**

Recommendations: HSAG recommends that:

- AHCCCS support Mercy Care ACC-RBHA in continuing to monitor the Contractor's processes for creating the PAT file and review this file for accuracy prior to submitting to AHCCCS.
- Mercy Care ACC-RBHA incorporate additional oversight and monitoring when transferring results to the ACOM Policy 436 template to ensure the most accurate results are being submitted to AHCCCS.

Mercy Care ACC-RBHA's Response:

Mercy Care ACC-RBHA has implemented updates to internal reporting processes based on findings from the HSAG NAV audit in 2024. These enhancements ensure that AHCCCS Contractors Operations Manual (ACOM) 436 reporting aligns with the data provided in the PAT file, which should significantly reduce the mismatches previously observed. Additionally, Mercy Care ACC-RBHA has strengthened oversight and validation steps during data transfer to improve accuracy and consistency in time/distance calculations.

HSAG Assessment:



Molina ACC

Performance Measure Validation

Opportunity for Improvement: While Molina ACC was successful in reporting valid rates for all AHCCCS-required performance measures for its ACC population, the audit identified a recommendation for future years' reporting. **[Quality]**

Recommendation: HSAG recommends that Molina ACC continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES.

Molina ACC's Response:

Initiatives Implemented Based on Recommendations

- Educated providers on the importance of accurate race and ethnicity data collection for identifying health disparities and targeting interventions.
- Collaborated with provider groups using electronic medical record (EMR) data exchange to encourage collection and reporting of demographic data in structured fields.
- Analyzed available demographic data for key performance measures to identify disparities and inform targeted interventions.
- Coordinated internally to align stratification efforts with federal and State reporting requirements.

Performance as a Result of Implemented Initiatives

- Molina ACC is actively implementing these interventions and will continue to monitor, evaluate, and report progress as data become available in future reporting cycles.

Barriers to Implementing Interventions

- Inconsistent capture of race and ethnicity fields across data sources and provider EMR systems.
- Member reluctance to disclose demographic information due to privacy concerns or lack of understanding of data use.
- Limited interoperability between external systems that capture demographic data and internal data warehouse systems.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Maternal and Perinatal Care measure group, Molina ACC's performance measure rate for *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, indicating an opportunity to increase access to timely postpartum care. **[Quality, Timeliness, Access]**

Recommendations:

Performance Measures

- While Molina ACC conducted a root cause analysis and implemented interventions specific to the *Prenatal and Postpartum Care—Postpartum Care* measure indicator, this rate remained low in MY 2023; therefore, HSAG recommends that Molina ACC continue to implement appropriate interventions to improve performance related to postpartum care.
- HSAG recommends that Molina ACC monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care* measure, submitting the results of interventions as required by AHCCCS.
- HSAG recommends that Molina ACC consider whether there are disparities/SDOH within the Molina ACC population that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that Molina ACC implement appropriate interventions to reduce barriers to care. A few strategies could include providing expanded access appointments outside of business hours to accommodate work schedules or childcare needs.
- HSAG recommends that Molina ACC identify payment structure types that will incentivize quality care. Bundling payments may cause disincentives for postpartum care, as providers might receive the same payment regardless of whether the member attends the postpartum visit.¹⁸¹

Molina ACC's Response:

Initiatives Implemented Based on Recommendations

- Care Connections and Care Management teams contacted members by phone and text to assist with scheduling appointments, confirm provider availability, and coordinate transportation as needed.
- Reminder education on the importance of postpartum care, including maternal mental health, family planning, and chronic condition follow-up.
- Discussed postpartum care best practices during provider quality meetings, including scheduling the visit prior to hospital discharge and offering extended hours.
- Partnered with providers to address appointment availability and encourage early scheduling within three weeks of delivery per ACOG recommendations.
- Reviewed maternity performance trends during Provider Quality JOC meetings to sustain engagement.
- Monitored postpartum visit completion through analytic reporting to identify gaps and track improvement trends.
- Encouraged providers to submit supplemental data for completed postpartum visits not captured through claims.

Performance as a Result of Implemented Initiatives

Metric: *Prenatal and Postpartum Care (PPC): Postpartum Care*

- Calendar Year 2023: 66.42%

¹⁸¹ Centers for Medicare & Medicaid Services. Lessons Learned about Payment Strategies to Improve Postpartum Care in Medicaid and CHIP, August 2019. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/postpartum-payment-strategies.pdf>. Accessed on: Feb 4, 2026.

Performance Measures

- Calendar Year 2024: 70.07%

Barriers to Implementing Interventions

- Difficulty reaching members postpartum due to disconnected phones, relocation, or return to work.
- Delays in claims or encounter data submission, impacting visibility of completed visits.
- Members experiencing postpartum depression or other SDOH barriers (e.g., childcare, transportation) affecting timely follow-up.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Behavioral Health measure group, Molina ACC's performance measure rate for *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication—18–64 Years* fell below the 25th percentile, indicating an opportunity for diabetes screening testing to be done. Molina ACC's performance measure rate for *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years* fell below the 25th percentile, indicating an opportunity for members to increase adherence to antipsychotics for members with schizophrenia. **[Quality]**

Recommendations:

- HSAG recommends that Molina ACC evaluate barriers to screening such as coordinating with laboratories or communication between behavioral health providers and PCPs.
- HSAG recommends that Molina ACC build in automatic screening alerts into the EMR if screening tests are necessary.
- HSAG also recommends that Molina ACC encourage members to see a PCP, as people with at least one primary care visit were more likely to be screened.
- HSAG recommends that Molina ACC continue to monitor and expand on interventions currently in place to improve performance related to the continuous medication treatment for members with a diagnosis of schizophrenia.

Molina ACC's Response:

Initiatives Implemented Based on Recommendations

- Conducted direct outreach to members with schizophrenia or bipolar disorder on antipsychotic medications to promote screenings.
- Supported members in scheduling lab appointments and facilitated transportation to remove access barriers.
- Distributed monthly provider gap-in-care reports and scorecards to highlight members due for diabetes screening.

Performance Measures

- Delivered provider education and tip sheets reinforcing the link between antipsychotic use and metabolic risk, with emphasis on integrating screening reminders into workflows.
- Reviewed performance quarterly through committees to identify additional data gaps and validate improvement trends.

Performance as a Result of Implemented Initiatives

Metric: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

- Calendar Year 2023: 76.74%
- Calendar Year 2024: 82.23%

Barriers to Implementing Interventions

- Coordination challenges between behavioral health and primary care providers, leading to missed screening opportunities.
- Some behavioral health providers lack access to EMR alerts and reminders that support routine screening documentation.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Preventive Screening measure group, Molina ACC's performance measure rate for *Cervical Cancer Screening—21–64 Years* fell below the 25th percentile, indicating that women were not always receiving timely screening for cervical cancer. [Quality]

Recommendations:

- HSAG recommends that Molina ACC continue to monitor and expand on interventions currently in place to improve performance related to the *Cervical Cancer Screening—21–64 Years* measure, submitting the results of interventions to AHCCCS in its QM/PI Plan.

Molina ACC's Response:

Initiatives Implemented Based on Recommendations

- Conducted targeted outreach to members due for cervical cancer screening using emails, text reminders, and phone calls from care coordinators.
- Educated members on the importance of early detection and routine Pap testing through culturally tailored outreach and health literacy materials.
- Collaborated with CHWs to provide one-on-one education and assistance in scheduling appointments.

Performance Measures

- Connected members with transportation and appointment coordination support to address identified barriers such as childcare and work schedules.
- Distributed monthly provider gap-in-care reports highlighting members due or overdue for cervical cancer screening.
- Conducted provider education sessions emphasizing guideline-based screening intervals and documentation requirements for both Pap and HPV tests.
- Reinforced timely claims and SDS to ensure all completed screenings are accurately reflected in measure performance.
- Expanded SDS collection from provider EMRs and laboratories performing Pap and HPV testing.

Performance as a Result of Implemented Initiatives

Metric: *Cervical Cancer Screening (CCS)*

- Calendar Year 2023: 43.55%
- Calendar Year 2024: 45.99%

Barriers to Implementing Interventions

- Low member awareness of screening importance or confusion about screening frequency.
- Transportation and childcare barriers limiting ability to attend appointments.
- Delays in receiving lab results or documentation from external sources impacting data completeness.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Pediatric Health measure group, Molina ACC's performance measure rate for *Child and Adolescent Well-Care Visits—Total (3–21 Years)* fell below the 25th percentile, indicating that children and adolescents were not always receiving their well-care visits. [Quality, Access]

Recommendations:

- HSAG recommends that Molina ACC continue to identify best practices to support children in receiving well-care visits according to recommended schedules.
- HSAG recommends that Molina ACC draw as needed from other states' performance improvement initiatives
- HSAG recommends that Molina ACC identify other barriers to care and conduct a focus group on identifying ways to address barriers.¹⁸²

¹⁸² Centers for Medicare & Medicaid Services. Well-Child Care. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html>. Accessed on: Feb 6, 2026.

Performance Measures

- HSAG recommends that Molina ACC provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.

Molina ACC's Response:

Initiatives Implemented Based on Recommendations

- Conducted targeted outreach to parents and guardians of members ages 3–21 due for annual well-care visits using text messages, phone calls, and emailed reminders.
- Provided education on the importance of preventive visits for immunizations, developmental milestones, and school or sports physical requirements.
- Offered member incentives for well-care visit completion and assisted with scheduling appointments and transportation when needed.
- Distributed monthly well-care gap reports to pediatric and family practice providers to identify members due for visits.
- Shared best practices from high-performing clinics, including reminder call campaigns, bundled family scheduling, and same-day appointment options.
- Reinforced provider education on documentation requirements for well-care visits to ensure accurate reporting.
- Partnered with providers in VBP arrangements to improve outreach and engagement for well-care visits.
- Expanded supplemental data collection from provider EMRs to capture completed well-care visits not yet reflected in claims.
- Reviewed performance monthly through analytic reporting to monitor closure progress and identify geographic areas with lower engagement.

Performance as a Result of Implemented Initiatives

Metric: *Child and Adolescent Well-Care Visits (WCV)*

- Calendar Year 2023: 43.53%
- Calendar Year 2024: 49.48%

Barriers to Implementing Interventions

- Caregiver barriers including transportation, limited work schedule flexibility, or competing family priorities.
- Difficulty contacting families due to disconnected or inaccurate phone numbers.
- Data lag from provider EMR systems delaying visibility of completed visits.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: Molina ACC's performance measure rates for *Childhood Immunization Status* fell below the 25th percentile, indicating opportunities for children who turned two years old during the measurement year to have recommended childhood vaccines. **[Quality, Access]**

Recommendation: HSAG recommends that Molina ACC provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.

Molina ACC's Response:

Initiatives Implemented Based on Recommendations

- Conducted outreach to parents and guardians of children due or overdue for immunizations through phone calls, text messages, and email reminders.
- Educated caregivers on the importance of vaccines for disease prevention and school readiness, emphasizing that mild illness should not delay immunization.
- Distributed monthly immunization gap reports to pediatric and family practice providers identifying children due for one or more vaccines.
- Reinforced education on ACIP (Advisory Committee on Immunization Practices) guidelines and encouraged vaccination during all eligible visits, including acute and mild illness visits.
- Discussed with providers reminder and recall systems and encouraged same-day vaccine administration.
- Highlighted best practices from high-performing clinics and reinforced timely documentation and claims submission to ensure accurate data capture.
- Strengthened reporting processes for immunization data from the Arizona State Immunization Information System (ASIIS) to improve measure accuracy.
- Encouraged providers to reconcile EMR and ASIIS records to ensure all administered vaccines are reported.

Performance as a Result of Implemented Initiatives

Metric: *Childhood Immunization Status (CIS)—Combination 3*

- Calendar Year 2023: 58.88%
- Calendar Year 2024: 64.48%

Barriers to Implementing Interventions

- Parental vaccine hesitancy or misinformation regarding safety and timing of immunizations.
- Incomplete reporting to ASIIS by provider offices and delays in data entry.
- Limited provider capacity for same-day vaccination appointments during high-volume seasons.
- Missed opportunities for vaccination during non-preventive visits due to competing clinical priorities.

Performance Measures

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Care of Acute and Chronic Conditions measure group, Molina ACC's *Controlling High Blood Pressure—18–85 Years* measure rate fell below the 25th percentile, indicating that some members are not adequately controlling their blood pressure.

[Quality]

Recommendations:

- HSAG recommends that Molina ACC continue to improve performance related to members' high blood pressure control. Molina ACC should submit updated barrier assessments and interventions as required by AHCCCS.
- HSAG recommends that Molina ACC identify trends within the data to identify which demographic groups and regions report lower blood pressure.
- HSAG recommends providing coverage for automated home blood pressure monitors for patients, while educating members about these benefits.
- HSAG recommends that Molina ACC provide incentives to members and providers to encourage blood pressure control.

Molina ACC's Response:

Initiatives Implemented Based on Recommendations

- Educated members on the importance of blood pressure management, medication adherence, and lifestyle modifications such as diet, exercise, and smoking cessation.
- Coordinated with Care Connections to provide at-home visits that include blood pressure screening and education on proper monitoring techniques.
- Distributed monthly gap reports and provider dashboards highlighting members with uncontrolled blood pressure.
- Reinforced best practices for accurate blood pressure measurement and timely follow-up, including rechecking elevated readings during the same visit.
- Collaborated with providers to encourage patient education on self-monitoring and to ensure medication adherence discussions occur during each encounter.
- Integrated discussions on hypertension control into Provider Quality JOC meetings to review performance trends and share improvement strategies.
- Expanded supplemental data collection from provider EMRs and home monitoring programs to capture updated readings not reflected in claims data.

Performance as a Result of Implemented Initiatives

Metric: *Controlling High Blood Pressure (CBP)*

Performance Measures

- Calendar Year 2023: 57.66%
- Calendar Year 2024: 67.40%

Barriers to Implementing Interventions

- Member barriers such as inconsistent medication adherence, limited understanding of hypertension management, or lack of access to home monitors.
- Provider variation in documenting and reporting blood pressure readings or follow-up actions.
- Social determinants such as food insecurity, limited access to healthy foods, and transportation barriers impacting care follow-up.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: Molina ACC's *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 %)—Total (18–75 Years)* and *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)* measure rates fell below the 25th percentile, indicating poor control over diabetes. [Quality]

Recommendations:

- HSAG recommends that Molina ACC continue to improve performance related to members' control over diabetes. HSAG also recommends that Molina ACC monitor and expand on interventions currently in place to improve performance related to members' HbA1c control.
- HSAG recommends that Molina ACC consider providing coverage for personal CGMs for Type 1 and Type 2 diabetes. Offering coverage for CGMs coupled with education of providers and patients of this coverage might improve diabetes control.
- HSAG also recommends that Molina ACC identify whether self-monitoring interventions might be effective, such as EpxDiabetes, which has bidirectional text and call capabilities.¹⁸³

Molina ACC's Response:

Initiatives Implemented Based on Recommendations

- Educated members on the importance of regular A1c testing, medication adherence, and healthy lifestyle practices such as balanced diet, exercise, and smoking cessation.

¹⁸³ Xu R, Xing M, Javaherian K, et al. Improving HbA1c with Glucose Self-Monitoring in Diabetic Patients with EpxDiabetes, a Phone Call and Text Message-Based Telemedicine Platform: A Randomized Controlled Trial. *Telemedicine journal and e-health : the official journal of the American Telemedicine Association* vol. 26,6 (2020): 784-793. Available at: <https://read.qxmd.com/read/31621523/improving-hba-1c-with-glucose-self-monitoring-in-diabetic-patients-with-epxd diabetes-a-phone-call-and-text-message-based-telemedicine-platform-a-randomized-controlled-trial>. Accessed on: Feb 4, 2026.

Performance Measures

- Coordinated with Care Connections to provide in-home A1c screenings for members unable to access in-office services.
- Shared monthly provider gap reports identifying members with poor or missing A1c results and highlighting opportunities for timely follow-up.
- Reinforced provider education on ADA (American Diabetes Association) guidelines, including quarterly A1c monitoring and individualized treatment goals.
- Collaborated with high-volume primary care and endocrinology practices to expand access to A1c testing and promote same-day lab draws.
- Discussed A1c performance trends and best practices for diabetes control during Provider Quality JOC meetings.
- Enhanced supplemental data submission from laboratories and provider EMRs to capture A1c results not reflected in claims.

Performance as a Result of Implemented Initiatives

Metric: *Glycemic Status Assessment for Patients With Diabetes (GSD)—Glycemic Status (>9.0%)*
(lower rates indicate better performance)

- Calendar Year 2023: 44.04%
- Calendar Year 2024: 34.55%

Barriers to Implementing Interventions

- Member challenges with self-management, including inconsistent medication use, limited access to healthy food, or difficulty maintaining follow-up appointments.
- Provider variation in ordering or documenting A1c tests and submitting lab results in a timely manner.
- Limited member awareness of continuous glucose monitor (CGM) coverage and benefits.
- Data lag in laboratory result reporting affecting real-time tracking of control rates.

HSAG Assessment:



Validation of Performance Improvement Projects - *Back to Basics* PIP

Opportunity for Improvement: HSAG identified no opportunities for improvement related to the *Back to Basics* PIP.

Recommendation: Although there were no opportunities for improvement identified, HSAG recommends that Molina ACC continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention as the PIP progresses.

Validation of Performance Improvement Projects - *Back to Basics* PIP

Molina ACC's Response:

Initiatives Implemented Based on Recommendations

- Maintained ongoing alignment with HSAG's technical guidance to ensure statistical testing and evaluation processes meet PIP validation requirements.
- Developed standardized evaluation templates to document each intervention's methodology, target population, and measurable outcomes.
- Integrated statistical testing into the analysis phase of PIPs to validate whether observed improvements are statistically significant.
- Reviewed intervention performance quarterly within the QI leadership team to identify trends, validate results, and refine data collection processes.
- Ensured that all active PIPs include both process and outcome measures, enabling evaluation of the direct impact of interventions on targeted populations.

Performance as a Result of Implemented Initiatives

- Molina ACC is actively implementing these interventions and will continue to monitor, evaluate, and report progress as data become available in future reporting cycles.

Barriers to Implementing Interventions

- Variability in available data sources across interventions, which can impact timeliness or completeness of outcome measurement.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: Isolated data issues may have contributed to specific instances affecting Molina ACC's compliance with time/distance standards. [Access]

Recommendation: HSAG recommends that AHCCCS support Molina ACC in continuing to monitor the Contractor's processes for creating the PAT file and review this file for accuracy prior to submitting to AHCCCS.

Molina ACC's Response:

Initiatives Implemented Based on Recommendations

- Molina ACC consistently audits provider data through provider reports that detail required elements for the PAT file submission. These reports are monitored monthly throughout the year to ensure that provider data is accurate within our operating system. This process is currently being modified to have reports generated daily to identify any data elements which would cause a record to error out on the PAT file submission. In addition, once the PAT file is generated, Molina ACC

Network Adequacy Validation

conducts a manual review ensuring that all populated data elements are in line with the PAT file specifications and required data elements are populated accordingly. If any discrepancies are identified, Molina ACC works with its technical team to address any issues prior to any submissions being uploaded to AHCCCS.

Performance as a Result of Implemented Initiatives

- Molina ACC has successfully transmitted and passed all PAT file submissions for the following contract years: 2023, 2024, and 2025.

Barriers to Implementing Interventions

- Molina ACC has no present barriers with passing the PAT file submissions, nor do we anticipate future concerns.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: Molina indicated that the QNXT database management system currently does not have the capability to capture active versus inactive providers. **[Access]**

Recommendation: HSAG recommends that Molina ACC explore its system capabilities to capture active versus inactive providers in the provider database management system.

Molina ACC's Response:

Initiatives Implemented Based on Recommendations

- Conducted an internal review of provider data management processes to assess how active and inactive provider status is captured and maintained.
- Molina ACC utilizes a front-end claims logic that reads the AHCCCS files to validate the AHCCCS status for provider billing. We either reject or accept based on the registration status for the date of service.
- Implemented additional validation steps in provider onboarding and termination workflows to confirm timely updates to provider activity status.
- Established periodic reconciliation between credentialing, contracting, and claims systems to ensure consistent provider status across all data sources.
- Enhanced provider record auditing processes to identify and correct discrepancies between active and inactive listings.
- Integrated data quality checks into monthly reporting to monitor accuracy and timeliness of provider status updates.
- Molina ACC is reviewing network adequacy for all provider types, specifically Behavioral Health Outpatient, Integrated Clinics, and Behavioral Health Residential Facilities. Molina ACC retains

Network Adequacy Validation

all AHCCCS-registered provider information and recruits on an as needed basis. Molina ACC contracted with several providers in the past 6 months. Molina ACC has had no deficiencies in adequacy. Molina ACC will continue to closely monitor adequacy.

Performance as a Result of Implemented Initiatives

- Implementation of these interventions is underway, and Molina ACC will continue to assess their impact and report outcomes in future reporting periods.

Barriers to Implementing Interventions

- Variability in data entry and timing of updates between internal systems (e.g., credentialing, contracting, claims).
- Limited automation within the existing provider database requiring manual verification of status changes.
- Dependency on external entities for timely notification of provider terminations or status updates.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: Molina ACC did not meet the minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; and BHRF. [Access]

Recommendation: HSAG recommends that Molina ACC maintain current compliance with network standards and continue to address network gaps, as applicable.

Molina ACC's Response:

Initiatives Implemented Based on Recommendations

- Continued proactive monitoring of provider network adequacy to ensure compliance with AHCCCS time and distance, appointment availability, and specialty access standards.
- Conducted quarterly geo-access and appointment availability analyses to identify and address potential network gaps.
- Collaborated with Provider Network and Contracting teams to recruit and onboard additional providers in areas identified with limited access or growing membership.
- Implemented ongoing review of member complaints and access-related grievances to identify emerging gaps in primary care, specialty, or behavioral health networks.
- Enhanced provider data accuracy through cross-system reconciliation and timely updates to provider directories to ensure members receive accurate access information.
- Maintained continuous collaboration with AHCCCS to review network adequacy reports and document corrective actions, if needed.

Network Adequacy Validation

- Molina ACC monitors network adequacy on a monthly basis and supplements with single case agreements (SCAs), as needed. Molina ACC also retains all provider information and request to recruit as needed.

Performance as a Result of Implemented Initiatives

- Molina ACC continues to advance these interventions and will evaluate performance trends as sufficient data becomes available for analysis.

Barriers to Implementing Interventions

- Provider workforce shortages and geographic limitations in rural and frontier regions.
- Extended credentialing and contracting timelines impacting onboarding of new providers.
- Variability in provider participation due to staffing turnover or changes in practice ownership.

HSAG Assessment:



UHCCP ACC

Performance Measure Validation

Opportunity for Improvement: While UHCCP ACC was successful in reporting valid rates for all AHCCCS-required performance measures for its ACC population, the audit identified a recommendation for future years' reporting. **[Quality]**

Recommendations:

- HSAG recommends that UHCCP ACC continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES.
- HSAG recommends that UHCCP ACC continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes AHCCCS' requirements for MCO-enrolled members who switch product lines or MCOs and members for whom UHCCP ACC does not hold the primary insurance contract.

UHCCP ACC's Response:

As an organization, there are multiple national initiatives being explored for additional data sources and strategies for race/ethnicity/language reporting. UnitedHealthcare is committed to only leveraging direct sources for RES reporting. While there are national initiatives being explored and vetted, currently UHC continues to leverage the 834 enrollment file as the source for RES reporting. All sources and hierarchy need to be approved by UHCCP'S national HEDIS auditor. Additionally, UHCCP ACC continues to comply with AHCCCS' requirements for continuous enrollment criteria

Performance Measure Validation

for (PMV reporting, including AHCCCS' requirements for MCO-enrolled members who switch product lines or MCOs and members for whom UHCCP ACC does not hold the primary insurance contract.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Behavioral Health measure group, UHCCP ACC's performance measure rate for *Use of Opioids at High Dosage—18+ Years* fell below the 25th percentile, indicating an opportunity to identify trends leading to opioid use. **[Quality]**

Recommendations:

- HSAG recommends that UHCCP ACC follow the CDC guidelines on opioid prescribing for chronic, nonmalignant pain, which recommend the use of “additional precautions” when prescribing dosages ≥ 50 MED and that providers avoid or “carefully justify” increasing dosages ≥ 90 mg MED.
- The opioid dosage assessed in this measure is a reference point for health plans to identify members who may be at high risk for opioid overuse and misuse. HSAG recommends outreach to members who fall within this category to assess and schedule interventions as necessary.¹⁸⁴
- HSAG recommends that UHCCP ACC identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts.

UHCCP ACC's Response:

UHCCP ACC encourages providers to follow the CDC guidelines on opioid prescribing for chronic, nonmalignant pain, which recommends the use of “additional precautions” when prescribing dosages ≥ 50 morphine equivalent dose (MED) and that providers avoid or “carefully justify” increasing dosages ≥ 90 mg MED. UHCCP ACC conducts provider outreach and education occurs through various platforms, including but not limited to: the UHCCP ACC Provider Manual, uhcprovider.com website, Network Bulletins, mailings, and direct outreach. Education includes directing prescribers to the current “CDC Guidelines for Prescribing Opioid for Chronic Pain,” “CDC Opioid Overdose Guidelines Resources,” as well as the “Arizona Department of Health Services Opioid Prescribing guidelines” web pages. Additionally, UHCCP ACC's retrospective DUR) includes outreach to prescribers of opioid dosages of an MME of greater than 90, or those who are concurrently prescribed opioids and benzodiazepines, requesting that they assess the member's use of opioids and schedule additional interventions as necessary. UHCCP ACC also performs a review of opioid prescribing patterns prior to credentialing or recredentialing all providers.

¹⁸⁴ National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/use-of-opioids-at-high-dosage-hdo/>. Accessed on: Feb 11, 2026.

Performance Measures

UHCCP ACC conducts member outreach, in alignment with AHCCCS Medical Policy manual (AMPM) Chapter 310-FF Monitoring Controlled and Non-Controlled Medication Utilization, inclusive of an evaluation of prescription utilization by members, prescribing patterns by clinicians and dispensing by pharmacies to identify and screen high-risk members and providers. The program interventions include, but are not limited to: provider education, Point-of-Sale (POS) safety edits and quantity limits, care/case management, coordination with behavioral health or other specialists, and assignment of members to an exclusive pharmacy and/or single prescriber. UHCCP's Lock-in Care Coordinator also conducts member outreach to ensure that they are connected with a provider and assess for any additional needs that may require support from UHCCP ACC or a community program.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Maternal and Perinatal Health measure group, UHCCP ACC's performance measure rate for *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, indicating an opportunity to increase access to timely postpartum care. **[Quality, Timeliness, Access]**

Recommendations:

- HSAG recommends that UHCCP ACC continue to implement appropriate interventions to improve performance related to postpartum care.
- HSAG also recommends that UHCCP ACC monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Postpartum Care* measure indicator, while adding interventions as appropriate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care*.

UHCCP ACC's Response:

The UHCCP ACC clinical quality manager continues to monitor the *Prenatal and Postpartum Care (PPC)* performance measures via the *PPC* PIP indicator rates monthly and reviews them with the *PPC* PIP workgroup during quarterly meetings.

The final MY 2024 final rates indicate improvements from the baseline rates: The *Timeliness of Prenatal Care (TOPC)* rate of 85.9% improved 3.4 percentage points from the baseline and exceeded the National Committee for Quality Assurance (NCQA) Medicaid Mean/National Average by 2.8 percentage points. The *Postpartum Care (PPC)* rate of 71.1% improved from the baseline rate by 3.5 percentage points but fell short of the NCQA Medicaid Mean/National Average. While neither met their PIP goals, UHCCP ACC conducted meaningful interventions, followed by intervention effectiveness analysis, and determined some intervention modifications for increased improvement.

Performance Measures

During MY 2024, the PPC PIP workgroup performed an annual review of their root cause and barrier analysis and discovered additional barriers that were under the umbrella of provider claim and coding confusion. Many postpartum visits were not captured through claims data because of incorrect coding and dates of service. Providers were using the global obstetric billing codes after delivery but not aware of the NCQA HEDIS measure requirement for the postpartum visit to occur between 7–84 days. This was confounded by their lack of awareness of PPC CPT II codes to close PPC quality gaps in care. UHCCP ACC has worked diligently to educate and encourage providers to submit claims with the PPC CPT II Codes and their patient's corresponding postpartum date of service (not just the global OB code right after delivery). This led to more challenges because providers' EMR systems, billing and clearing house rules to accept CPT II Codes and/or zero billed, including secondary claims, were not set up properly. UHCCP ACC's Clinical Practice Consultants (CPCs) work closely with provider groups to educate, collaborate, and overcome these issues so that quality gaps in care are closed. Educating providers that the payor platform is a continuous data feed but needs to be set up with UHCCP ACC's Network Team has helped. To date, several provider groups have completed integration into the payor platform which will greatly improve data exchange and close quality gaps.

Qualitative feedback from providers and CPCs identified the importance of the CPC Monthly Talking Points (PPC provider education), which were continued during MY 2024 to address valuable PPC information: CPT II Code utilization to close quality gaps, NCQA HEDIS requirements to complete postpartum visits by seven to 84 days after delivery was educated (not just submit claim with OB global billing code right after delivery—i.e., before seven days). Additionally, CPCs expanded provider education for the prenatal CPT codes, and the importance of the PCP role during member pregnancy and postpartum periods.

During the first and second quarters of 2024, a deep dive audit was conducted for several PPC interventions to determine any potential improvement opportunities. The UHCCP ACC live prenatal calls and the Maternity Navigation Program provided by UHCCP ACC's partner organization deep dives both identified that members need to get to their prenatal appointments within the first trimester to close the quality gap per the NCQA HEDIS measure specifications. Identifying pregnant members early enough to impact their prenatal care is difficult, but UHCCP ACC is using both interventions to improve in this area. This topic was discussed with the PIP work group and increased efforts are underway to ensure prenatal and postpartum care are conducted and documented during the specified time frames to meet the NCQA HEDIS specifications. CPC Monthly Talking Points (Provider Education) continued with some modification for improvement including updated information for several programs: Member Rewards, Obstetrical Risk Assessment (OBRAF) & NOP Forms. Getting members and providers engaged in time for prenatal and postpartum care is a continued challenge.

In the third quarter of 2025 mid-year effectiveness analysis, UHCCP ACC identified that CPT II Code utilization decreased compared to the previous year. A deep dive audit and claims analysis was performed. UHCCP ACC identified members with postpartum gaps in care, with delivery claims and OB global billing, but no postpartum claim indicating that either the member did not have a postpartum visit or the provider did not submit a claim for the postpartum visit; typically these will

Performance Measures

have the CPT II Code 0503F. UHCCP ACC honed in on the top provider and analyzed further to understand the decreased CPT II Code utilization, keeping in mind this is still a hybrid measure and that maybe providers are thinking it is not as important as the open care gap would be addressed during the annual chart chase. UHCCP ACC's CPC met with their assigned provider to discuss the findings, confirm if there was a postpartum visit or not, and address the postpartum gaps in care. Questions were prepared in advance to present to the provider:

1. Was a postpartum visit completed? Yes or No (if no, ask why if it seems appropriate). If yes,
2. What was the postpartum visit date of service (DOS) and was it within the 7–84 days after delivery time frame?
3. Was a claim submitted?
4. Was claim coded with a postpartum code?

If the postpartum visit was completed accordingly, but no claim with postpartum code, would the provider submit a zero or penny claim with 0503F to close the postpartum care gap, if not already done? This effort increased awareness of the importance of submitting a claim with 0503F with the postpartum visit date, and the provider agreed to submit claims where appropriate. CPCs performed Monthly Talking Points during August 2025 with their assigned providers, which included important PPC topics, including using CPT II Codes to close postpartum care gaps.

UHCCP ACC is also working in partnership with Accountable Care Organizations (ACOs) and contracted providers to expand the current supplemental data processes and increase data capture of completed services. This will be an ongoing initiative with implementation for the first ACO to be completed by the end of 2025.

HSAG Assessment:



Validation of Performance Improvement Projects - *Back to Basics* PIP

Opportunity for Improvement: For Indicator 1, UHCCP ACC had a decline of 0.4 percentage points in the indicator rate between the baseline year and Remeasurement Year 2. UHCCP ACC had a decline of 2.0 percentage points in the indicator rate between the baseline year and Remeasurement Year 2 for Indicator 2. **[Quality, Access]**

Recommendations:

- HSAG recommends that UHCCP ACC revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.
- HSAG recommends that UHCCP ACC continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.
- HSAG recommends that UHCCP ACC assure that all interventions are evaluated for effectiveness

Validation of Performance Improvement Projects - *Back to Basics* PIP

through a measure directly linked to the intervention.

UHCCP ACC's Response:

Based on final MY 2024 rates, both ACC *Back to Basics* (B2B) indicators (the *Well-Child Visits in the First 15 Months*: 0–14 months [W30R1] and *Child and Adolescent Well-Care Visits* [WCV] performance measures) significantly improved and achieved their PIP goals during Remeasurement Year 3 (MY 2024). Additionally, both rates exceeded the NCQA Medicaid Mean/National Average, and W30R1 exceeded the AHCCCS Value Based Purchasing (VBP) High Performing Benchmark. The PIP baseline was 2019 and was pre-pandemic. The public health emergency (PHE) took a considerable toll on well-child visits and rates plummeted. As discussed in The Arizona Partnership on Immunizations (TAPI), parents were leery of bringing their children in for well-child visits (in part due to coronavirus disease 2019 [COVID-19] and also vaccine hesitancy). However, YOY, rates slowly improved since 2022 and patients/members are slowly returning for their well-child visits.

During MY 2024, UHCCP ACC reviewed the root cause analysis (RCA), and the PIP Work Group and CPC Team agreed that provider billing and claims submissions continued to affect most providers for all indicators/measures and closing quality gaps in care. Provider and UHCCP ACC collaboration on these barriers continued, and CPCs have worked diligently to share the best practices of high-performing providers: checking appointments daily and changing office visits to well-child visits, submitting secondary claims, incorporating well-child visits into sick visits.

Main barriers included:

- Coordination of Benefit (COB) issues when a member has secondary insurance with UHCCP ACC and the provider does not submit a secondary claim
- Provider billing system that does not allow secondary billing with zero billed, mostly due to Provider Clearinghouse and Business Rules set-up
- EMRs not allowing flow of supplemental data and working with the UHCCP ACC Data Aggregators

CPCs work closely with provider groups to educate, collaborate, and overcome these issues (finding and discussing solutions) so that quality gaps in care are closed. Educating providers that the payor platform is a continuous data feed but needs to be set up with UHCCP ACC's Network Team has helped. To date, several provider groups have completed integration into the payor platform, which greatly improves data exchange, therefore closing quality gaps.

As part of the interventions' PDSA cycles, UHCCP ACC modified some interventions during 2024 to increase member and provider outreach with the intent of improved member health outcomes and rate performance. Additionally, increased effectiveness analysis was performed and reviewed during PIP workgroup meetings to identify intervention status and any need for improvement:

- The provider tip sheet for MY 2024 was refreshed again by the UHC Community and State provider marketing team, posted on uhcprovider.com for easier and increased access by providers, and shared during CPC Monthly Talking Points. This helpful document educates providers on best practices for achieving well-child visits. Effectiveness analysis was completed with qualitative

Validation of Performance Improvement Projects - *Back to Basics* PIP

feedback from providers and CPCs and remained very positive.

- Again, the myth vs fact member/guardian/parent letter and flyer continued to be helpful as evidenced by the effectiveness analysis. The PIP work group plans to continue this intervention in MY 2025 (PDSA Cycle 5).
 - MY 2024 Effectiveness Analysis (PDSA Cycle 4: Study) was completed for the 3 to 17 age group: Of the 4,458 ACC members aged 3 to 17 years with WCV open care gaps, identified as having a sick visit but no well-child visit via the missed opportunities report, and therefore were sent the Myth vs. Fact letter and flyer, 47.9% (2,136/4,458) obtained WCV quality gap closures, indicating moderate effectiveness of this intervention.
 - MY 2024 Effectiveness Analysis (PDSA Cycle 4: Study) was completed for the 18 to 21 age group: Of the 835 ACC members aged 18 to 21 years with WCV open care gaps, identified as having a sick visit but no well-child visit via the missed opportunities report, and therefore were sent the Myth vs. Fact letter and flyer, 23.1% (193/835) obtained WCV quality gap closures, indicating some effectiveness of this intervention. The PIP work group plans to continue this intervention in MY 2025 (PDSA Cycle 5). The PIP work group is also evaluating other opportunities to improve annual well visits for the 18–21 age group.
 - During 2024, the QM (EPSDT & Member Outreach Team performed additional live calls to members regarding their need for a well-child visit and their eligibility for a gift card (UHCCP ACC Member Rewards Program). MY 2024 Effectiveness Analysis (PDSA Cycle 1: Study): The QM Team outreached 706 members from three selected provider groups and a list of 978 members to remind them of their needed WCV and eligibility for the 2024 Member Rewards. This was an additional/increased effort during the fourth quarter of 2024 to close WCV care gaps. Using the MY 2024 Member Level Detail (MLD) Report as of January 2025, the call outcomes were compared to WCV compliance: Of the 978 members eligible for the 2024 WCV Member Rewards Program and who were on the QM Member Outreach Call List, 22.2% (217/978) of members had WCV gap closures. At this time, UHCCP ACC tentatively plans to perform this intervention again in MY 2025.

During MY 2025, the interventions from 2024 were continued and the PIP work group strategized additional meaningful interventions.

- Discussion ensued regarding the 18–21 age group. Analysis was completed revealing this age group has significantly lower WCV compared to the 3–17 age group. UHCCP ACC developed a member survey to seek member information on not attending WCV and to understand this better so that interventions can be developed or modified to target the findings. Planned interventions include:
 - Leveraging more digital communications rather than mailed materials: UHCCP ACC is working to convert materials to email format so that members who have an email address on file will receive the emailed version of the communication instead of mailed version. Members without an email address on file will receive the communication via mail.
 - Supporting members who do not know their assigned PCP: UHCCP ACC is exploring adding the assigned PCP in the email messaging communications per the above intervention.

Validation of Performance Improvement Projects - *Back to Basics* PIP

- Supporting members who do not know their assigned PCP: UHCCP ACC call staff will be reminded to inform the members of their assigned PCP when they connect with members through outreach calls. If the member reports that they are seeing a PCP different than the one that they are assigned, the member is transferred to Member Services to update their PCP in the system.
- UHCCP ACC is also working in partnership with ACOs and contracted providers to expand the current supplemental data processes and increase data capture of completed services. This will be an ongoing initiative with implementation for the first ACO to be completed by the end of 2025.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: UHCCP ACC had a high level of compliance mismatch between its submitted results and HSAG's calculated results. [Access]

Recommendation: HSAG recommends that UHCCP continue to work with AHCCCS and HSAG to reduce the amount of compliance discrepancies.

UHCCP ACC's Response:

UHCCP ACC has reviewed the HSAG validation data and identified discrepancy with the methodology used by UHCCP ACC and HSAG, specifically regarding the member location used to complete the adequacy analysis. UHCCP ACC utilizes the member's residential address and allows the network software to pinpoint their physical location, not the fiscal location documented in the member's AHCCCS file. This information has been shared with AHCCCS and was provided to HSAG on March 10, 2025.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: UHCCP ACC did not meet the minimum network requirements for Dentist, Pediatric. [Access]

Recommendation: HSAG recommends that UHCCP ACC maintain current compliance with network standards and continue to address network gaps, as applicable.

UHCCP ACC's Response:

UHCCP ACC evaluates the contracted network quarterly via the quarterly PAT file monitoring and review process and conducts a review of the area and category that has underperformed. A thorough audit of the provider community is conducted and includes a review of any noncontracted providers,

Network Adequacy Validation

and new providers that enter the county. UHCCP ACC will continue to monitor and review the PAT file for any opportunities to UHCCP ACC's network quarterly.

HSAG Assessment:



ACC-RBHA SMI-Designated Program Contractors' Follow-Up on Prior Year's Recommendations

The tables below present recommendations made to each ACC-RBHA SMI-Designated Program Contractor in the CYE 2024 Annual Technical Report¹⁸⁵ and the Contractors' follow-up to the recommendations, as well as an assessment of the degree to which each Contractor effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by each Contractor. Follow-up responses may be based on Contractor internal data and not EQR-validated rates.

AzCH-CCP ACC-RBHA

Performance Measure Validation

Opportunity for Improvement: While AzCH-CCP ACC-RBHA was successful in reporting valid rates for all AHCCCS-required performance measures for its SMI-Designated population, the audit identified some considerations and recommendations for future years' reporting. **[Quality]**

Recommendations:

- HSAG recommends that AzCH-CCP ACC-RBHA continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES.
- HSAG recommends that AzCH-CCP ACC-RBHA continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes AHCCCS' requirements for MCO-enrolled members who switch product lines or MCOs and members for whom AzCH-CCP ACC-RBHA does not hold the primary insurance contract.

AzCH-CCP ACC-RBHA's Response:

- AzCH-CCP ACC-RBHA is continuing to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES.
- AzCH-CCP ACC-RBHA is continuing to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting, including AHCCCS' requirements for MCO-enrolled members who switch product lines or MCOs and members for whom AzCH-CCP ACC-RBHA does not hold the primary insurance contract.

¹⁸⁵ Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2024 External Quality Review Annual Technical Report*. Available at: <https://www.azahcccs.gov/Resources/Downloads/EQR/2024/CYE2024ExternalQualityReviewAnnualTechnicalReport.pdf>. Accessed on: Feb 11, 2026.

Performance Measure Validation

- The AzCH-CCP HEDIS Stratification Dashboard provides an NCQA-directed RES of applicable HEDIS performance measures.
- The AzCH-CCP Health Literacy Workgroup, a cross-functional monthly committee, reviews measures by contract stratified by race and ethnicity to determine opportunities to close disparity gaps and implement focused interventions.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Maternal and Perinatal Care measure group, AzCH-CCP ACC-RBHA's performance measure rates for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* remain below the 25th percentile, indicating continued opportunity to increase access to timely prenatal and postpartum care. **[Quality, Timeliness, Access]**

Recommendations:

- HSAG recommends that AzCH-CCP ACC-RBHA continue to implement appropriate interventions to improve performance relative to prenatal and postpartum care.
- HSAG also recommends that AzCH-CCP ACC-RBHA monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Postpartum Care* measure indicators, while adding interventions as appropriate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care*.

AzCH-CCP ACC-RBHA's Response:

As of CY2024, AzCH-CCP had implemented the following interventions:

- A proprietary care management/coordination and member education program. The program attempts to engage members in care management or care coordination, based on their risk and medical, behavioral, or other needs. This intervention is considered effective because it solicits a NOP risk assessment from the member or provider as early as possible to establish a relationship between the member, their healthcare provider and their health plan care team. In addition, studies by other Centene health plans have found a positive correlation between participation in the program and positive birth outcomes.
- A digital care management program that provides specialized care plans for pregnant and postpartum members, with daily health check lists, providers alerts, care gap alerts, and progress tracking for case managers. It also allows for two-way video/text communication with care management, if the member prefers.
- A self-management tool to provide multiple resources, support, and education across a variety of topics inclusive of prenatal and postpartum care that is accessible through the member portal.
- A mobile application to address loneliness and social isolation, assist in developing a support system, and provide resources to address SDOH. The program also offers the ability to connect

Performance Measures

with a care coordinator for personalized coordination and resource navigation, along with empathy-led coaching for behavior change and self-reliance. Overall, members participating had an overall 49% reduction in loneliness scores between their baseline and final screenings, indicating that the intervention is effective.

- The AzCH-CCP ACC-RBHA Prenatal and Postpartum Work Group, an internal workgroup that meets to identify additional opportunities, identify/address racial disparities, and increase prenatal/postpartum outcome measures, including developing specific strategies to enhance member outreach and pregnancy outcomes.
- A cross-functional monthly committee convened to review identified measures, including PPC, by contract stratified by race and ethnicity to determine opportunities to close disparity gaps and implement focused interventions.
- The HEDIS Stratification Dashboard, which provides an NCQA-directed RES of applicable HEDIS performance measures.
- Outreach to birthing parents through weekly newborn calls to educate them and assist with making postpartum appointments.

The final ACC-RBHA Medicaid rate for *Postpartum Care* for CY2024 was 0.7% lower than the final rate for CY2023 ($p = 1.0000$), showing no YOY improvement. The final ACC-RBHA Medicaid rate for *Timeliness of Prenatal Care* was 5.6% higher than the rate for CY2023, although the difference was not significant ($p = 0.2230$), due to the relatively small ACC-RBHA population.

New/enhanced interventions in CY2025 include:

- Expanding provider outreach to OB/GYN specialty providers around PPC, including (but not limited to) measure specifications, NOP forms, practice-specific performance rates, and care gap lists.
- Partnering with a CHW program to complete face-to-face outreach for high-risk OB members that the health plan has been unable to reach.
- Implementing a new member incentive for completing a prenatal visit within the first trimester or 42 days of joining the health plan.
- Enhancing its proprietary care management/care coordination program with improvements that include, but are not limited to: a streamlined NOP form to increase completion by members and providers, trimester-based assessments to continuously identify and address barriers to care, additional reminder calls to members to ensure they attend scheduled appointments, and care coordinator teams specializing in prenatal or postpartum outreach.
- Implementing a value-added program that will allow pregnant members to receive items such as a car seat or stroller at no cost to them upon submission of an NOP and completion of a prenatal appointment in the first trimester.

Performance Measures

The overall ACC-RBHA Medicaid rate for *Postpartum Care* as of Quarter 3 (Q3) of CY2025 was 2.5% higher than the rate for Q3 of CY2024 and the overall rate for *Timeliness of Prenatal Care* was 3.1% higher than the rate for Q3 of CY2024, indicating YOY improvement.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Behavioral Health measure group, AzCH-CCP ACC-RBHA's performance measure rate for *Use of Opioids at High Dosage—18+ Years* remains below the 25th percentile. This result indicates a continued opportunity for AzCH-CCP ACC-RBHA to monitor prescribing and utilization data and to implement interventions to improve care and services around opioid prescribing. The CDC guidelines on opioid prescribing for chronic, nonmalignant pain recommend the use of “additional precautions” when prescribing dosages ≥ 50 MED and that providers avoid or “carefully justify” increasing dosages ≥ 90 mg MED.¹⁸⁶ **[Quality]**

Recommendations:

- HSAG recommends that AzCH-CCP ACC-RBHA monitor and expand on interventions currently in place to improve performance related to the *Use of Opioids at High Dosage—18+ Years* measure.
- HSAG recommends outreach to members who fall within this category to assess and schedule interventions as necessary.
- HSAG also recommends that AzCH-CCP ACC-RBHA identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts.

AzCH-CCP ACC-RBHA's Response:

As of CY2024, AzCH-CCP ACC-RBHA had implemented the following interventions:

- PQLs, who work with providers through on-site or virtual visits and provide technical assistance on quality care gaps, accessing and utilizing available provider analytic tools, member experience, risk, and incentive programs.
- Outreach to providers regarding members receiving dosages that exceed the recommended guidelines, including a DUR program, which notifies providers of identified opioid safety concerns. Currently, the success rate for reducing the use of high-dose opioids is approximately 23%.
- A medication adherence reward program that incentivizes members to take their daily prescribed medication for opioid use disorder treatment. In CY2024, the program had an average daily

¹⁸⁶ National Committee for Quality Assurance. Use of Opioids at High Dosage (HDO). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/use-of-opioids-at-high-dosage-hdo/>. Accessed on: Feb 10, 2026.

Performance Measures

engagement rate of 81.0%. Members completing the program demonstrated significant improvements in medication, as well as decreases in inpatient and emergency department utilization.

- A mobile application to address loneliness and social isolation, assist in developing a support system, and provide resources to address SDOH. The program also offers the ability to connect with a care coordinator for personalized coordination and resource navigation, along with empathy-led coaching for behavior change and self-reliance. Overall, members participating had an overall 49% reduction in loneliness scores between their baseline and final screenings, indicating that the intervention is effective.
- A telehealth provider for members with SUD, providing a specialized option to members who might not otherwise access care due to their condition and SDOH factors such as social isolation and lack of transportation. Telehealth has been shown to support increased access to care and member engagement for behavioral health needs.

In CY2024, the measure rate decreased by 0.3% from the final rate for CY2023; however, the change was not significant ($p = 1.000$).

New/enhanced interventions in CY2025 include:

- The provider outreach campaign regarding members receiving dosages of opioids that exceed the recommended guidelines now includes referral of certain members to the health plan medical director for additional review and peer-to-peer follow up with prescribers.
- The medication adherence reward program was expanded to focus on early identification of high-risk members to be considered for an additional 12-months enrollment and/or connecting members to additional health plan programs that will support member needs and continue to promote medication adherence.

The Q3 2025 rate was 3.9% lower (better) than the Q3 CY2024 rate, indicating YOY improvement.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Preventive Screening measure group, AzCH-CCP ACC-RBHA's performance measure rates for *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* remain below the 25th percentile, indicating that not all women were receiving timely screening for breast and cervical cancers. Early detection reduces the risk of dying

Performance Measures

from these types of cancers and can lead to a greater range of treatment options and lower healthcare costs.¹⁸⁷ [Quality]

Recommendations:

- HSAG recommends that AzCH-CCP ACC-RBHA continue to implement appropriate interventions to improve performance related to preventive screenings.
- HSAG also recommends that AzCH-CCP ACC-RBHA monitor and expand on interventions currently in place to improve performance related to the *Breast Cancer Screening* and *Cervical Cancer Screening* measures.
- HSAG recommends that AzCH-CCP ACC-RBHA consider utilizing one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve cervical cancer screening rates. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness.

AzCH-CCP ACC-RBHA's Response:

As of CY2024, AzCH-CCP ACC-RBHA had implemented the following interventions:

- Mobile mammogram events to increase access to breast cancer screenings. These events are open to the public to encourage breast cancer screening education, reduce stigma, and completion.
- Education and promotion of the annual My Health Pays member incentive for members who obtain their cervical cancer screening. A total of 456 rewards were distributed to RBHA members for completing a cervical cancer screening.
- Multi-prong member outreach campaigns to educate and encourage members to obtain needed screenings and tests. In CY2024, targeted live outreach calls to adults with care gaps for multiple measures including BCS and CCS had a reach rate of 14.8%. Targeted BCS calls made during Breast Cancer Awareness Month achieved a reach rate of 13.6%. Targeted CCS calls made during Cervical Cancer Awareness Month achieved a reach rate of 10.5%. Additionally, a year-end women's health calling campaign achieved a reach rate of 12.9%. Mailers were also sent to members with an open BCS care gap, and a well-woman text campaign in Q4 CY2024 achieved a 79% reach rate.
- Motivational Interviewing (MI) training for providers on how to address barriers and engage members to complete recommended cancer screenings. MI training topics were specific to cancer screenings: BCS, CCS, and COL. Attendance in CY2024 was not as high as expected.
- Member Care Gap Passports, a customized list of open care gaps sent to members with information on the frequency and importance of screening and how to access applicable member rewards. In CY2024, the member passport targeted 13 health measures, resulting in a total care gap closure rate of 9.3%.

¹⁸⁷ National Committee for Quality Assurance. Breast Cancer Screening (BCS). Available at: <https://www.ncqa.org/hedis/measures/breast-cancer-screening/>. Accessed on: Feb 19, 2025.

Performance Measures

- Collaboration with partners who serve high acuity and vulnerable members referred by Care Management. This initiative seeks to capitalize on the existing outreach to engage members in physical health care measures.
- Quarterly care gap lists sent to the COT team for follow up and coordination with each member's assigned health home. The COT team outreached a total of 224 BCS gaps in 2024, with a 28.3% gap closure rate for BCS among members who were outreached.

The final *BCS* rate for CY2024 was 1.5% above the CY2023 final rate, although the YOY change was not significant ($p=0.2668$). For *CCS*, the final CY2024 rate was 2.9% above the CY2023 final rate, although the YOY change was not significant ($p=0.4416$).

New/enhanced interventions in CY2025 include:

- Utilizing opportunities to expand awareness of mobile mammography outreach events, with the health plan promoting the events to members with BCS gaps through the use of live outreach calls and text campaigns, as well as sharing the information with providers.
- Updating the MI training information for providers to better clarify the value of the training and levels of staff for whom the training is appropriate and sharing information on the training during on-site provider visits, calls and emails, which has led to increased attendance.
- Deploying additional waves of the Member Care Gap Passport throughout the year, supported by live phone calls as applicable.
- Implementing an incentive for members completing a breast cancer screening.
- Incorporating MI techniques into call scripts for the AzCH-CCP ACC-RBHA Member Outreach Team to facilitate conversations with members that provide education on the screening. Staff ask the member about their knowledge or understanding of the service(s) needed, and address member concerns or anxiety surrounding their appointment.
- Collaborating with CHWs to complete face-to-face outreach to members that the health plan has been unable to reach, utilizing an approach that focuses on SDOH and racial/ethnic disparities. Community partnerships and utilizing non-licensed workers to connect with members in their communities in this way is a best practice in locating and engaging Medicaid members.
- The health plan began notifying providers of a new self-collection test kit for HPV that is available for use in office and sent to the lab for processing, to support the HPV co-testing element of the measure.

The year-to-date (YTD) rate for *Breast Cancer Screening* ages 50–74 was 2.4% lower than the YTD rate for CY2024. The *Cervical Cancer Screening* rate was 0.2% lower than the Q2 rate for CY2024.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Appropriate Utilization of Services measure group, AzCH-CCP ACC-RBHA's performance measure rates for *Plan All-Cause Readmissions O/E Ratio—Total (18–64 Years)* remained below the 25th percentile. **[Quality]**

Recommendations:

- HSAG recommends that AzCH-CCP ACC-RBHA continue to follow through on performance improvement strategies in order to increase provider and member outreach and improve follow-up care after discharge from an acute inpatient admission or observation.
- HSAG recommends that AzCH-CCP ACC-RBHA consider reviewing the Re-Engineered Discharge (RED), which has been shown to reduce readmissions and posthospital ED visits.¹⁸⁸ Other interventions that might be effective include technology platforms, including AI or machine learning, that can assist the plan in identifying members more at risk of re-admission.
- HSAG recommends that AzCH-CCP ACC-RBHA utilize case management strategies that focus on person-centered techniques, addressing barriers and/or SDOH as needed.

AzCH-CCP ACC-RBHA's Response:

As of CY2024, AzCH-CCP ACC-RBHA had implemented the following interventions:

- PQLs, who work with providers through on-site or virtual visits and provide technical assistance on quality care gaps, accessing and utilizing available provider analytic tools, member experience, risk, and incentive programs.
- A reward program that incentivizes members to take their daily medication, to better manage chronic disease and reduce inpatient utilization. This initiative focuses on ACC and RBHA members ages >18 with diabetes, chronic obstructive pulmonary disease (COPD)/asthma, heart failure, HIV, schizophrenia, bipolar disorder, depression, and opioid use disorder who demonstrate <80% adherence to one or more prescribed medications.
- A mobile application to address loneliness and social isolation, assist in developing a support system, and provide resources to address SDOH. The program also offers the ability to connect with a care coordinator for personalized coordination and resource navigation, along with empathy-led coaching for behavior change and self-reliance. In CY2024, a new feature of direct messaging was implemented. Overall, members participating had an overall 49% reduction in loneliness scores between their baseline and final screenings, indicating that the intervention is effective.
- Post-discharge follow-up calls within three business days of discharge to confirm the member's well-being and progress of the discharge plan according to assessed and anticipated clinical (behavioral and physical health) and social needs.
- A mobile app that provides specialized care plans (based on certain tracks) for members with specialized daily health check lists, provider alerts, care gaps alerts, and progress tracking to care

¹⁸⁸ Agency for Healthcare Research and Quality. Re-Engineered Discharge (RED) Toolkit. Available at: <https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool1.html>. Accessed on: Feb 5, 2026.

Performance Measures

managers. The app allows for two-way video/text communication with care managers, according to member preference.

- A telehealth provider for members with SUD, providing a specialized option to members who might not otherwise access care due to their condition and SDOH factors such as social isolation and lack of transportation. Telehealth has been shown to support increased access to care and member engagement for behavioral health needs.
- Utilizing a DUR program that uses an evidence-based clinical rules engine to identify gaps in care and alert providers to those gaps The use of clinical decision support systems has been shown to facilitate evidence-based medicine and therefore promises to substantially improve health care quality.

CY2024 shows the AzCH-CCP ACC-RBHA O/E ratio was 0.7212 above the final rate for CY2023. The YOY difference was significant ($p=0.0007$).

New/enhanced interventions in CY2025 include:

- Working more closely with the vendor offering the mobile application to address loneliness and social isolation to enhance engagement and referral of members who have expressed SDOH needs.
- BH and PH UM teams are continuing to share data/trends and have been working to identify actionable interventions for improvement in post-discharge call TATs. The PH UM team implemented a software application designed to perform automated repetitive tasks (bot) to improve efficiency in closing authorizations, and BH UM is exploring implementation of the bot.
- Identifying provider groups and health homes that have higher readmission rates and utilizing PQL visits to discuss activities and share best practices for improvement.
- Developing a text message to be sent to members post discharge, encouraging follow-up appointments with their providers.
- Convening the AzCH-CCP ACC-RBHA PCR Workgroup, a cross-functional workgroup that is analyzing data and trends, and identifying opportunities to deploy new or enhanced interventions.
- Incorporating components of the Case Management Transitions of Care Model.

The Q3 CY2025 rate was 0.1488 above the rate in Q3 of CY2024.

HSAG Assessment:



Validation of Performance Improvement Projects - Preventive Screening PIP

Opportunity for Improvement: For Indicator 2 in the *Preventive Screening* PIP, AzCH-CCP ACC-RBHA had a decline of 1.7 percentage points between the baseline year and Remeasurement Year 2. [Quality, Access]

Validation of Performance Improvement Projects - Preventive Screening PIP**Recommendations:**

- HSAG recommends that AzCH-CCP ACC-RBHA seek technical assistance from HSAG to understand the PIP submission requirements, if needed.
- HSAG recommends that AzCH-CCP ACC-RBHA revisit the causal/barrier analysis used to develop interventions and adjust the existing interventions or develop new interventions to facilitate improvement for the CCS performance indicator.
- HSAG recommends that AzCH-CCP ACC-RBHA continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.

AzCH-CCP ACC-RBHA's Response:

As of CY2024, AzCH-CCP ACC-RBHA had implemented the following interventions:

- Mobile mammogram events to increase access to breast cancer screenings. These events are open to the public to encourage breast cancer screening education, reduce stigma, and completion. A total of 188 BCS care gaps were closed in CY2024, inclusive of the ACC and RBHA populations.
- Education and promotion of the annual My Health Pays member incentive for members who obtain their cervical cancer screening. A total of 12,356 rewards were distributed to members for a cervical cancer screening (inclusive of ACC and RBHA members).
- Multi-prong member outreach campaigns to encourage members to obtain needed screenings and tests. In CY2024, the Member Outreach Team conducted targeted live outreach calls to adults with care gaps for multiple measures including BCS and CCS, with reach rate of 14.8%. Targeted BCS calls made during Breast Cancer Awareness Month achieved a reach rate of 13.6%. Targeted CCS calls made during Cervical Cancer Awareness Month achieved a reach rate of 10.5%. Additionally, a year-end women's health calling campaign achieved a reach rate of 12.9%. Mailers were also sent to members with an open BCS care gap, with a care gap closure rate of 12.9% attributed to the intervention. A well-woman text campaign in Q4 CY2024 achieved a 79% reach rate.
- MI training for providers on how to address barriers and engage members to complete recommended cancer screenings. MI training topics were specific to cancer screenings: BCS, CCS, and COL. Attendance in CY2024 was not as high as expected.
- Member Care Gap Passports, a customized list of open care gaps sent to members with information on the frequency and importance of screening and how to access applicable member rewards. In CY2024, the member passport targeted 13 health measures, resulting in a total care gap closure rate of 9.3%.
- Collaboration with partners who serve high acuity and vulnerable members referred by Care Management. This initiative seeks to capitalize on the existing outreach to engage members in physical health care measures.

Validation of Performance Improvement Projects - Preventive Screening PIP

- Quarterly care gap lists sent to the COT team for follow up and coordination with each member's assigned health home. The COT team outreached a total of 224 BCS gaps in 2024, with a 28.3% gap closure rate among members who were outreached.

AzCH-CCP ACC-RBHA revisited the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. New/enhanced interventions in CY2025 include:

- Utilizing opportunities to expand awareness of mobile mammography outreach events, with the health plan promoting the events to members with BCS gaps through the use of live outreach calls and text campaigns, as well as sharing the information with providers.
- Updating the MI training information for providers to better clarify the value of the training and levels of staff for whom the training is appropriate and sharing information on the training during on-site provider visits and calls, as well as via email to reach a broader audience, which has led to increased attendance.
- Deploying additional waves of the Member Care Gap Passport to members throughout the year, supported by live phone calls as applicable.
- Implementing an incentive for members completing a breast cancer screening.
- Incorporating MI techniques into call scripts for the AzCH-CCP ACC-RBHA Member Outreach Team to facilitate conversations with members that provide education on the screening. Staff ask the member about their knowledge or understanding of the service(s) needed, and address member concerns or anxiety surrounding their appointment.
- Collaborating with CHWs in Yuma County to complete face-to-face outreach for members that the health plan has been unable to reach, utilizing an approach that focuses on SDOH and racial/ethnic disparities. Community partnerships and utilizing non-licensed workers to connect with members in their communities in this way is a best practice in locating and engaging Medicaid members. To date, outreach completed in collaboration with the partner resulted in a 9.2% care gap closure rate for CCS.
- The health plan began notifying providers of a new self-collection test kit for HPV that is available for use in office and sent to the lab for processing, to support the HPV co-testing element of the measure.

AzCH-CCP RBHA did not meet the identified goal of 61.6% for *Breast Cancer Screening* but showed a statistically significant increase ($p < 0.0001$) of 11.3% from the CYE2019 baseline rate of 38.5% to the Remeasurement Year 3 (CY2024) rate of 49.8%. AzCH-CCP RBHA did not meet the identified goal of 64.8% for *Cervical Cancer Screening* but showed a statistically significant increase ($p = 0.0434$) of 2.1% from the CY2019 baseline rate of 43.9% to the Remeasurement Year 3 (CY2024) rate of 46.0%.

AzCH-CCP will seek technical assistance from HSAG to understand the PIP submission requirements, if needed.

Validation of Performance Improvement Projects - Preventive Screening PIP

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: AzCH-CCP ACC-RBHA did not meet the minimum network requirements for Dentist, Pediatric. [Access]

Recommendation: HSAG recommends that AzCH-CCP ACC-RBHA maintain current compliance with network standards and continue to address network gaps, as applicable.

AzCH-CCP ACC-RBHA's Response:

Outlined below are AzCH-CCP ACC-RBHA's strategies, efforts, and exception requests as of April 2025, applicable to both the Medicaid and CHIP populations, to address the identified areas of non-compliance:

- *Dental—Pediatric—Cochise County (South GSA):* 85.7% of AzCH-CCP ACC-RBHA pediatric members have access to a dental provider within the defined time and distance standards. The decrease in adequacy for Cochise County is due to member movement. There is one pediatric dental member that is outside of time and distance standards with the first provider being 12.1 miles and 13.2 minutes. The second provider is 12.4 miles and 13.4 minutes. AzCH-CCP utilized the Saturation Report and identified that there were no additional providers within adequacy guidelines to increase adequacy coverage. AzCH-CCP ACC-RBHA will continue to search for pediatric dental providers in Cochise County to add to our network. While the health plan recognizes that this is a gap, based on the town's size and the member aging out of the benefit in September, AzCH-CCP ACC-RBHA does not plan on submitting an exception. AzCH-CCP ACC-RBHA does not expect this gap to be reoccurring, but will reevaluate for the next network adequacy submission.
- *Dental—Pediatric—La Paz County (South GSA):* 50% of AzCH-CCP ACC-RBHA pediatric members have access to a dental provider within the defined time and distance standards. On August 25, 2023, AHCCCS approved the AzCH-CCP ACC-RBHA Network Exception submitted for Dentist—Pediatric—La Paz County. AzCH-CCP ACC-RBHA will continue to closely monitor any changes to the network and identify potential recruitment opportunities to close this gap.
- *Pharmacy—Gila County (South GSA):* 83.3% of AzCH-CCP ACC-RBHA members have access to a pharmacy provider within the defined time and distance standard. The decrease in adequacy for Gila County is due to a change in membership. There has been no change to the available providers in this county and specialty. There is one member that is outside of the time and distance standards. The average time and distance to the first provider is 14.6 miles and 15.9 minutes. The average time and distance to the second provider is 17.5 miles and 19 minutes. AzCH-CCP ACC-RBHA will continue to closely monitor any changes to the network and identify potential recruitment opportunities to close this gap.

Network Adequacy Validation

Additionally, on February 19, 2025, AHCCCS approved a network exception for the plan's RBHA pharmacy gap in La Paz County. While the gap is no longer an issue due to member movement, it is important to note that there is still a shortage of pharmacies in the area, and the closure of gap is not attributed to the introduction of new pharmacy contracts.

HSAG Assessment:



Mercy Care ACC-RBHA

Performance Measure Validation

Opportunity for Improvement: While Mercy Care ACC-RBHA was successful in reporting valid rates for all AHCCCS-required performance measures, the audit identified some considerations and recommendations for future years' reporting. **[Quality]**

Recommendations:

- HSAG recommends that Mercy Care ACC-RBHA continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes AHCCCS requirements for Contractor-enrolled members who switch product lines or Contractors and members for whom Mercy Care ACC-RBHA does not hold the primary insurance contract.
- HSAG recommends that Mercy Care ACC-RBHA continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES.

Mercy Care ACC-RBHA's Response:

Mercy Care ACC-RBHA continues collaboration with the Aetna Medicaid Quality & Report team to update the 834 mapping to include all applicable data. Mercy Care ACC-RBHA is leveraging the CMS enrollment files and Case/Care Management data for capturing additional data for 2024. As part of this additional work, Mercy Care ACC-RBHA and Aetna Medicaid are collaborating to identify if indirect data sources can be captured to supplement the direct data sources. Mercy Care ACC-RBHA has been working with the HIE on receiving the A08 alerts for race and ethnicity data directly.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Behavioral Health measure group, Mercy Care ACC-RBHA's performance measure rate for *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total (18+ Years)* also

Performance Measures

fell below the 25th percentile, suggesting that barriers exist for some members with a diagnosis of major depression to remain on antidepressant medication. **[Quality]**

Recommendations:

- HSAG recommends that Mercy Care ACC-RBHA monitor and expand on interventions currently in place to improve performance related to these measures.
- HSAG recommends that Mercy Care ACC-RBHA consider clinical recommendations shown to improve adherence to antidepressants, such as assessing depressive symptoms at baseline and each follow-up, as well as providing psychoeducation to the member and family.¹⁸⁹

Mercy Care ACC-RBHA's Response:

Mercy Care ACC-RBHA is pleased to report improvement in the *Acute Phase* submeasure, which achieved a rate of 50.77% in MY2024, as well as the *Continuation Phase* submeasure, which reached 38.56%. Although this measure will be retired in MY2025, Mercy Care ACC-RBHA remains committed to prioritizing depression medication adherence as a key component of member care and overall quality improvement.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Preventive Screening measure group, Mercy Care ACC-RBHA's performance measure rates for *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* remained below the 25th percentile, indicating that not all women were receiving timely screening for breast and cervical cancers. **[Quality]**

Recommendations:

- HSAG recommends that Mercy Care ACC-RBHA monitor and expand on interventions currently in place to improve performance related to these measures.
- HSAG recommends that Mercy Care ACC-RBHA utilize one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve cervical cancer screening rates. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness.

Mercy Care ACC-RBHA's Response:

In MY2024, the *BCS* rate remained unchanged, while the *CCS* measure improved to 45.26%. Although these measures continue to present challenges for Mercy Care ACC-RBHA, they remain a top priority. The interventions currently in place to address these measures are outlined below:

¹⁸⁹ Solmi M, Miola A, Croatto G, et al. How can we improve antidepressant adherence in the management of depression? A targeted review and 10 clinical recommendations. *Brazilian Journal of Psychiatry*. 2021;43(2):189–202.

Performance Measures

- In Q1 of 2025, Mercy Care ACC-RBHA implemented a comprehensive HEDIS governance structure, assigning each priority measure to an accountable owner. We conduct monthly HEDIS workgroup meetings to review high-priority measures, escalate challenges, evaluate interventions and their effectiveness, and provide quarterly updates to executive leadership. To support this work, Mercy Care ACC-RBHA developed an internal tracking system that houses measure rates, goals, and intervention details. This system enables monthly intervention updates, identifies gaps to goal, and streamlines targeted strategies.
- Mercy Care ACC-RBHA launched a QPL program in Q4 2025 to connect providers with the quality team for HEDIS education, performance updates, care gap identification, and support in addressing barriers to quality care.
- Educational outreach to female members ages 21–74 to encourage well-woman exams.
 - Female members ages 21–39 receive the CCS self-mailer.
 - Female members ages 40–74 receive the BCS/CCS self-mailer.
- Multi-channel member outreach campaign provides info on covered service and the importance of screenings.
- Provider “Gaps-in-Care” well-woman mailing includes a list of members who need a cervical cancer screening.
- Outreach staff contact members who need Pap test and assist with scheduling appointment.
- Provider site visits to provide education on the CCS screening guidelines and furnish a list of members still in need of Pap test.
- Outreach follow-up: Members receive a reminder card after a three-way-call where an appointment is scheduled.
- Participate in active coalition meetings and workgroups.
- A member web portal to provide educational information regarding gaps in care along with digital and written member outreach.
- Women’s Wellness Prevention Flyer encourages to encourage well-woman exams and mammograms (BCS).
- Staying Healthy Fall/Winter 2025 Member Newsletter provides the member with information on women’s wellness exams, CCS and BCS.
- For RHBA and DD, an incentive is delivered to members who still need cervical cancer screening. Once the claims are submitted, then the member has access to the gift card.
- Provider outreach and education.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Appropriate Utilization of Services measure group, Mercy Care ACC-RBHA's performance measure rates for *Plan All-Cause Readmissions O/E Ratio—Total (18–64 Years)* remains below the 25th percentile. **[Quality]**

Recommendations:

- HSAG recommends that Mercy Care ACC-RBHA continue to follow through on performance improvement strategies to increase provider and member outreach and improve follow-up care after discharge from an acute inpatient admission or observation.
- HSAG recommends that Mercy Care ACC-RBHA consider reviewing the Re-Engineered Discharge (RED), which has been shown to reduce readmissions and posthospital ED visits.¹⁹⁰ Other interventions that might be effective include technology platforms, including AI or machine learning, that can assist the plan in identifying members more at risk of readmission.
- HSAG recommends that Mercy Care ACC-RBHA utilize case management strategies that focus on person-centered techniques, addressing barriers and/or SDOH as needed.

Mercy Care ACC-RBHA's Response:

Mercy Care ACC-RBHA developed the following interventions aimed at reducing the unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay:

- In Q1 of 2025, Mercy Care ACC-RBHA implemented a comprehensive HEDIS governance structure, assigning each priority measure to an accountable owner. We conduct monthly HEDIS workgroup meetings to review high-priority measures, escalate challenges, evaluate interventions and their effectiveness, and provide quarterly updates to executive leadership. To support this work, Mercy Care ACC-RBHA developed an internal tracking system that houses measure rates, goals, and intervention details. This system enables monthly intervention updates, identifies gaps to goal, and streamlines targeted strategies.
- Mercy Care ACC-RBHA launched a QPL program in Q4 2025 to connect providers with the quality team for HEDIS education, performance updates, care gap identification, and support in addressing barriers to quality care.
- Level 1 Assertive Community Treatment (ACT) referrals (RBHA)—Mercy Care Manages Level 1 Hospital Referrals to ACT teams to screen for admission.
- Benefits Results Referrals—Utilized when a member is identified as a possible candidate for ALTCS to help increase the amount of support and services available to these members including LTC placement which can help reduce readmissions.
- CM Referrals—Utilized whenever it is determined that a member may benefit from the additional involvement of a CM. In 2024, there was the creation of a new level of care of case management

¹⁹⁰ Agency for Healthcare Research and Quality. Re-Engineered Discharge (RED) Toolkit. Available at: <https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool1.html>. Accessed on: Feb 5, 2026.

Performance Measures

- at RBHA health homes, Intensive Level of Care, to help provide more assistance with members who have higher utilization and greater clinical needs.
- Admit/Discharge (DC)/Transfer Notifications to the member's CM and PCP.
- Readmission Monitoring and Discussion—Mercy Care ACC-RBHA reviews readmission data and reports trends, variances, analysis/evaluation, interventions through the MM Committee, MMUM meeting, or like meeting.
- Facility Leadership Meetings—Mercy Care ACC-RBHA BH supervisors and BH provider relations representatives meet monthly, bimonthly, or quarterly with institutions for mental disease (IMD) facility directors to address high readmissions rates, IMD monthly overages, UM issues, and/or identified disposition planning or coordination of care issues.
- Quarterly Discharge Planner Meeting with RHBA Health Home Staff—Mercy Care ACC-RBHA BH Manager facilitates a quarterly meeting, including ASOC and Mercy Care ACC-RBHA Discharge Coordinators, for RHBA health home staff to discuss and provide feedback on the following: updates and information regarding levels of care frequently utilized as hospital DC locations (ex: BHRF, SUD residential treatment center (RTC), transitional living program (TLP)), addressing disposition planning barriers when members are inpatient, and providing education on member benefits and community resources to prevent hospital readmissions.
- Referral to Community Navigators—Members with all lines of business (except ALTCS) can be referred for any SDOH barrier or identified need in the community. The recovery navigators help to prevent readmissions by assisting with care coordination, medication management, social and emotional support, and follow-up care.
- Creation of a VBS program with the new RBHA BHH ACO, ANP, which includes incentivizing this measure.
- Creation of a new level of care of case management at RBHA health homes, Intensive Level of Care, to help provide more assistance with members who have higher utilization and greater clinical needs. The caseload size maximum will be between ACT and supportive and the case manager but be a licensed professional such as a registered nurse (RN), licensed master social worker (LMSW), licensed associate counselor (LAC), licensed marriage and family therapist (LMFT).
- BH UM managers and supervisors meet with newly contracted psychiatric hospitals within 90 days of the contract go live date, and then as needed or requested, to review UM and disposition planning processes, answer questions, provide education, and identify barriers potentially impacting member outcomes. The goal is to establish strong relationships between hospital and Mercy Care ACC-RBHA leaders, support new providers on how to support best member outcomes through coordination of care, disposition planning, and reducing the potential for hospital readmissions.
- Ongoing concurrent review and proactive discharge planning during the admission in collaboration with internal and external staff involved in the member care.
- Annual review of related policies and desktops for new changes and interventions.

Performance Measures

- Monday through Friday a report is sent to each health home showing all new inpatient discharges and ED visits so that the clinics may perform outreach and follow-up with the members.
- Post Discharge Follow-Up Referral—Referrals for at-risk members without established follow-up for timely post discharge follow-up and assessment. Regular meetings to discuss outcomes, barriers, and data collection.
- Post Discharge Outreach—Post discharge outreach calls to members to ensure the discharge was successful, to encourage and assist with post discharge follow-up, and to assess for any ongoing needs or concerns.
- ED visit alerts being sent in real time to the assigned care manager to assist with member outreach and support.
- Mercy Care ACC-RBHA partnering with Aetna Enterprise plans to analyze why this measure is such a challenge across all markets and share barriers and interventions in a Quality Workgroup.

HSAG Assessment:



Validation of Performance Improvement Projects - Preventive Screening PIP

Opportunity for Improvement: For Indicator 2, Mercy Care ACC-RBHA had a decline of 5.3 percentage points between the baseline year and Remeasurement Year 2. **[Quality, Access]**

Recommendations:

- HSAG recommends that Mercy Care ACC-RBHA seek technical assistance from HSAG to understand the PIP submission requirements, if needed.
- HSAG recommends that Mercy Care ACC-RBHA revisit the causal/barrier analysis used to develop interventions and adjust the existing interventions or develop new interventions to facilitate improvement for the CCS performance indicator.
- HSAG recommends that Mercy Care ACC-RBHA continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.

Mercy Care ACC-RBHA's Response:

In MY2024, the BCS rate remained unchanged, while the CCS measure improved to 45.26%. Although these measures continue to present challenges for Mercy Care ACC-RBHA, they remain a top priority.

Mercy Care ACC-RBHA hired a Senior Manager in July 2025 to lead and manage PIPs, bringing extensive experience in PIP development and evaluation. This role ensures interventions are assessed for effectiveness using measures directly linked to the intervention, and that statistical testing requirements are understood and applied appropriately. Mercy Care ACC-RBHA is also hiring a new data analyst who will assist with the statistical testing process in Q4 of this year.

Validation of Performance Improvement Projects - Preventive Screening PIP

At the start of this year, Mercy Care ACC-RBHA implemented a comprehensive HEDIS governance structure, assigning each priority measure—including those within PIPs—to an accountable owner. We conduct monthly HEDIS workgroup meetings to review high-priority measures, escalate challenges, evaluate interventions and their effectiveness, and provide quarterly updates to executive leadership. To support this work, Mercy Care ACC-RBHA developed an internal tracking system that houses measure rates, goals, and intervention details. This system enables monthly intervention updates, identifies gaps to goal, and streamlines targeted strategies.

Mercy Care ACC_RBHA will continue to seek technical assistance from HSAG as needed and maintain rigorous evaluation of all interventions.

HSAG Assessment:



Compliance Reviews

Opportunity for Improvement: Mercy Care ACC-RBHA scored below 95 percent in the Member Information (MI) focus area. **[Quality]**

Recommendation: HSAG recommends that Mercy Care ACC-RBHA continue to work with AHCCCS on closing remaining CAPs.

Mercy Care ACC-RBHA's Response:

Mercy Care ACC-RBHA confirms that the CAP was successfully closed on May 19, 2025. The following actions were completed to address AHCCCS findings and ensure compliance:

1. Policy and Procedure Updates:
 - Mercy Care ACC-RBHA updated and resubmitted policies and procedures to clearly define how provider failure to report or late reporting is addressed when identified during incident triage or QOC investigations.
2. Alignment with AHCCCS Requirements:
 - All updates ensure compliance with AHCCCS contract requirements and AMPM policies, including processes for addressing provider late or non-reporting during incident triage and QOC investigations.
3. Communication to AHCCCS:
 - Updated documents were submitted to AHCCCS as part of the CAP closure process.

HSAG Assessment:



Network Adequacy Validation

Opportunities for Improvement: Isolated data issues may have contributed to specific instances affecting Mercy Care ACC-RBHA's compliance with time/distance standards. [Access]

HSAG identified an opportunity for Mercy Care ACC-RBHA to improve the results to calculate time/distance indicators. [Access]

Mercy Care ACC-RBHA had a high level of compliance mismatch between its submitted results and HSAG's calculated results. [Access]

Recommendations: HSAG recommends that:

- AHCCCS support Mercy Care ACC-RBHA in continuing to monitor the Contractor's processes for creating the PAT file and review this file for accuracy prior to submitting to AHCCCS.
- Mercy Care ACC-RBHA incorporate additional oversight and monitoring when transferring results to the ACOM Policy 436 template to ensure the most accurate results are being submitted to AHCCCS.
- Mercy Care ACC-RBHA continue to work with AHCCCS and HSAG to reduce the amount of compliance discrepancies.

Mercy Care ACC-RBHA's Response:

Mercy Care ACC-RBHA has implemented updates to internal reporting processes based on findings from the 2024 HSAG NAV audit. These enhancements ensure ACOM 436 reporting aligns with data in the PAT file, significantly reducing prior mismatches. Additionally, we have strengthened oversight and validation steps during data transfers to improve accuracy and consistency in time/distance calculations. Mercy Care ACC-RBHA supports HSAG's recommendations and will continue collaborating with the Division and AHCCCS. The process for creating and validating the PAT file is now embedded in our standard workflows. If there are specific areas where the Division or AHCCCS expects improvement, we welcome that feedback and will implement changes as needed.

HSAG Assessment:



DCS CHP Program Follow-Up on Prior Year's Recommendations

The table below presents recommendations made to the DCS CHP Program Contractor in the CYE 2024 Annual Technical Report¹⁹¹ and the Contractor's follow-up to the recommendations, as well as an assessment of the degree to which the Contractor effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR-validated rates.

DCS CHP

Performance Measure Validation

Opportunity for Improvement: While DCS CHP generally had appropriate data systems, processes, and oversight, the audit identified the following considerations and recommendations for future years' reporting: [Quality]

Recommendations:

- HSAG recommends that DCS CHP continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting.
- HSAG recommends that DCS CHP continue to ensure that the mapping of provider specialties to HEDIS provider types is compliant with AHCCCS' requirements for PMV reporting.
- DCS CHP has continued to contract with Mercy Care as its subcontracted health plan to produce AHCCCS-required performance measures, and HSAG recommends that DCS CHP continue to maintain this partnership, which allows DCS CHP to appropriately report the AHCCCS PMV measures.
- HSAG recommends that DCS CHP continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES.

DCS CHP's Response:

DCS CHP continues to comply with AHCCCS requirements for continuous enrollment and specialty-to-provider-type mappings as part of AHCCCS PMV reporting. DCS CHP maintains its partnership with Mercy Care DCS CHP to ensure accurate and timely performance measure submission.

¹⁹¹ Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2024 External Quality Review Annual Technical Report*. Available at: <https://www.azahcccs.gov/Resources/Downloads/EQR/2024/CYE2024ExternalQualityReviewAnnualTechnicalReport.pdf>. Accessed on: Feb 10, 2026

Performance Measure Validation

For RES-related measures, DCS CHP focused on refining race/ethnicity stratification efforts in MY2024. Initiatives included training staff to improve enrollment data collection and engaging EHR vendors to support structured RES data fields.

DCS CHP also collaborated with AHCCCS to improve the accuracy and completion of RES data, identifying additional data sources where appropriate. These enhancements support future stratification and compliance with NCQA and AHCCCS guidelines.

HSAG Assessment:



Validation of Performance Improvement Projects - *Back to Basics* PIP

Opportunity for Improvement: HSAG identified no opportunities for improvement related to the *Back to Basics* PIP.

Recommendation: Although there were no opportunities for improvement identified, as the PIP progresses, HSAG recommends that DCS CHP continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.

DCS CHP's Response:

As part of the *Back to Basics* PIP, DCS CHP reviewed the barrier analysis to align interventions with remeasurement findings. Interventions were refined in MY2024 to target broader population coverage. DCS CHP also reviewed effectiveness post-Year 1 remeasurement and scaled outreach to address the most impactful barriers using enhanced member engagement and case manager follow-up workflows.

HSAG Assessment:



Compliance Reviews

Opportunity for Improvement: DCS CHP has remaining CAPs in the following focus areas:

- Delivery Systems (DS) [Timeliness, Access]
- Adult, EPSDT and Maternal Child Health (MCH) [Quality, Timeliness, Access]
- Quality Management (QM) [Quality]
- Quality Improvement (QI) [Quality, Access]

Recommendation: HSAG recommends that DCS CHP continue to work on outstanding CAP items and submit to AHCCCS in the approved time frame.

DCS CHP's Response:

Compliance Reviews

DCS CHP continues to address outstanding CAP items from the previous operational review cycle. In MY2024, open items were tracked in the internal QOC dashboard and submitted to AHCCCS within required timelines. Follow-up reports were aligned with CAP closeout criteria.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: Isolated data issues may have contributed to specific instances affecting Mercy Care DCS CHP's compliance with time/distance standards. [Access]

Recommendation: HSAG recommends that AHCCCS support Mercy Care DCS CHP in continuing to monitor its processes for creating the PAT file and review this file for accuracy prior to submitting to AHCCCS.

DCS CHP's Response:

Mercy Care DCS CHP continues existing processes to ensure that the plan maintains compliance with the AHCCCS required network coverage requirements.

Mercy Care DCS CHP made updates to the internal reporting based on the results of the HSAG NAV audit in 2024. Mercy Care DCS CHP's ACOM 436 reporting matches the data provided in the PAT report and should subsequently reduce mismatches that were previously observed/noted in the PAT file, in turn, increasing the accuracy of time/distance calculations and increasing the compliance between submitted and HSAG calculated results.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: HSAG identified an opportunity for Mercy Care DCS CHP to improve the results to calculate time/distance indicators. [Access]

Recommendation: HSAG recommends that Mercy Care DCS CHP incorporate additional oversight and monitoring when transferring results to the ACOM Policy 436 template to ensure the most accurate results are being submitted to AHCCCS.

DCS CHP's Response:

Mercy Care DCS CHP continues existing processes to ensure that the plan maintains compliance with the AHCCCS required network coverage requirements.

Network Adequacy Validation

Mercy Care DCS CHP made updates to the internal reporting based on the results of the HSAG NAV audit in 2024. Mercy Care DCS CHP's ACOM 436 reporting matches the data provided in the PAT report and should subsequently reduce mismatches that were previously observed/noted in the PAT file, in turn, increasing the accuracy of time/distance calculations and increasing the compliance between submitted and HSAG calculated results.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: Mercy Care DCS CHP had a high level of compliance mismatch between its submitted results and HSAG's calculated results. [Access]

Recommendation: HSAG recommends that Mercy Care DCS CHP continue to work with AHCCCS and HSAG to reduce the amount of compliance discrepancies.

DCS CHP's Response:

Mercy Care DCS CHP continues existing processes to ensure that the plan maintains compliance with the AHCCCS required network coverage requirements.

Mercy Care DCS CHP made updates to the internal reporting based on the results of the HSAG NAV audit in 2024. Mercy Care DCS CHP's ACOM 436 reporting matches the data provided in the PAT report and should subsequently reduce mismatches that were previously observed/noted in the PAT file, in turn, increasing the accuracy of time/distance calculations and increasing the compliance between submitted and HSAG calculated results.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: Mercy Care DCS CHP did not meet the minimum network requirements for BHRF; Dentist, Pediatric; and Pharmacy. [Access]

Recommendation: HSAG recommends that Mercy Care DCS CHP maintain current compliance with network standards and continue to address network gaps, as applicable.

DCS CHP's Response:

Mercy Care DCS CHP continues existing processes to ensure that the plan maintains compliance with the AHCCCS required network coverage requirements.

Network Adequacy Validation

Mercy Care DCS CHP made updates to the internal reporting based on the results of the HSAG NAV audit in 2024. Mercy Care DCS CHP's ACOM 436 reporting matches the data provided in the PAT report and should subsequently reduce mismatches that were previously observed/noted in the PAT file, in turn, increasing the accuracy of time/distance calculations and increasing the compliance between submitted and HSAG calculated results.

HSAG Assessment:



Consumer Assessment of Healthcare Providers and Systems

Opportunities for Improvement:

- DCS CHP's member experience rating for Rating of Specialist Seen Most Often was below the 25th percentile for the general child population. **[Quality]**
- DCS CHP's member experience ratings for Rating of Health Plan, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, Coordination of Care, Access to Specialized Services, FCC: Personal Doctor Who Knows Child, Coordination of Care for Children with Chronic Conditions, Access to Prescription Medicines, and FCC: Getting Needed Information were below the 25th percentile for the CCC population. **[Quality, Timeliness, Access]**
- DCS CHP's member experience ratings for *Rating of Health Plan*, *Getting Needed Care*, and *Coordination of Care* were at or between the 25th and 49th percentile for the general child population. **[Quality, Access]**
- DCS CHP's member experience rating for *How Well Doctors Communicate* was at or between the 25th and 49th percentile for the CCC population. **[Quality]**
- DCS CHP's 2024 score for *How Well Doctors Communicate* was statistically significantly lower than the 2023 score for the general child population. **[Quality]**
- DCS CHP's 2024 scores were not statistically significantly lower than the 2023 scores; therefore, no substantial weaknesses were identified for trend results for the CCC population. **[Quality]**

Recommendation: HSAG recommends that DCS CHP explore what may be driving lower experience scores and develop initiatives designed to improve the quality of and access to care, including a focus on improving parents'/caretakers' overall experiences with the health plan, specialist seen most often, getting needed care/information, access to care in a timely manner, access to prescription medicines, and coordination of care for child members.

DCS CHP's Response:

Mercy Care DCS CHP is completing the following activities to address CAHPS:

- Outreach to member campaigns
- Outreach calls to members
- Ongoing internal CAHPS workgroups to discuss interventions, issues, and barriers

Consumer Assessment of Healthcare Providers and Systems

- Mock CAHPS survey
- Provider education materials
- Provider notices
- Member materials
- CAHPS training course for staff

DCS CHP implemented CAHPS improvement strategies including member education campaigns, provider reminder tools, and concierge-style outbound calls from MCA teams. These were supported by provider-facing tip sheets and member materials that promoted timely access and satisfaction. Staff across departments received targeted CAHPS training during Q2 and Q3 of MY2024.

HSAG Assessment:



ALTCS-EPD Program Contractors' Follow-Up on Prior Year's Recommendations

The tables below present recommendations made to each ALTCS-EPD Program Contractor in the CYE 2024 Annual Technical Report¹⁹² and the Contractors' follow-up to the recommendations, as well as an assessment of the degree to which each Contractor effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by each Contractor. Follow-up responses may be based on Contractor internal data and not EQR-validated rates.

BUFC LTC

Performance Measure Validation

Opportunity for Improvement: While BUFC LTC was successful in reporting valid rates for nearly all rates for its ALTCS-EPD population, the audit review identified some considerations and recommendations for future years' reporting. **[Quality]**

Recommendations:

¹⁹² Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2024 External Quality Review Annual Technical Report*. Available at: <https://www.azahcccs.gov/Resources/Downloads/EQR/2024/CYE2024ExternalQualityReviewAnnualTechnicalReport.pdf>. Accessed on: Feb 11, 2026.

Performance Measure Validation

- While BUFC LTC integrated available EHR and HIE data to report the required measure stratifications by race and ethnicity for MY 2023 data reporting, BUFC LTC should work to integrate race data that BUFC LTC noted it is receiving as of April 2024 for future stratification reporting to improve data completeness. BUFC LTC should ensure that it submits all Record of Administration, Data Management, and Processes (Roadmap) and associated attachments as part of its ISCAT submission, including all data inventories and supplemental data documentation to allow for a more streamlined review of documentation, which will reduce the amount of follow-up requests.
- The MRRV and CM MRRV processes revealed several criterial errors which impacted BUFC LTC's ability to report the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition* measure indicators using the hybrid methodology. In addition, the LTSS measures required several measures with second samples and revisions to the final medical record compliant case counts. HSAG recommends that BUFC LTC incorporate the feedback provided during this year's validation process into its abstraction process to mitigate these issues in future years.

BUFC LTC's Response:

BUFC LTC identified key takeaways from this audit and have implemented process improvement activities as a result. Beginning in MY2024, overreads were increased to 100% for all numerator-positive chases. For LTSS, BUFC LTC better understands the measure specifications and follows the NCQA guidelines. The final LTSS fix will be implemented for MY2025 and will re-run the MY2024 member sample to share during the LTSS resampling process. Additionally, 100% overreads are now completed for all selected members, instead of the previous 95% pass rate per employee and 10% overall.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Preventive Screening measure group, BUFC LTC's performance measure rate for *Breast Cancer Screening Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023, indicating that not all women were receiving timely screening for breast or cervical cancer. [Quality]

Recommendations:

- HSAG recommends that BUFC LTC identify disparities or SDOH within the plan's populations that contributed to breast cancer and cervical cancer screening rates. Upon identification of a root cause, HSAG recommends that BUFC LTC implement appropriate interventions to reduce barriers to care.

Performance Measures

- HSAG recommends that BUFC LTC provide scheduled reminders, messages directly from providers, and utilize personalized outreach for overdue patients. Communication messages should be clear and concise and include information on the procedure time. Some of these interventions might include a mobile clinic to conduct the screening, transportation assistance, and adjusting hours for visits to accommodate those with job/childcare concerns.

BUFC LTC's Response:

Breast Cancer Screening: Subpopulation analyses were conducted to identify and assess potential areas of disparity.

Previously implemented interventions have continued to be monitored for effectiveness and refined as needed. Planning is also underway for new strategies to be introduced in the upcoming year. Current and planned interventions include:

- Gaps in care reports are generated and sent monthly to the ALTCS Case Management team for outreach and follow-up.
- Facilitate community-based wellness events that provide on-site screening.
- Member-facing outreach team contacts members who are due for screening and offers education and assistance with scheduling.
- Provider education on best practices, measure specifications, member barriers, and tips on overcoming barriers has been routinely shared through JOCs, BUHP Provider Forums, and provider newsletters.
- Provider collaboration through Provider Advisory Councils sharing regionally specific data, performance, and subpopulation analysis along with education on best practices, strategies, interventions, and measure specifications.
- Billboards in various languages have been posted as reminders of the importance to get screened in areas with high membership of American Indian/Alaska Native members.
- Member education shared through mailers, post cards, and on various social media outlets.
- Well-Women's Preventive Care text message campaign continued and increased to two times annually. Text messages include education on the importance of prenatal and postpartum care as well as resources for engaging with providers.
- Implementation in CY2025 of a member incentive campaign available to members in subpopulations identified as having disparities. Members are offered an OTC gift card upon completion of screening between July 1, 2025, and December 31, 2025.
 - These subpopulations include 52–55-year-olds, American Indian/Alaska Native members, Black/African American members, members in a Long Term Institution (LTI), members with an SMI designation, rural communities including Cochise, Graham, and La Paz counties, and urban communities including Maricopa and Pinal counties.

Cervical Cancer Screening: Subpopulation analyses were conducted to identify and assess potential areas of disparity.

Performance Measures

The following interventions have been established or continue with planned enhancements for implementation in the upcoming year:

- Provider education on best practices, measure specifications, member barriers and tips on overcoming barriers has been routinely shared through JOCs, BUHP Provider Forums, Provider Advisory Councils, and provider newsletters.
- Implementation in CY2025 of a member incentive campaign available to members in subpopulations identified as having disparities. Members are offered an OTC gift card upon completion of screening between July 1, 2025, and December 31, 2025.
 - These subpopulations include 50–64-year-olds, Native Hawaiian/Pacific Islander members, members in an LTI, members with an SMI designation, rural communities including Cochise and Gila counties, and urban communities including Maricopa County.
- Well-Women's Preventive Care text message campaign continued and increased to 2x annually. Text messages include education on the importance of prenatal and postpartum care as well as resources for engaging with providers.
- Additional initiation of an internal PIP utilizing CY2025 as the baseline measurement year will allow subject matter experts to further assess national initiatives, evidence-based practices, root causes, and disparities to better target improvement within this performance measure.
- Facilitate community-based Wellness Events that provide on-site screening.
- Gaps in care reports are generated and sent monthly to the ALTCS Case Management team for outreach and follow-up.
- Member-facing outreach team contacts members who are due for screening and offers education and assistance with scheduling.
- Member education shared through mailers, post cards, and on various social media outlets.
- Provider collaboration through Provider Advisory Councils sharing regionally specific data, performance, and subpopulation analysis along with education on best practices, strategies, interventions, and measure specifications.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Behavioral Health measure group, BUFC LTC's performance measure rate for *Use of Opioids at High Dosage (18+ Years)* fell below the 25th percentile. This result provides an opportunity for BUFC LTC to monitor prescribing and utilization data and to implement interventions to improve care and services around opioid prescribing. **[Quality]**

Recommendations:

- HSAG recommends that BUFC LTC follow the CDC guidelines on opioid prescribing for chronic, nonmalignant pain, which recommend the use of "additional precautions" when prescribing

Performance Measures

dosages ≥ 50 MED and that providers avoid or “carefully justify” increasing dosages ≥ 90 mg MED.¹⁹³

- The opioid dosage assessed in this measure is a reference point for health plans to identify members who may be at high risk for opioid overuse and misuse. HSAG recommends outreach to members who fall within this category to assess and schedule interventions as necessary.¹⁹⁴
- HSAG also recommends that BUFC LTC identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts.

BUFC LTC's Response:

Previously implemented interventions have continued to be monitored for effectiveness and refined as needed. Planning is also underway for new strategies to be introduced in the upcoming year. Current and planned interventions include:

- Established the Opioid Strategic Planning committee which meets at a minimum of quarterly.
- Pharmacy Controls: Prior authorization requirements for long- and short-acting opioids and restrictions on multiple short-acting prescriptions within 30 days.
- Provider Education: Opioid prescribing best practices, alternative pain management education, and DEA-mandated education.
- Interdisciplinary Care Team: A collaborative team reviews high-dose opioid patients, monitors opioid use trends, and educates patients on Narcan.
- Embed the routine use of the opioid prescription database into the standard workflow.
- Implement provider-level monitoring to identify and address providers with higher-than-expected prescribing rates.
- Mandated education sessions for providers involved in opioid prescribing, focusing on best practices, risk management, and alternative pain management options.
- Distribute “Narcan 101” materials to providers to support patient and family education on the importance and use of Narcan.
- Implemented tracking system to track Narcan prescription data, using it to assess the impact of provider education.
- Screening Tool Assessment: Identifying which validated opioid screening tools are currently available and being used within our organization and assessing their effectiveness.
- Provider Practice Evaluation: Identifying current provider practices to determine what types of screenings are being conducted and under what circumstances screenings are being overlooked.
- Continued pharmacy practices for Opioid Specific Data Extensive Program for monitoring and intervention:

¹⁹³ National Committee for Quality Assurance. Use of Opioids at High Dosage (HDO). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/use-of-opioids-at-high-dosage-hdo/>. Accessed on: Feb 10, 2026.

¹⁹⁴ Ibid.

Performance Measures

- Members identified with high dose opioid use from pharmacy data are sent letters about the risks.
- Providers of members identified with high dose opioid use from pharmacy data are sent letters about the risks.
- These identified members are assigned to a Care Manager.
- Outcomes are reviewed by the Opioid Strategic Planning Committee.
- Identified members with no change to the high rate of use are reviewed by the Medical Director to determine next steps.
 - Members may be enrolled in pharmacy restriction program.
 - Egregious cases may be sent to AHCCCS credentialing board.
- Ensure that opioid risk screening is a mandatory step for providers before prescribing opioids or managing chronic pain, ensuring consistency across the Banner Health systems.
- Establish protocols for joint care plans between physical health providers (PCPs and pain specialists) and behavioral health teams to ensure care coordination.
- Dedicated care coordination teams that include physical health, behavioral health, and pharmacy professionals to manage the care of at-risk individuals, ensuring communication and follow-up between departments.
- A subpopulation analysis has been conducted to identify any areas of membership or subpopulations that are displaying a disparity.
 - This information will be reviewed with members of leadership and pharmacy to develop additional interventions to target these populations.

HSAG Assessment:



Validation of Performance Improvement Projects - *Breast Cancer Screening* PIP

Opportunity for Improvement: HSAG identified no opportunities for improvement related to the *Breast Cancer Screening* PIP.

Recommendation: Although there were no opportunities for improvement identified, as the PIP progresses, HSAG recommends that BUFC LTC continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.

BUFC LTC's Response:

The *Breast Cancer Screening* PIP workgroup continues to meet at least quarterly, bringing together key leaders and data analysts to review outcomes, trends, and ongoing initiatives. These meetings enable subject matter experts to evaluate national best practices, root causes, and areas of disparity to better inform targeted improvement strategies. BUFC LTC applies the PDSA cycles to monitor interventions, assess outcomes, and ensure long-term sustainability.

Validation of Performance Improvement Projects - Breast Cancer Screening PIP

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: In BUFC LTC's ISCAT responses and supporting documentation, BUFC used multiple naming conventions for its database systems. **[Access]**

Recommendation: HSAG recommends that BUFC LTC identify one consistent naming convention for each relevant database system as part of reporting to help ensure clarity in references and mitigate potential confusion.

BUFC LTC's Response:

An ongoing initiative is in place to educate staff on the standardized naming convention to be used across all systems.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: BUFC LTC manually entered provider data updates from the AzAHP forms and provider rosters into the Provider Manager system. **[Access]**

Recommendation: Although BUFC LTC had quality assurance checks and validations in place, HSAG recommends that BUFC LTC explore options to automate data transfer from electronic versions of the AzAHP forms and rosters into the Provider Manager system.

BUFC LTC's Response:

An active initiative is underway to implement a new software solution. The implementation will be executed in phases over the course of 2026 and will encompass functionality for the automated ingestion of AzAHP forms and rosters data.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: HSAG identified concerns with BUFC LTC's network adequacy indicator reporting processes regarding the lack of data checks conducted on the member data extracts used for network adequacy indicator calculation sent to the provider network management vendor and the minimal data checks conducted on the provider data extracts used for network adequacy indicator calculation sent to the provider network management vendor. **[Access]**

Network Adequacy Validation

Recommendation: HSAG recommends incorporating additional oversight through data reasonability checks and data quality checks. BUFC LTC may be able to mitigate the downstream impact of incorrect identification of member populations, provider classifications, and the results of network adequacy indicator calculation that would allow for better trending/comparison for additional oversight and monitoring activities. This would allow BUFC LTC to better identify gaps and monitor changes to members' access in its service areas.

BUFC LTC's Response:

BUFC LTC will incorporate additional oversight measures through enhanced data reasonableness and quality checks. These improvements will help mitigate potential inaccuracies related to members' identification, provider classification, and network adequacy indicator calculations. The updated process will include additional validation steps to support accurate trending, comparison, and monitoring activities. Membership data will continue to be retrieved directly from the source system, and once received by the IT team, data reasonableness checks will be performed to assess consistency and identify any anomalies. Any discrepancies identified will be promptly addressed in collaboration with the IT team to ensure risks are mitigated in a timely and effective manner.

HSAG Assessment:



Mercy Care LTC

Performance Measure Validation

Opportunity for Improvement: While Mercy Care LTC was successful in reporting valid rates for all AHCCCS-required performance measures, the audit review identified some considerations and recommendations for future years' reporting. [Quality]

Recommendations:

- HSAG recommends that Mercy Care LTC continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes AHCCCS' requirements for MCO-enrolled members who switch product lines or MCOs and members for whom Mercy Care LTC does not hold the primary insurance contract.
- HSAG recommends that Mercy Care LTC continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES.

Mercy Care LTC's Response:

Historically, Mercy Care LTC has followed the NCQA HEDIS guidelines regarding continuous enrollment, which varied from the AHCCCS guidance. However, AHCCCS has announced that for

Performance Measure Validation

MY2023 forward, AHCCCS will require plans to follow the NCQA HEDIS guidelines. As a result, Mercy Care LTC is in compliance with the current requirements. The National Medicaid Quality Data team ensures that necessary source code changes are made by the software vendor with the release of any changes to event data, and rates are reviewed monthly. Any anomalies, discrepancies, or outliers that are found are reviewed, researched, and tested thoroughly before any data are reported to regulatory bodies. Additionally, monthly event checks using vendor resources as compared to any technical specifications to ensure that the vendor is accurately capturing the right reporting elements for all core and non-core activities, as well as higher monitoring of internal back-end system integrations to ensure that all data elements are within scope to be captured for reporting.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Preventive Screening measure group, Mercy Care LTC's performance measure rates for *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* fell below the 25th percentile, indicating that not all women were receiving timely screening for breast or cervical cancer. **[Quality]**

Recommendations:

- HSAG recommends that Mercy Care LTC identify disparities or SDOH within the plan's populations that contributed to breast cancer and cervical cancer screening rates. Upon identification of a root cause, HSAG recommends that Mercy Care LTC implement appropriate interventions to reduce barriers to care.
- HSAG recommends that Mercy Care LTC provide scheduled reminders, messages directly from providers, and utilize personalized outreach for overdue patients. Communication messages should be clear and concise and include information on the procedure time. Some of these interventions might include a mobile clinic to conduct the screening, transportation assistance, and adjusting hours for visits to accommodate those with job/childcare concerns.

Mercy Care LTC's Response:

Mercy Care LTC continued the interventions that were reported in 2023, after completion of a root cause analysis, and also developed and implemented additional interventions to further drive improvement.

Subjective analysis regarding the *Breast Cancer Screening* measure demonstrates that factors which may impact compliance with mammograms include:

- Incomplete data due to inclusion of members with other primary insurance—Those claims may not be sent to Mercy Care LTC as they are paid by the member's primary insurance.

Performance Measures

- SDOH: Low income and lack of socioeconomic resources appear as common barriers to adherence as well as being a foreigner, transportation issues, and unemployment.
- Member postponement of many non “essential” health services.
- Limited provider resources to reach out to members to schedule appointments or to those who cancel appointments and assist them with rescheduling as soon as possible.
- Member fear of pain or discomfort with the procedure.
- Member may have loss of work or reduced work hours due to a mammogram appointment.

Enhanced interventions include:

- Offer additional provider education for those areas identified as under utilizers and work with those providers to discuss how we can help utilize a mobile mammogram program to reach their members and promote our incentive program for breast cancer screenings.
- Partner with Mercy Care LTC VBS providers to provide standard supplemental data feeds to improve data capture.
- Mercy Care Health Assistant Application—Member web portal to provide educational information regarding gaps in care along with digital and written member outreach.
- Increased/improved member incentive.
- Pursue hosting a Mercy Care LTC sponsored health fair where individuals can receive a mobile mammogram.
- Women’s Wellness Prevention Flyer provides members with information on women’s wellness exams, CCS, and BCS.

Existing interventions:

- Educational outreach to female members ages 40–74 to encourage well-woman exams and mammograms (BCS).
- Educational materials on the importance of CCS and menopause.
- Providers are notified via mail of members who are due for a mammogram. They are given an order form to sign and send to us. We then contact the members and assist with scheduling a mammogram and submitting the order form.
- Providing education to providers on the importance of HPV vaccines, cervical cancer screening, and sexually transmitted infection (STI) screening.
- Outreach staff contact members who still have not had a mammogram to assist with scheduling an appointment.
- Incentive letter mailed to members who still need a mammogram, once they receive a mammogram and the facility signs the form, the member can submit to us for gift card if met before deadline.
- Provider outreach educating on breast cancer screening guidelines and provide them with a list of members in need of mammogram.

Performance Measures

- Text messaging, email, and IVR outreach to close gaps in care to members with MCA.
- Content that is specific to mammogram disparities was included in provider newsletters and the Mercy Care Provider Conference.
- This topic was reviewed at the ALTCS Member Council to obtain member feedback to address disparities.
- Improved communication to the ALTCS case management team and members about the availability of incentives for mammograms.
- Offer additional provider education for those areas identified as under utilizers and work with those providers to discuss how we can help utilize a mobile mammogram program to reach their members and promote our incentive program for breast cancer screenings.
- Partner with a radiology group to outreach members specifically assigned to these providers.
- Addition of BCS measure to value-based programs.
- Collaboration with a health care organization by providing targeted gap lists of members in need of mammography screening.
- Collection of non-standard supplemental data, particularly for members with other primary coverage, to close gaps in data.
- Improve value-based program incentives to include the *BCS* measure in the VBS contract for Mercy Care LTC's largest ALTCS PCP.
- Pay for Quality (P4Q) program for smaller ALTCS providers and Skilled Nursing Facilities who close gaps in care for members who are in need of a mammogram.
- Partner with Mercy Care LTC VBS providers to provide standard supplemental data feeds to improve data capture.
- Member web portal to provide educational information regarding gaps in care along with digital and written member outreach.

Mercy Care LTC will continue to monitor the plan's performance with this measure through the additional phases of the PDSA cycle and modify existing interventions or implement additional interventions as necessary.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Behavioral Health measure group, Mercy Care LTC's performance measure rate for *Use of Opioids at High Dosage (18+ Years)* fell below the 25th percentile. This result provides an opportunity for Mercy Care LTC to monitor prescribing and utilization data and to implement interventions to improve care and services around opioid prescribing. [Quality]

Performance Measures

Recommendations:

- HSAG recommends that Mercy Care LTC follow the CDC guidelines on opioid prescribing for chronic, nonmalignant pain, which recommend the use of “additional precautions” when prescribing dosages ≥ 50 MED and that providers avoid or “carefully justify” increasing dosages ≥ 90 mg MED.¹⁹⁵
- The opioid dosage assessed in this measure is a reference point for health plans to identify members who may be at high risk for opioid overuse and misuse. HSAG recommends outreach to members who fall within this category to assess and schedule interventions as necessary.¹⁹⁶
- HSAG also recommends that Mercy Care LTC identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts.

Mercy Care LTC's Response:

As a result of this analysis, Mercy Care LTC developed the following interventions aimed at reducing the number and percentage of members who are prescribed high dose opioids:

- Pharmacy Risk Prevention Report including members at risk for adherence non-compliance and gap in care data (measures: *AMM*, *HDO*, *SAA*, *SPD*, *SPC*, *SSD*, and *UOP*).
- Opioid/SUD Best Practices Presentation to Mercy Care LTC VBS providers by Mercy Care Associate Chief Medical Officer.
- Educational Outreach Program (EOP) with provider fax including targeted member information for providers identified as having members on > 90 MME. This also includes an opioid prescriber report card.
- Telephonic one-on-one provider outreach to the top 10 high MME prescribers.
- SMS (PBM program): This program targets high-risk drug classes, focusing on controlled substances, and inappropriate use and misuse related indicators such as poly-pharmacy, provider shopping, and high-total controlled substance claims volume. On a quarterly basis, clinical pharmacists will evaluate controlled substance claims and any available supporting medical data to identify potential medication misuse and inappropriate claims for appropriate intervention. During subsequent quarters, pharmacists conduct follow-up activities utilizing physician responses and current claim activity. Situations identified as being potentially inappropriate may be referred to the client (plan) for further action.
- Creation and distribution of a report of members who are utilizing 50-89 MME for provider awareness and intervention prior to the member reaching 90 MME.
- Mercy Care Associate Chief Medical Officer outreach to prescribing providers of members who are in the HDO measure numerator.

¹⁹⁵ National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/use-of-opioids-at-high-dosage-hdo/>. Accessed on: Feb 10, 2026.

¹⁹⁶ Ibid.

Performance Measures

- Mercy Care LTC case managers will outreach members in the HDO measure for care coordination.

Mercy Care LTC will continue to monitor the plan's performance with this measure through the additional phases of the PDSA cycle and modify existing interventions or implement additional interventions as necessary.

HSAG Assessment:



Validation of Performance Improvement Projects—*Breast Cancer Screening* PIP

Opportunity for Improvement: HSAG identified no opportunities for improvement related to the *Breast Cancer Screening* PIP.

Recommendation: Although there were no opportunities for improvement identified, as the PIP progresses, HSAG recommends that Mercy Care LTC continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.

Mercy Care LTC's Response:

Mercy Care LTC continues to review the PIP rates at least quarterly, with an annual final measurement year evaluation once the data are finalized. When the health plan identifies declines in performance, or that the rates are not on track to reach the defined goal, we initiate or follow to the next step in the PDSA cycle. Interventions are assessed for effectiveness, and best practices are identified, documented, and incorporated into the health plan's standard operating procedures.

HSAG Assessment:



Compliance Reviews

Opportunity for Improvement: Mercy Care LTC has a remaining CAP in the Quality Management (QM) focus area.

Recommendation: HSAG recommends that Mercy Care LTC continue to work on the outstanding CAP item and submit updates to AHCCCS in the approved time frame, as applicable.

Mercy Care LTC's Response:

The CAP was closed on January 29, 2025. The following activities were completed to address AHCCCS findings and ensure compliance:

1. Root Cause Analysis (RCA):

Compliance Reviews

- Mercy Care LTC QM collaborated with Grievance and Appeals (G&A) to conduct an RCA regarding delayed reporting of potential quality of care (PQoC) concerns.
- 2. **Policy and Procedure Updates:**
 - All relevant policies, procedures, and desktops were reviewed and updated to align with AHCCCS contract and AMPM policies 960 and 961.
 - Definitions were standardized across all documents.
- 3. **Training Initiatives:**
 - Training provided to G&A and QM teams on timely submission of PQoC concerns.
 - QOC staff trained on provider notification, incident submission, and addressing provider non-compliance.
 - Additional training on abuse, neglect, and exploitation reporting for all allegations.
- 4. **Quality Assurance Measures:**
 - Interrater reliability process completed to ensure consistency in incident referral and submission.
 - Examples of standardized processes provided.
- 5. **Member Communication Enhancements:**
 - Updated member letter templates to clearly reflect Mercy Care LTC QM Department authorship.
 - Established a dedicated telephone line for members to contact QM directly regarding QOC concerns.
- 6. **Tools and Resources:**
 - Developed desktop/guideline/assessment tools for direct interviews with members, care staff, and witnesses.
 - Updated QM Portal per AMPM policies and communicated changes to AHCCCS QM.
- 7. **Case File Re-Review:**
 - Re-reviewed requested case files to address AHCCCS findings on provider late or non-reporting.
 - Ensured corrective actions for providers as necessary.
- 8. **Communication to AHCCCS:**
 - Submitted notification via QM Portal regarding re-review completion and amendments.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: HSAG identified an opportunity for Mercy Care LTC to improve the results to calculate time/distance indicators. [Access]

Network Adequacy Validation

Recommendation: HSAG recommends that Mercy Care LTC incorporate additional oversight and monitoring when transferring results to the ACOM Policy 436 template to ensure the most accurate results are being submitted to AHCCCS.

Mercy Care LTC's Response:

Mercy Care LTC made updates to the internal reporting based on the results of the HSAG NAV audit in 2024. Mercy Care LTC's ACOM 436 reporting matches the data provided in the PAT report and should subsequently reduce mismatches that were previously observed and noted.

HSAG Assessment:



UHCCP LTC

Performance Measures

Opportunity for Improvement: In the Preventive Screening measure group, UHCCP LTC's performance measure rates for *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* fell below the 25th percentile, indicating that women were not always receiving timely screening for breast and cervical cancer. Early detection reduces the risk of dying from cancer and can lead to a greater range of treatment options and lower healthcare costs. **[Quality]**

Recommendations:

- HSAG recommends that UHCCP LTC identify disparities or SDOH within the plan's populations that contributed to breast cancer and cervical cancer screening rates.
- Upon identification of a root cause, HSAG recommends that UHCCP LTC implement appropriate interventions to reduce barriers to care.
- Further, HSAG recommends that UHCCP LTC provide scheduled reminders, messages directly from providers, and utilize personalized outreach for overdue patients. Communication messages should be clear and concise and include information on the procedure time. Some of these interventions might include a mobile clinic to conduct the screening, transportation assistance, and adjusting hours for visits to accommodate those with job/childcare concerns.

UHCCP LTC's Response:

In the early fourth quarter of 2025, UHCCP LTC completed an analysis for health disparities within the Long Term Care (LTC) population for *BCS* and *CCS*. The analysis had member data for subpopulations including ethnicity, race, and language. An additional analysis was performed for the LTC member's residence, as defined by placement type.

Performance Measures

The health disparity analysis results for the LTC members in Measurement Year 2024 with the *BCS* performance measure are below.

The analysis of race for members in the *BCS* denominator demonstrated that the White subpopulation had the lowest compliance rate with 35.3 percent. The subpopulation by race with the highest rate for compliance for *BCS* was the Unknown Race with 43.0 percent. The American Indian or Alaska Native had a compliance rate of 42.1 percent, and Black or African American also had a compliance rate of 42.1 percent.

The analysis for Ethnicity displayed the Hispanic or Latina subpopulation had the highest *BCS* compliance rate of 81.3 percent for members in the *BCS* denominator. The Not Hispanic or Latina subpopulation had the lowest *BCS* rate with 39.2 percent of members that demonstrated compliance. The analysis by Language showed the subpopulation with the highest rate of compliance was Spanish speaking with a rate of 85.0 percent. The lowest compliance was the subpopulation with the language of English with a rate of 38.8 percent for members in the *BCS* denominator.

An additional review was to determine if the placement type, the residence of the LTC member, may have a disparity with Measurement Year 2024 Breast Cancer Screening compliance. The December 2024 member-level detail report for LTC members was used to determine the member's residence during 2024 calendar year end. The LTC members in the *BCS* denominator were cross-referenced with the report to identify the placement type. 54.2 percent of LTC members in the *BCS* denominator resided in the Home and Community-based setting. 22.2 percent of LTC members in the *BCS* denominator were found to reside in a Nursing Home, and 22.1 percent of LTC members in the denominator resided in an Assisted Living Facility. As far as compliance, the LTC members in the Home and Community-based setting had a *BCS* compliance rate of 53.7 percent. LTC members that resided in a Nursing Home had a compliance rate of 19.1 percent, and LTC members that resided in an Assisted Living Facility had a compliance rate of 27.9 percent. The Home and Community-based setting had a significantly higher compliance rate for *BCS* than members that resided in either a Nursing Home or Assisted Living Facility. The residents in the Nursing Home setting had the lowest compliance for *BCS*, and the root cause analysis includes barriers of potential advanced illness and frailty, fear, or difficulty setting up an appointment.

Interventions are in place to reduce barriers in care for *BCS* for LTC members.

- UHCCP LTC has been working on cobranded letters to remind members of the importance of completing breast cancer screening, and to encourage them to get the screening completed. The letters were mailed in October 2025. UHCCP LTC will continue to collaborate with a partner for additional resources to provide to LTC members and providers.
- Case Management representatives attend the Breast Cancer Screening workgroup. In the third quarter of 2025, an article was placed in the case management newsletter to inform Case Managers to remind their assigned members of the importance of breast cancer screening and eligibility for a Member Reward, gift card, if completed by December 31. Six hundred and

Performance Measures

twenty-five LTC members are eligible for a Member Reward in 2025. Letters were mailed to members in July. In 2026, UHCCP LTC will perform a final post-analysis to see how many gift cards were redeemed.

- In quarter three 2025, the Case Managers were informed of the flyer “Right to Know” from the CDC, English and Spanish versions, to share with their assigned LTC members. The article addresses common challenges that women with disabilities may face. It provides detailed information of what to expect when getting a mammogram. This intervention would include members residing in a Nursing Home or Assisted Living Facility.
- A Women’s Health email campaign for UHCCP LTC members with care opportunities was initiated in quarter three 2025. The Breast Cancer Screening emails target members still in need of getting a mammogram.

The health disparity analysis results for the LTC members in Measurement Year 2024 with the CCS performance measure are below.

For the analysis of Race, it was found that the American Indian and Alaska Native subpopulation had the lowest compliance rate of 19.2 percent for CCS completion. The population with the largest CCS compliance rate was the Unknown subpopulation with 36.3 percent compliance. The White population had a compliance rate of 26.3 percent.

With the analysis for Ethnicity, there was a similar rate for the two subpopulations. The Not Hispanic or Latina subpopulation had a compliance rate of 31.2 percent. The subpopulation of Hispanic or Latina had a compliance rate of 33.3 percent. With the analysis for Language, the subpopulation who indicated Spanish as a language had the largest compliance rate of 41.2 percent. The subpopulation for English as a language had a compliance rate of 31.1 percent.

An additional review was performed to see if the placement type, the residence of the LTC member, may have a disparity with Measurement Year 2024 CCS compliance. The member level detail report for LTC member placement type in December 2024 was used to determine the member’s residence at the time of calendar year end. For the members in the CCS denominator, compliance was cross-referenced with the placement type for the LTC members. 59.6 percent of the members in the CCS performance measure denominator resided in the Home and Community-based setting. 20.1 percent of the LTC members in the CCS performance measure denominator resided in a Nursing Home, and 17.6 percent of members in the CCS denominator displayed a placement type of Assisted Living Facility. For the compliance rates, the LTC members that resided in the Home and Community-based setting had a CCS compliance rate of 36.7 percent. The compliance rate for LTC members in an Assisted Living Facility was 31.3 percent, and the compliance rate for LTC members in a Nursing Home was 14.5 percent. The members that resided in a Nursing Home in December 2024 had a significantly lower CCS compliance rate than the members that lived in the Home and Community-based setting or an Assisted Living Facility. The residents in the Nursing Home setting had the lowest compliance for CCS, and the root cause analysis includes barriers of fear, possible advanced illness and frailty, or difficulty setting up an appointment.

Performance Measures

Interventions are in place to reduce barriers in care for cervical cancer screening for LTC members.

- UHCCP LTC has been working on cobranding letters to remind members of the importance of completing cervical cancer screening, and to encourage them to get the screening completed. The letters were mailed in May 2025. UHCCP LTC will continue to collaborate with a partner for additional resources to share with LTC members and providers.
- Mailers will be sent to members to provide information for the option for HPV Self-Collection for cervical cancer screening. Letters will be sent in October or early November.
- UHCCP LTC CPCs have educated providers in quarter two about the HPV self-collection guidelines and sending the specimens for processing.
- A provider bulletin was created in quarter three 2025 to provide information regarding the new option of HPV self-collection to complete cervical cancer screening. This will remain on the uhcprovider.com site.
- A Women's Health email campaign for UHCCP LTC members with care opportunities was initiated in quarter three 2025. Emails regarding cervical cancer screening targets members that have an open care opportunity.

UHCCP LTC CPCs meet with provider groups and ACOs monthly. Some provider groups have indicated to the CPCs that there is a process in place for direct messaging to their assigned members to inform them of a preventative care need, to include breast cancer screening and cervical cancer screening. Reminder text messages have become more widely used with provider groups as a form of communication to their patients. The messages include the details of the appointment and procedure time. Some larger provider groups have expanded their service hours to add Saturday screenings and radiology departments to extend work hours. Also, UHCCP LTC Case Managers assist their assigned LTC members with setting up transportation for the appointment.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Behavioral Health measure group, UHCCP LTC's performance measure rates for *Use of Opioids at High Dosage—18+ Years*, *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)*, and *Follow-Up After Hospitalization for Mental Illness 7-Day Follow-Up—Total (6+ Years)* fell below the 25th percentile. This result provides an opportunity for UHCCP LTC to monitor prescribing and utilization data and to implement interventions to improve care and services around opioid prescribing. [Quality]

Recommendations:

- Regarding the *Use of Opioids at High Dosage—18+ Years* measure, HSAG recommends that UHCCP LTC follow the CDC guidelines on opioid prescribing for chronic, nonmalignant pain,

Performance Measures

which recommend the use of “additional precautions” when prescribing dosages ≥ 50 MED and that providers avoid or “carefully justify” increasing dosages ≥ 90 mg MED.¹⁹⁷ The opioid dosage assessed in this measure is a reference point for health plans to identify members who may be at high risk for opioid overuse and misuse. HSAG recommends outreach to members who fall within this category to assess and schedule interventions as necessary.¹⁹⁸ HSAG also recommends that UHCCP LTC identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts.

- Regarding the *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Engagement of SUD Treatment—Total—Total (13+ Years) measure*, HSAG recommends UHCCP LTC review patient data for any patterns present by zip code and other demographics for case management prioritization.
- Regarding the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years) measure*, HSAG recommends that UHCCP LTC consider utilizing effective interventions to reduce repeat hospitalizations for people with mental illness, such as Critical Time Intervention (CTI), Assertive Community Treatment (ACT), case management, and focusing on co-occurring substance abuse disorders.

UHCCP LTC's Response:

- UHCCP LTC's response regarding the *Use of Opioids at High Dosage*: UHCCP LTC encourages providers to follow the CDC guidelines on opioid prescribing for chronic, nonmalignant pain, which recommends the use of “additional precautions” when prescribing dosages ≥ 50 MED and that providers avoid or “carefully justify” increasing dosages ≥ 90 mg MED. UHCCP LTC conducts provider outreach and education occurs through various platforms, including but not limited to: the UHCCP LTC Provider Manual, uhcprovider.com website, Network Bulletins, mailings, and direct outreach. Education includes directing prescribers to the current “CDC Guidelines for Prescribing Opioid for Chronic Pain,” “CDC Opioid Overdose Guidelines Resources,” as well as the “Arizona Department of Health Services Opioid Prescribing guidelines” web pages. Additionally, UHCCP LTC's retrospective DUR includes outreach to prescribers of opioid dosages of an MME of greater than 90, or those who are concurrently prescribed opioids and benzodiazepines, requesting that they assess the member's use of opioids and schedule additional interventions as necessary. UHCCP LTC also performs a review of opioid prescribing patterns prior to credentialing or recredentialing all providers.

UHCCP LTC conducts member outreach, in alignment with AMPM Chapter 310-FF Monitoring Controlled and Non-Controlled Medication Utilization, inclusive of an evaluation of prescription utilization by members, prescribing patterns by clinicians and dispensing by pharmacies to

¹⁹⁷ National Committee for Quality Assurance. Use of Opioids at High Dosage (HDO). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/use-of-opioids-at-high-dosage-hdo/>. Accessed on: Feb 10, 2026.

¹⁹⁸ Ibid.

Performance Measures

identify and screen high-risk members and providers. The program interventions include, but are not limited to: provider education, POS safety edits and quantity limits, care/case management, coordination with behavioral health or other specialists, and assignment of members to an exclusive pharmacy and/or single prescriber. UHCCP LTC's Lock-in Care Coordinator also conducts member outreach to ensure that they are connected with a provider and assesses for any additional needs that may require support from the health plan or a community program.

- UHCCP LTC's response to the *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Engagement of SUD Treatment—Total (IET-E)*:

In addition to the above efforts with opioid use, UHCCP LTC has started an Initiation and Engagement of Substance Use Disorder Treatment workgroup. Meetings started to take place in the third quarter to review and discuss potential interventions for LTC population. Attendees include Case Management staff, Behavioral Health staff, and members from the Quality department. A comprehensive analysis of members in the *IET-E* measure was performed. Findings for place of service for the initiation of treatment and the assigned providers with the most members in the measure have been reviewed. Keeping providers informed of their assigned members' substance use diagnosis and need for treatment is ideal, however these diagnoses with the 42 CFR Part 2 make it difficult for UHCCP LTC to currently share member details.

For *IET-E*, the Quality department and Case Management department reviewed the analysis for the Skilled Nursing Facilities (SNFs) or Assisted Living Facilities (ALFs) with the largest number of members that are current residents and are in the *IET-E* denominator. UHCCP LTC is currently continuing to analyze the data and claims. There will be continued collaboration with Case Management to review the members residing in the top facilities and to see if there are providers we can educate on remission codes.

UHCCP LTC's response for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (FUH-7)*:

UHCCP LTC utilizes the Practice Assist portal for quality measures and admissions, discharges, and transfers. Providers that have opted in to using the portal can utilize it to identify admissions, discharges, and transfers in addition to open care opportunities. When it is a mental illness, there is a barrier in which the diagnosis is not always displayed. The ACOs, in collaboration with UHCCP LTC, use another clinical tool to track daily discharges from hospitals. There is also a daily Behavioral Health discharge report that the Clinical Transformation Consultants share with ACOs, which would flag the members with a mental illness in most cases. The report may be useful for Case Management, to identify if a member is assigned to a case manager. However, the report data may be delayed if the hospital or provider did not file the claim with UHCCP LTC timely.

The UHCCP LTC Behavioral Health team collaborates with inpatient facilities through meetings which often include many ancillary departments and leadership to address the barriers to successful aftercare. Provider follow-up for patients is reviewed and identifying ways to improve

Performance Measures

collaboration between the inpatient facility and the facility managing care is discussed. For 2025, there are incentive programs to seven behavioral health facilities which include the *FUH-7* measure if the target rate for care opportunities is met. And an email blast from the Behavioral Health team was sent January 2025 to providers to educate on follow-up after discharge with coordination of care, and the ability to facilitate virtual visits.

Member outreach is performed by the UHCCP LTC Behavioral Health team to ensure enrollees have a timely follow-up appointment and that they are aware of the details such as date and time and address. It is also a goal with the outreach to identify any barriers to access to care, such as transportation, food insecurity, or other SDOH. The focus is to address the barriers and to reduce readmissions with aftercare with a patient-centered approach. The Behavioral Health team has reporting with diagnoses to see if there are co-occurring substance abuse disorders.

HSAG Assessment:



Validation of Performance Improvement Projects - *Breast Cancer Screening* PIP

Opportunity for Improvement: HSAG identified no opportunities for improvement related to the *Breast Cancer Screening* PIP.

Recommendation: Although there were no opportunities for improvement identified, as the PIP progresses, HSAG recommends that UHCCP LTC continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.

UHCCP LTC's Response:

The MY 2024 LTC *BCS* final rate was 39.1 percent, which was slightly lower than the PIP goal of a statistically significant improvement from baseline ($p = 0.0523$). The final rate was 5 percentage points better than the baseline rate of 34.1 percent and 2 percentage points better than the previous year's final rate of 37.1 percent. LTC *BCS* lowest compliance rates were found in the 71–74 age group in a recent analysis. There were 105 LTC members aged 71–74 years with open *BCS* care gaps. UHCCP LTC is evaluating and discussing further, including looking at their placement setting. One hypothesis is that many of these members may qualify for the Advanced Illness and Frailty exclusion but do not have documented claims with appropriate coding to remove them from the measure denominator.

The Long Term Care and the Performance Improvement Project work group continued all interventions into MY 2024 and completed effectiveness analysis with similar results as the previous year (MY 2023), as detailed in the annual PIP Report. UHCCP LTC also implemented two new interventions.

Validation of Performance Improvement Projects - Breast Cancer Screening PIP

UHCCP LTC is working to improve data exchange with provider groups, including the use of a payor platform. CPCs work diligently with provider groups to encourage providers to use the payor platform and ensure they are set up with the UnitedHealthcare network appropriately to ensure the best data exchange and closure of quality gaps. Additionally, provider challenges with Electronic Medical Record/Billing System to exchange data with UHCCP LTC and lacking processes for secondary claim submissions. For example, if a member's primary insurance is with another health plan, we may not receive a secondary claim submission from the provider, and therefore won't get gap closure, unless the provider with the other health plan is the same networked provider for UHCCP Medicaid, and we get the claim via data aggregators and supplemental data. Many providers do not submit secondary claims, especially for preventative care, in which there is no reimbursement. One solution UHCCP LTC implemented late 2024 was to allow for unstructured data to be manually input into Practice Assist to close gaps in care for selected providers and certain measures, including BCS. For MY 2024, there were 130 BCS records approved and entered into Practice Assist.

Another new intervention is the National Women's Health Email Campaign for both BCS and CCS members with gaps in care. The email contains valuable educational information, stresses the importance of cancer screenings, and calls members to action with information on how to schedule appointments or call and ask for help. The 2025 National Women's Health Email Campaign for BCS includes members 40 to 74 years of age with an open care opportunity. The campaign started in August with 2,365 emails sent and 729 emails opened for all lines of business. The emails will be sent to align with each member's age.

HSAG Assessment:



Compliance Reviews

Opportunity for Improvement: UHCCP LTC has remaining CAPs in the Case Management (CM) and Quality Management (QM) focus areas. **[Quality, Access]**

Recommendation: HSAG recommends that UHCCP LTC continue to work on the outstanding CAP items and submit updates to AHCCCS in the approved time frame, as applicable.

UHCCP LTC's Response:

AHCCCS has approved the contractor's proposed CAPs, and the contractor must submit evidence of compliance.

- Case Management (CM) [Quality, Access]

UHCCP LTC received a response from AHCCCS dated 10/7/2024 that stated that all CAPs are closed.

- Quality Management (QM) [Quality]

UHCCP LTC received a response from AHCCCS dated 10/7/2024 that stated that all CAPs are closed.

Compliance Reviews	
HSAG Assessment:	
Network Adequacy Validation	
Opportunities for Improvement: UHCCP LTC had a high level of compliance mismatch between its submitted results and HSAG's calculated results. [Access] HSAG identified an opportunity to improve the results to calculate time/distance indicators for UHCCP LTC. [Access] Recommendations: HSAG recommends that: - UHCCP continue to work with AHCCCS and HSAG to reduce the amount of compliance discrepancies. - UHCCP LTC incorporate additional oversight and monitoring when transferring results to the ACOM Policy 436 template to ensure the most accurate results are being submitted to AHCCCS.	
UHCCP LTC's Response: UHCCP LTC has reviewed the HSAG validation data and identified a discrepancy with the methodology used by UHCCP LTC and HSAG, specifically in regard to the member location used to complete the adequacy analysis. UHCCP LTC utilizes the members' residential addresses and allows provider network management software to pinpoint their physical locations, not the fiscal location documented in the members' AHCCCS files. This information has been shared with AHCCCS and was provided to HSAG on 03/10/25. UHCCP LTC will continue to monitor that data transferred onto the ACOM Policy 436 template and implement additional oversight to ensure the most accurate results are submitted.	
HSAG Assessment:	

ALTCS-DD Program Follow-Up on Prior Year's Recommendations

The table below presents recommendations made to the ALTCS-DD Program Contractor in the CYE 2024 Annual Technical Report¹⁹⁹ and the Contractor's follow-up to the recommendations, as well as an

¹⁹⁹ Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2024 External Quality Review Annual Technical Report*. Available at: <https://www.azahcccs.gov/Resources/Downloads/EQR/2024/CYE2024ExternalQualityReviewAnnualTechnicalReport.pdf>. Accessed on: Feb 10, 2026.

assessment of the degree to which the Contractor effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR-validated rates.

DES/DDD

Performance Measure Validation

Opportunity for Improvement: While DES/DDD was successful in reporting valid rates for all AHCCCS-required performance measures for its ALTCS-DD population, and HSAG did not identify specific opportunities for DES/DDD to improve RES, DES/DDD could benefit from continuing to focus on refining RES reporting where required in keeping with measure specifications. **[Quality]**

Recommendations:

- HSAG recommends that DES/DDD work with AHCCCS on collaborative efforts to improve the completion and accuracy of race/ethnicity data and explore other methods to augment enrollment data information.
- HSAG also recommends that DES/DDD explore other potential data sources for the capture of race/ethnicity data to support future performance measure reporting that may require stratification related to RES.
- To ensure data reporting accuracy, HSAG recommends that DES/DDD investigate conducting sample reviews on the subcontractor's reported rates prior to submission as a component of its ongoing quality review process, along with benchmark reviews of the individual subcontractor rates.

DES/DDD's Response:

The Division recently achieved the NCQA CM-LTSS accreditation and will continue continuous improvement efforts to identify opportunities and promote enhancements in data collection in the areas of race, ethnicity, and language accessibility. The Division continues to implement enhancements to capture data to improve program and service access for people of different races, ethnicities, geographic areas, different languages and address disparities in care. In 2024, the Division updated its database system to align with race/ethnicity categories from the United States' Office of Management and Budget. Additionally, all Arizona Native American tribes have been added as a subcategory when American Indian/Alaska Native is selected. The next phase of this project will focus on Division staff engaging with members and families to ensure this data field is accurately collected. The Division is leveraging a subcommittee as a mechanism to promote, evaluate and monitor initiatives to promote improvements in RES data collection.

As reported by UHCCP DD, there are multiple national initiatives being explored for additional data sources and strategies for race/ethnicity/language reporting. UHCCP DD is committed to only leveraging direct sources for RES reporting. While there are national initiatives being explored and vetted, currently UHCCP DD continues to leverage the 834-enrollment file as the source for RES

Performance Measure Validation

reporting. All sources and hierarchy need to be approved by UHCCP DD's national HEDIS® auditor. For member-reported changes, UHCCP DD completes the member demographics maintenance process with AHCCCS. AHCCCS will then verify the information UHCCP DD has with the member and update accordingly.

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Preventive Screening measure group, DES/DDD's performance measure rate for *Cervical Cancer Screening—21–64 Years* fell below the 25th percentile, suggesting that female members were not always receiving timely access to screening for cervical cancer. [Quality]

Recommendations:

- HSAG recommends that DES/DDD consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended cancer screenings and make appropriate health decisions.
- HSAG recommends that DES/DDD consider utilizing one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve cervical cancer screening rates. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness.
- HSAG recommends that DES/DDD provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge.
- HSAG recommends that DES/DDD work with its subcontracted health plans to analyze their data and consider if there are disparities within DES/DDD's populations that contributed to lower screening rates.

DES/DDD's Response:

The Division is continually assessing current processes and identifying opportunities to improve the collaboration and oversight of the subcontracted health plans. The Division is enhancing the reach of the Performance Improvement and Monitoring Subcommittee (PIM) in establishment of a dedicated subcontracted health plan workgroup(s); designed to initiate a focused discussion on development of interventions for performance measures not meeting performance expectations. The workgroups are scheduled to begin in early 2025 to include the Division's Behavioral Health Administrator, Maternal Child Health & EPSDT Coordinator, Cultural Competency Manager or designee, System and Practice Improvement Administrator, and other key Division staff as applicable.

UHCCP DD:

UHCCP DD implemented a CCS self-selected PIP which began collaborating in October 2024. A PIP report for each LOB was submitted July 2025. During MY 2025, as part of the PIP process, a health

Performance Measures

disparity analysis was completed, findings were identified, and interventions developed and implemented to address the disparities (details discussed in the DD CCS PIP report). In summary, the health disparity analysis identified several disparate sub-populations and opportunities in the DD CCS measure population:

- Evaluation of members by LOB revealed that DD members had the poorest (highest) CCS non-compliance rate (81.6%) in the UHCCP DD CCS measure population.
- Evaluation of members by LOB and ethnicity showed that the DD Hispanic or Latina members had the poorest compliance rate (85.4%), and this finding was statistically significant.
- Evaluation of members by LOB and race showed that DD American Indian/Alaskan Native (AI/AN) members had the poorest compliance rates, and this finding was statistically significant.
- Analysis by LOB and language identified the DD Spanish language category had the poorest rates (87.0% non-compliance; 194/223) compared to both AHCCCS Complete Care (ACC) Spanish non-compliance (48.1%; 2,823/5,875) and Long-Term Care (LTC) Spanish (50.0%; 10/20).

To address the identified health disparities in the DD population as discussed above, UHCCP DD developed and implemented several interventions during CYE 2025:

- Member outreach to DD Hispanic Spanish-speaking members with CCS care gaps. The QM team performs telephonic member outreach via live calls to educate and assist Hispanic Spanish-speaking members in understanding CCS and assist them in scheduling their appointment.
- Dedicated member outreach to AI/AN members with CCS care gaps. The UHCCP Tribal RN Coordinator assists members with dedicated and culturally sensitive and appropriate communications regarding CCS including finding root cause (why members haven't completed CCS), CCS education, and assistance scheduling their appointments.

Although this analysis did not identify significant health disparities in the Black or African American CCS measure population, UHCCP DD continues to send a postcard reminder (July) and a reminder letter (October) to Black or African American members with CCS care gaps to educate, encourage, and call them to action for CCS. This intervention was developed to address an identified health disparity in previous years. Effectiveness analysis will be completed in the first quarter of 2026 as the interventions are still in process.

Additional interventions implemented by UHCCP DD during CYE2025 include: Promotion of self-collection for HPV screening, which may be more comfortable and convenient for these members including creation and distribution of a provider bulletin regarding the new options for HPV self-collection to complete cervical cancer screening and distribution of member educational material to educate members about cervical cancer screening, including the new options for HPV self-collection. Partnership with ACOs and contracted providers to expand the current supplemental data processes and increase data capture of completed services. This will be an ongoing initiative with implementation for the first ACO to be completed by the end of 2025.

Performance Measures

Mercy Care DD:

In comparing the rate of cervical cancer screening rates in the DD population to that of the Mercy Care ACC population, the DD membership demonstrated a statistically lower rate of screening for DD members (24.3%) when compared to ACC members (54.3%).

Mercy Care DD implemented the following interventions to address the identified disparities:

- Member Incentives
- Collaboration with a health care organization
- Care Manager Outreach
- Member-facing web portal delivers personalized educational content related to care gaps. The platform also facilitates both digital and mailed outreach to engage members and encourages timely screenings.
- Provider Gaps-In-Care mailer
- MCH Coordinators conduct in-person or virtual site visits with provider with education of importance of CCS
- Provider outreach on CCS screening and guidelines along with list of members still in need of testing
- Member education utilizing educational videos on Mercy Care DD member website
- Women's Wellness Prevention Flyer education sent to members
- Staying Healthy Fall/Winter 2025 Member Newsletter with prevention and wellness on cervical cancer screenings and wellness exams
- Health Literacy Education available to Mercy Care DD Providers (2024)

HSAG Assessment:



Performance Measures

Opportunity for Improvement: In the Pediatric Health measure group, DES/DDD's performance measure rate for *Childhood Immunization Status—Combination 7* fell below the 25th percentile, suggesting that some children were not receiving these immunizations, which are a critical aspect of preventive care for children. **[Quality]**

Recommendations:

- HSAG continues to recommend that DES/DDD identify best practices to support children in receiving preventive vaccinations according to recommended schedules.
- HSAG recommends that DES/DDD provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.

Performance Measures

DES/DDD's Response:

In early 2025, the Division will establish a dedicated subcontracted health plan workgroup intended to improve collaboration promoting focused discussions on performance measure data and identification of population-specific disparities. Workgroups will have appropriate representation from internal and external stakeholders to identify interventions specifically designed for the DD population.

UHCCP DD:

UHCCP DD leveraged several QI tools such as literature research, cause-and-effect (Ishikawa) diagramming, and brainstorming to identify barriers to member receipt of the recommended childhood immunizations and identify opportunities for improvement. As shared by the AHCCCS during the April 15, 2025, MCO QI Workgroup meeting, there continue to be ongoing challenges with returning to pre-COVID-19 performance. Specific barriers that were shared include:

- Families think they cannot afford vaccines and/or may not understand insurance coverage
- Families unsure where to go and lack technology or skills to find resources
- Cultural barriers, including communities not “liking” the providers in town
- Lack of “appointment slots” (e.g., not enough providers, flexible office hours not available, long wait times, decreasing Vaccines for Children (VFC) providers)
- Challenging to make revenue stream for vaccines more profitable
- Workforce challenges (vaccine management duties displace other duties important to clinic)

Additional barriers may include but are not limited to: A renewed spread of misinformation on a link between vaccines and autism and related neurodevelopmental disorders; providers may be missing or have incomplete immunization data that can lead to inaccurate performance measurement; and providers may not follow immunization schedules or may fail to document administered vaccines.

UHCCP DD identified an opportunity for improvement to include implementation of targeted outreach calls to members who are 22 months and in need of only 1–2 more immunizations to become numerator compliant. Through these member outreach calls, which were initiated in the second quarter of 2025, UHCCP DD offers to assist the member's parent/guardian in scheduling an appointment to receive the remaining immunizations prior to their second birthday. UHCCP DD continues to provide additional member outreach and education through:

- Online toolkits, articles, resources, and webcasts.
- Omni-Channel member outreach program based on member preference: text, email, IVR.
- Live outreach calls to members with gaps in care for select measures at 4, 9, 12, and 24 months. During these calls, UHCCP DD reminds members of the service(s) that they are due for and provides assistance with appointment scheduling. They also address gaps in care for family members during the same call.
- Reminder mailers and emails to members due for preventive care services or screenings.

Performance Measures

- Live outreach calls program to members with gaps in care for select measures. During these calls, UHCCP DD reminds members of the service(s) that they are due for and provides assistance with appointment scheduling.

UHCCP DD also provides outreach and education to contracted providers through the following interventions:

- UHCCP DD CPC quality transformation efforts through targeted clinical education and approved materials related to EPSDT and HEDIS® or state-specific quality measures.
- Distribution of Patient Care Opportunity Reports (PCORs).
- Gaps in care report mailing to PCP groups not aligned with a CPC.
- Medical ACO Value Based Contracts (VBCs), which offer bonuses for meeting target rates for select measures.
- Release of the HEDIS measure quality reference guide on UHC website, which is reviewed and updated at least annually.
- Provider mailing which is sent to PCPs listing assigned members 13/14 months of age who have open gaps in care for the *CIS* measure.
- Newborn provider notification mailing.

UHCCP DD identified an opportunity for improvement to include implementation of targeted outreach calls to members who are 22 months and in need of only 1–2 more immunizations to become numerator compliant. Through these member outreach calls, which were initiated in the second quarter of 2025, UHCCP DD offers to assist the member's parent/guardian in scheduling an appointment to receive the remaining immunizations prior to their second birthday. UHCCP DD is also working in partnership with ACOs and contracted providers to expand the current supplemental data processes and increase data capture of completed services. This will be an ongoing initiative with implementation for the first ACO to be completed by the end of 2025.

Mercy Care DD:

Based on the findings of a 2023 root cause analysis, Mercy Care DD implemented targeted interventions designed to increase both the number and percentage of children receiving preventative vaccinations in accordance with recommended immunization schedules:

- HEDIS Gaps in Care Report for Providers—Comprehensive list of members who are due or overdue for preventive care services, including vaccinations.
- Ongoing efforts to enhance data sharing with ASIIS to obtain additional vaccine data. This information is integrated into the performance measurement tracking system to support continuous monitoring and improvement throughout the year.
- Member-facing web portal that delivers personalized educational content related to care gaps. The platform also facilitates both digital and mailed outreach to engage members and encourage timely immunizations.

Performance Measures

- Distribution of the latest AHCCCS Periodicity Schedule to Mercy Care DD Care Managers to reinforce awareness among caregivers regarding recommended well-child intervals and associated immunizations.
- Partnership and collaboration with pediatric providers to promote EPSDT “awareness.”
- Member incentives for completing EPSDT visits (0–14 months, up to 6 visits) and (15–30 months, up to 2 visits).
- Targeted outreach calls to parents/guardians/caregivers of 6, 9, 11 and 18-month-olds; includes scheduling support and immunization education.
- Written communication to parents/guardians/caregivers of 1-month-old members includes well-child visit magnets, immunization booklets, and mailing of CDC shot schedules to parents of 18-month-olds.
- Provider outreach mailings which include notifications to PCPs about members needing EPSDT visits, immunizations, developmental screenings, and dental care.
- Virtual provider engagement with EPSDT Coordinator hosts virtual sessions with providers to review immunization schedules and identify members needing services.

Childhood Immunization Status (Combo 3) MY2024 final rate: 64.6% (a 3.0%-point decrease over the 2023 rate 67.6%)

Childhood Immunization Status (Combo 7) MY2024 final rate: 28.05% (a 4.35%-point decrease over the 2023 rate 32.4%)

Childhood Immunization Status (Combo 10) MY2024 final rate: 17.07% (a 19.7%-point decline over the 2023 rate 36.8%)

HSAG Assessment:



Validation of Performance Improvement Projects - *Back to Basics* PIP

Opportunity for Improvement: DES/DDD deleted the subcontractor Mercy Care’s baseline data from this year’s submissions. The issue was identified in the initial submission and not corrected in the resubmission. [Quality]

Recommendations:

- HSAG recommends that DES/DDD seek technical assistance from HSAG to understand the requirements for the PIP submission.
- HSAG recommends that DES/DDD include baseline data for the subcontractor Mercy Care.

DES/DDD’s Response:

The Division’s PIM Committee is responsible for the oversight and monitoring of the PIP. PIP progress, data analysis, root causes, barriers, and other critical details are provided to committee members for additional insight and recommendations to help the projects reach their goals. The

Validation of Performance Improvement Projects - *Back to Basics* PIP

creation of the PIM Subcommittee workgroup added a venue for coordination with the subcontracted health plan(s) on their progress and a more focused review and analysis of PIP data. The Division reviewed previous submissions and have made the necessary updates, as requested by HSAG, and ensured the Mercy Care DD baseline data were added back into the PIP report and were included in the Division's July 2025 submission to AHCCCS.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: Isolated data issues may have contributed to specific instances affecting the DES/DDD subcontracted health plans' compliance with time/distance standards. [Access]

Recommendation: HSAG recommends that AHCCCS support the DES/DDD subcontracted health plans in continuing to monitor their processes for creating the PAT file and review this file for accuracy prior to submitting to AHCCCS.

DES/DDD's Response:

The Division will continue to partner with AHCCCS and subcontracted health plans to ensure there is an adequate network of providers able to serve the DD population.

UHCCP DD: UHCCP DD evaluates the contracted network quarterly via the quarterly PAT file monitoring and review process and conducts a review of the data utilized in analysis. UHCCP DD will continue to review the data used in UHCCP DD's adequacy reporting on a quarterly basis.

Mercy Care DD: Mercy Care DD supports the recommendation from HSAG and will work with the Division and AHCCCS. The process for creating the PAT file and reviewing for accuracy is built into Mercy Care DD's standard workflows. If there is specific detail around the areas in which the Division or AHCCCS is expecting to see improvement, we welcome feedback and will implement changes as necessary.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: Based on the NAV results, neither of the DES/DDD subcontracted health plans met the standards for Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult; and Dentist, Pediatric. [Access]

Network Adequacy Validation

Recommendation: HSAG recommends that AHCCCS support each DES/DDD subcontracted health plan in continuing to monitor and maintain its existing provider network coverage as of CYE 2024 S1, with specific attention to ensuring the availability of the following provider categories where both DES/DDD subcontracted health plans did not meet the network requirement:

- Behavioral Health Outpatient and Integrated Clinic, Adult in Apache County.
- Cardiologist, Adult in Apache County.
- Dentist, Pediatric in Apache, Gila, Greenlee, and La Paz counties.

DES/DDD's Response:

The Division will continue to partner with AHCCCS and subcontracted health plans to ensure there is an adequate network of providers able to serve the DD population.

UHCCP DD: UHCCP DD evaluates the contracted network quarterly via the quarterly PAT file monitoring and review process and conducts a review of the area and category that has underperformed. A thorough audit of the provider community is conducted and includes a review of any noncontracted providers, and new providers that enter the county. UHCCP DD will continue to monitor and review the PAT file for any opportunities to UHCCP DD's network quarterly.

Mercy Care DD: Mercy Care DD supports the recommendation from HSAG and will work with the Division and AHCCCS. The process for identifying and recruiting providers is built into Mercy Care DD's standard workflows. When there are no viable providers in known provider deserts, Mercy Care DD will continue to note this and work to request exemptions as necessary.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: HSAG identified an opportunity for Mercy Care DD to improve the results to calculate time/distance indicators. [Access]

Recommendation: HSAG recommends that Mercy Care DD incorporate additional oversight and monitoring when transferring results to the ACOM Policy 436 template to ensure the most accurate results are being submitted to AHCCCS.

DES/DDD's Response:

The Division will continue to partner with AHCCCS and subcontracted health plans to ensure there is an adequate network of providers able to serve the DD population.

Network Adequacy Validation

Mercy Care DD: Mercy Care DD made updates to the internal reporting based on the results of the HSAG NAV audit in 2024. Mercy Care DD's ACOM 436 reporting matches the data provided in the PAT report and should subsequently reduce mismatches that were previously observed/noted.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: Mercy Care DD had a high level of compliance mismatch between its submitted results and HSAG's calculated results. [Access]

Recommendation: HSAG recommends that Mercy Care DD continue to work with AHCCCS and HSAG to reduce the amount of compliance discrepancies.

DES/DDD's Response:

The Division will continue to partner with AHCCCS and subcontracted health plans to ensure there is an adequate network of providers able to serve the DD population.

Mercy Care DD: Mercy Care DD made updates to the internal reporting based on the results of the HSAG NAV audit in 2024. Mercy Care DD's ACOM 436 reporting matches the data provided in the PAT report and should subsequently reduce mismatches that were previously observed/noted.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: Mercy Care DD did not meet the minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult; and Dentist, Pediatric. [Access]

Recommendation: HSAG recommends that Mercy Care DD maintain current compliance with network standards and continue to address network gaps, as applicable.

DES/DDD's Response:

The Division will continue to partner with AHCCCS and subcontracted health plans to ensure there is an adequate network of providers able to serve the DD population.

Mercy Care DD: Mercy Care DD supports the recommendation from HSAG and will work with the Division and AHCCCS. Mitigating and closing gaps is built into the framework of Mercy Care DD's day-to-day operations. Where there are gaps in the network, there is also evidence of non-viability;

Network Adequacy Validation

there are no viable, registered providers in these counties who are not already contracted with Mercy Care DD. Gap mitigation through telehealth and mobile services are offered as alternatives. NEMT services are offered to members to ensure they are able to receive services from the closest provider available. When appropriate, out-of-network authorizations are issued to support gap mitigation.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: UHCCP DD had a high level of compliance mismatch between its submitted results and HSAG's calculated results. [Access]

Recommendation: HSAG recommends that UHCCP DD continue to work with AHCCCS and HSAG to reduce the amount of compliance discrepancies.

DES/DDD's Response:

The Division will continue to partner with AHCCCS and subcontracted health plans to ensure there is an adequate network of providers able to serve the DD population.

UHCCP DD: UHCCP DD has reviewed the HSAG validation data and identified discrepancy with the methodology used by UHCCP DD and HSAG, specifically regarding the member location used to complete the adequacy analysis. UHCCP DD utilizes the member's residential address and allows provider network management software to pinpoint their physical location, not the fiscal location documented in the member's AHCCCS file. This information has been shared with AHCCCS and was provided to HSAG on 03/10/25.

HSAG Assessment:



Network Adequacy Validation

Opportunity for Improvement: UHCCP DD did not meet the minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; BHRF; Cardiologist, Adult; Dentist, Pediatric; PCP, Adult and Pediatric; and Pharmacy. [Quality]

Recommendation: HSAG recommends that UHCCP DD maintain current compliance with network standards and continue to address network gaps, as applicable.

DES/DDD's Response:

The Division will continue to partner with AHCCCS and subcontracted health plans to ensure there is an adequate network of providers able to serve the DD population.

Network Adequacy Validation

UHCCP DD: UHCCP DD evaluates the contracted network quarterly via the quarterly PAT file monitoring and review process and conducts a review of the area and category that has underperformed. A thorough audit of the provider community is conducted and includes a review of any noncontracted providers, and new providers that enter the county. UHCCP DD will continue to monitor and review the PAT file for any opportunities to UHCCP DD's network quarterly.

HSAG Assessment:



Appendix A. Methodology

Appendix A. Methodology presents, for each EQR activity:

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

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

Validation of Performance Measures

Objectives

Conducted in alignment with the CMS EQR Protocol 2 cited earlier in this report, the primary objectives of the PMV process were to:

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

Technical Methods of Data Collection

The CMS EQR Protocol 2 identifies key types of data that should be reviewed as part of the validation process. The following list describes the types of data collected and how HSAG analyzed these data:

- **ISCAT:** Contractors completed and submitted an ISCAT to address data collection and reporting specifics of their performance measures. HSAG used the responses from the ISCAT to complete the pre-on-site assessment of information systems.
- **Source code (programming language) for performance measures:** Contractors calculated, or contracted with vendors to calculate, the non-HEDIS performance measures using source code and were required to submit the source code used to generate non-HEDIS performance measures being validated. HSAG completed a line-by-line review of the supplied source code to ensure compliance

with the measure specifications required by AHCCCS. If HEDIS Certified Measures^{SM, 200} vendors were used, HSAG reviewed a copy of the certified measures reports to confirm each measure's certification status. HSAG identified any areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any).

- **Medical record documentation:** Contractors submitted the following documentation for review: medical record hybrid tools and instructions, training materials for MRR staff, and policies and procedures outlining the processes for monitoring the accuracy of the reviews performed by the review staff.
- **Supporting documentation:** HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

Pre-Review Activities:

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

- **Define the scope of the validation:** HSAG worked with AHCCCS to identify the performance measures to be validated for each Contractor and to confirm all standardized measure specifications (e.g., sampling guidelines, eligible population criteria, and numerator and denominator identification). HSAG submitted final validated performance measure results in an agreed-upon, AHCCCS-approved Microsoft Excel workbook format. HSAG provided AHCCCS with each Contractor's program-specific rate reporting template and provided AHCCCS with a consolidated view of the final validated rates as well. HSAG used Contractor-to-Contractor comparisons; comparisons to CY 2024 rates, where applicable; and comparisons to national Medicaid benchmarks, as reasonability checks.
 - A rate was considered materially biased and received a *Do Not Report (DNR)* designation if any identified error or errors impacted the performance measure rate by more than 5 percentage points.
 - For hybrid measure reporting, each Contractor's sampling and oversampling methodology was required to align with the measure steward's hybrid reporting specifications. If the Contractor used an oversampling rate greater than 20 percent, HSAG required the Contractor to provide evidence of NCQA approval. HSAG did not accept an oversampling rate greater than the established NCQA standard without the Contractor providing its evidence of NCQA approval.
 - HSAG followed CMS EQR Protocol 2 in reviewing hybrid measures by conducting MRR validation of 30 records for at least two performance measures, across programs as applicable per Contractor, as selected by each Contractor's lead auditor.

²⁰⁰ HEDIS Certified MeasuresSM is a service mark of the NCQA.

- **Audit preparation:** HSAG confirmed the final scope of the audit with AHCCCS to ensure all written communication to the Contractors contained accurate information on the measures being reported. Upon obtaining AHCCCS' approval of the document request packet templates, HSAG prepared customized document request packets for each Contractor. The memorandum accompanying the packet provided details of the audit process and requirements, including:
 - The audit timeline.
 - Information about virtual review scheduling.
 - A list of all measures under the scope of the audit.
 - The ISCAT to complete and reference to appropriate use of the HEDIS4 Record of Administration, Data Management, and Processes (Roadmap).
 - Information on source code review, as well as MRRV and supplemental database review, as applicable.
 - Information on where and how to submit performance measure rates and required documentation.
 - Next steps and whom to contact for additional information.
- **Assess the integrity of the Contractor's information systems (IS):** As part of the ISCAT, HSAG received detailed information regarding all data systems that feed into collecting and reporting performance measures, including patient data, provider data, claims/encounter data, survey data, and data integration processes.

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

If a Contractor had a comprehensive, independent assessment of its IS during or after January 2024 as conducted during an NCQA HEDIS Compliance Audit, HSAG reviewed and assessed the Contractor's responses to NCQA's Roadmap and its associated attachments. Additionally, if the Contractor had not yet received NCQA Medicaid Health Plan Accreditation but was working through a certified HEDIS compliance auditor specific to its Arizona Medicaid rates, HSAG accepted and reviewed the HEDIS Roadmap responses as applicable to the Contractor's Medicaid product.

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

1. Ensure strict compliance with current technical specifications, regardless of source (e.g., HEDIS or CMS) and the accuracy of programming logic. The reviewer documented any noted deviation from the specifications and provided detailed feedback to the Contractor's programmer.
2. Identify and estimate the potential for bias that each deviation can introduce to the measure calculation.
3. Flag issues requiring corrections to code, further investigation, or fixes to the sample. The reviewer documented each issue clearly and initiated discussion with the Contractor to determine action steps for resolving the identified issues.

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

- **Medical record and Case Management Record review and Validation (MRRV/CMRRV):**
HSAG provided the Contractors with guidance through each step of the MRR and CMRR to ensure all obstacles that potentially impact hybrid reported rates were identified and corrected early in the audit process. HSAG's MRR team participated in each Contractor's kick-off call to discuss the MRR process and answer any of the Contractor's questions. HSAG did not request a convenience sample but conducted an over-read of approximately 30 records from two hybrid measures to ensure the accuracy of the medical record data abstracted by each Contractor. For ALTCS-DD and ALTCS-EPD contractors reporting LTSS measures, HSAG conducted an over-read of 16 cases across the case management measures. HSAG followed NCQA's guidelines to validate the integrity of the MRRV processes used by each Contractor and used the MRRV results to determine if the findings impacted the audit results for each performance measure rate. As part of the MRRV, the MRR team:
 - Reviewed and clarified all ISCAT responses (inclusive of the Roadmap, when applicable) pertaining to the Contractor's MRR process, including reviewer training and quality assurance, the medical record procurement approach, data integration with administrative data, and medical record vendor oversight.
 - Conducted a thorough review of the Contractor's selected data abstraction tools, functionality, and reviewer instructions.
 - Conducted a final over-read review of a sample of 30 records from two hybrid measures and all medical record exclusions, inclusive of cases across the Contractors' applicable programs (when applicable), to ensure the accuracy of the medical record data abstracted.
 - Conducted a final over-read review of a sample of 16 cases across case management measures, if applicable for an MCO
 - Identified errors and determined if they were critical or noncritical based on the following definitions:
 - **Critical error:** Any finding that changed the compliance of a measure from numerator positive to numerator negative impacting the overall rate.

- **Non-critical error:** Any finding that did not change the overall compliance of the member and resulted in no change to the overall rate; e.g., data entry errors, lab result date collected versus read by MD.
- If errors were identified, a Contractor could be required to provide additional records for review, based on the auditor's request. Samples with errors equal to or exceeding 10 percent were determined to be materially biased, and HSAG reported the results to AHCCCS to consider adjusting the Contractor's reporting from hybrid to administrative in such instances. Error rates less than 10 percent were evaluated for overall rate impact, and hybrid data collection would be allowed if the rate was not materially biased, based on an impact analysis.
- **Prepare for the Contractor virtual audit:** HSAG worked with each Contractor to identify a date for the virtual audit so that all appropriate Contractor staff could be present. Once the audit schedule was finalized, HSAG sent it to AHCCCS and coordinated for AHCCCS staff to observe audits based on AHCCCS' request. HSAG produced a detailed agenda for the virtual audit and worked with each Contractor to ensure the agenda timeline included appropriate staff in the sessions for which they are responsible. Before the date of the virtual audit, HSAG sent the agenda to the Contractor and to AHCCCS, if applicable.
 - Before the virtual audit, HSAG scheduled and facilitated a kick-off call with each Contractor to:
 - Discuss the audit logistics, including virtual review hosting preferences (i.e., Contractor or HSAG), key Contractor attendees, and potential vendor and/or subcontractor attendance if applicable.
 - Review the draft agenda.
 - Discuss any changes in the Contractor's processes or systems since the previous year's PMV audit.
 - Discuss the MRR/CMRR process and timeline.
 - Discuss the timelines for ISCAT submission, use of the HEDIS Roadmap, identification of supplemental data, administrative rate review, preliminary rate review, and performance measure rate submission.
 - Remind the Contractor of the scope of the audit, including measures and primary source verification (PSV) processes.
 - Discuss supplemental databases.
 - Confirm the Contractor's vendor for certified measures, if applicable.
 - Address any Contractor questions or concerns.

Virtual Audit Review Activities:

HSAG conducted a virtual review with each Contractor. HSAG collected information using several methods, including interviews, system demonstration, review of data output files, PSV, observation of data processing, and review of data reports. The virtual review activities are described as follows:

- **Opening remarks:** At the start of the virtual audit, HSAG facilitates introductions of the audit team and the key MCO staff members involved in the performance measure calculation or reporting.

HSAG provides an overview of the audit objectives and process, allowing time for the MCO to present an overview of its structure and processes, and review the agenda.

- **Review Information Systems Underlying Performance Measurement**—This session is designed to be interactive with key MCO staff members so the audit team can obtain a complete picture of all steps taken to generate responses to the ISCAT and evaluate the degree of compliance with written documentation. HSAG uses structured staff interviews and system demonstrations to assess receipt, management, storage, and reporting of data through the examination of key information systems, including service data (e.g., claims/encounters, prior authorization) and eligibility/enrollment, provider, and ancillary data sources (e.g., prior authorization, laboratory, pharmacy)—specifically, discussions with staff members target overall system infrastructure and configuration, data security, data management processes, and quality assurance protocols while system demonstrations were used to confirm the accuracy of data collection efforts. Additionally, HSAG will request MCO staff members provide information about performance measure-based provider incentive programs and oversight.
- **Review Data Integration and Control for Performance Measure Calculation**—The goal of this session is to determine how the MCO extracts and integrates data sources and produces the analytic file necessary to calculate and report the selected performance measures. HSAG interviews MCO staff members regarding software products they use during data integration, analytic file production, sampling, medical record review and abstraction (if applicable), and measure computation. The HSAG auditor discusses the processes to collect, store, validate, and report performance measure data; clarifies outstanding issues; and ascertains that the MCO uses and follows written policies and procedures in daily practice. Additionally, if medical records are used to calculate a performance measure, HSAG assesses the sampling methodology the MCO applied. The auditor also asks the MCO to demonstrate key analytic systems and reporting software in order to observe the systems and data directly.
- **Review Performance Measure Production**—The virtual audit evaluates the processes the MCO uses to produce the performance measures, including accurate numerator and denominator identification and algorithmic compliance. The auditor uses interviews, primary source verification, and observation to examine the data collection, calculation, and reporting processes. HSAG evaluates the MCO's ability to report performance measures to AHCCCS using appropriate reporting tools.
- **Primary source verification:** HSAG performed a detailed review of the measures through PSV to validate performance measure output data. PSV is a review technique used to confirm that information from the primary source matches the output information used for reporting. With this technique, HSAG assessed the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected at least five cases across a minimum of two measures, including members from all MCO lines of business as applicable, to verify that the MCOs have system documentation to support the records included in measure reporting. This review targeted specific components in the measure specifications needed to correctly identify the eligible population, applicable exclusions, the denominator, numerators, and measure stratification.

- **Closing conference:** At the end of the virtual audit, HSAG conducted a summation conference with key MCO staff members, during which the auditor summarized preliminary findings and outlined the documentation and/or corrective actions that were requested to occur post-virtual audit.

Table A-1 provides a general timeline of the PMV activities and milestones during CYE 2025.

Table A-1—CYE 2025 PMV Activities

PMV Activities and Milestones	Dates
HSAG conducts PMV introductory kick-off call with MCOs.	06/11/2025
HSAG finalizes virtual site review dates with MCOs.	07/22/2025
HSAG conducts MRRV/CMRRV technical assistance call with MCOs.	07/14/2025
MCOs submit completed document request packet, including ISCAT, source code, MRRV Attachment 1: Final Summary of Medical Record/Case Management Record Abstraction Counts and preliminary performance measure rates, if available, to HSAG.	08/14/2025
HSAG conducts desk review and source code review.	08/14/2025-09/12/2025
HSAG conducts virtual site reviews with each MCO.	08/27/2025-09/05/2025
MCOs submit final performance measure rate reporting templates to HSAG.	09/19/2025
HSAG submits final (F1) PMV reports with final performance measure rates for each LOB/MCO to AHCCCS and MCOs.	04/01/2026

Description of Data Obtained

As identified in the CMS EQR Protocol 2, HSAG obtained and reviewed the following key types of data for CY 2024 as part of the PMV:

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

5. **Virtual interviews and demonstrations:** HSAG obtained information through interaction, discussion, and formal interviews with key Contractor staff as well as through system demonstrations.

How Data Were Aggregated and Analyzed

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

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

How Conclusions Were Drawn

Information Systems Standards Review

Contractors were required to demonstrate compliance with IS standards. Contractors' compliance with IS standards is linked to the validity and reliability of reported performance measure data. HSAG reviewed and evaluated all data sources to determine Contractor compliance with *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*.²⁰¹ The IS standards are as follows:

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

²⁰¹ National Committee for Quality Assurance. HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5. Washington D.C.

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

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

Based on all validation activities, HSAG determined results for each performance measure. According to the CMS EQR Protocol 2, the validation designation for each performance measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be noncompliant based on the review findings. Consequently, an error for a single audit element may result in a designation of *DNR* because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, leading to a designation of *R*.

Any suggested corrective action that was closely related to accurate rate reporting that could not be implemented in time to produce validated results rendered a particular measure as *DNR*.

Performance Measure Results

Each Contractor's performance measure results for CY 2024 were compared to program-level aggregate rates, prior year's Contractor-specific performance, and NCQA's Quality Compass national Medicaid HMO mean for CY 2024, where applicable.

To draw conclusions about the quality and timeliness of, and access to care and services provided by the Contractors, HSAG assigned each of the performance measures to one or more of the three domains of care (i.e., Quality, Timeliness, and Access). This assignment to domains of care is depicted in Table A-2.

Table A-2—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains

Performance Measure	Quality	Timeliness	Access
Maternal and Perinatal Care			
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	✓	✓	✓
<i>Prenatal and Postpartum Care—Postpartum Care</i>	✓	✓	✓
Behavioral Health			
<i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia</i>	✓		
<i>Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment</i>	✓		

Performance Measure	Quality	Timeliness	Access
<i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication</i>	✓		
<i>Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total and 30-Day Follow-Up—Total</i>	✓	✓	✓
<i>Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total</i>	✓	✓	✓
<i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total</i>	✓	✓	✓
<i>Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and Continuation and Maintenance Phase</i>	✓	✓	✓
<i>Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total and Engagement of SUD Treatment—Total—Total</i>	✓	✓	✓
<i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</i>	✓		
<i>Use of Opioids at High Dosage</i>	✓		
Care of Acute and Chronic Conditions			
<i>Controlling High Blood Pressure</i>	✓		
<i>Glycemic Status Assessment for Patients With Diabetes Glycemic Status <8.0% and Glycemic Status >9.0%</i>	✓		
Pediatric Health			
<i>Child and Adolescent Well-Care Visits</i>	✓		✓
<i>Childhood Immunization Status— Combination 3: diphtheria, tetanus and acellular pertussis [DTaP]; polio [IPV]; measles, mumps and rubella [MMR]; haemophilus influenza type B [HiB]; hepatitis B [HepB]; chicken pox [VZV]; pneumococcal conjugate [PCV] Combination 7: DTaP, IPV, MMR, HiB, HepB, VZV, PCV, hepatitis A [HepA], rotavirus [RV] Combination 10: DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV, influenza [flu]</i>	✓		✓
<i>Immunizations for Adolescents—Combinations 1 (tetanus; diphtheria toxoids and acellular pertussis [Tdap]) and 2 (tetanus, Tdap, human papillomavirus [HPV])</i>	✓		
<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing</i>	✓		
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total, Counseling for Nutrition—Total, and Counseling for Physical Activity—Total</i>	✓		

Performance Measure	Quality	Timeliness	Access
<i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months and Well-Child Visits for Age 15 Months–30 Months</i>	✓		✓
Preventive Screening			
<i>Breast Cancer Screening</i>	✓		
<i>Cervical Cancer Screening</i>	✓		
<i>Colorectal Cancer Screening</i>	✓		
Appropriate Utilization of Services			
<i>Plan All-Cause Readmissions</i>	✓		
Oral Health			
<i>Oral Evaluation, Dental Services</i>			✓

Validation of Performance Improvement Projects

Objectives

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

The primary objective of PIP validation is to determine the validity and reliability of a PIP through assessing a Contractor's compliance with the requirements. For CYE 2025, AHCCCS required Contractors to conduct PIPs in accordance with 42 CFR 438.330(b)(1) and 438.330(d)(2)(i–iv). In accordance with 438.330(d)(2)(i–iv), each PIP must include:

- Measuring performance using objective quality indicators.
- Implementing system interventions to achieve improvement in quality.
- Evaluating effectiveness of the interventions.
- Planning and initiating activities for increasing and sustaining improvement.

The goal of HSAG's PIP validation is to ensure that AHCCCS and key stakeholders can have confidence that the Contractor executed a methodologically sound improvement project, and any

reported improvement is related to and can be reasonably linked to the QI strategies and activities conducted by the Contractor during the PIP.

Technical Methods of Data Collection

In its PIP evaluation and validation, HSAG used the CMS EQR *Protocol 1: Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023.²⁰² HSAG's evaluation of the PIP includes two key components of the QI process:

- HSAG evaluates the technical structure of the PIP to ensure that the Contractor designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (i.e., Aim statement, population, sampling methods, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
- HSAG evaluates the implementation of the PIP. Once designed, a Contractor's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the Contractor improves its rates through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results).

HSAG used the *AHCCCS Performance Improvement Project (PIP) Report* which each Contractor completed and submitted to HSAG for review and validation. The *AHCCCS Performance Improvement Project (PIP) Report* standardizes the process for submitting information regarding PIPs and ensures alignment with the CMS EQR Protocol requirements.

HSAG, with AHCCCS's input and approval, developed a PIP Validation Tool to ensure a uniformed validation of the PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS EQR Protocols. The HSAG PIP Team consisted of, at a minimum, an analyst with expertise in statistics, PIP design, and performance improvement processes and a clinician with expertise in performance improvement processes. The CMS EQR Protocol 1 identifies nine steps that should be validated for each PIP.

The nine steps included in the PIP Validation Tool are listed below:

1. Review the Selected PIP Topic
2. Review the PIP Aim Statement
3. Review the Identified PIP Population
4. Review the Sampling Method

²⁰² Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Sep 1, 2025.

5. Review the Selected Performance Indicator(s)
6. Review the Data Collection Procedures
7. Review the Data Analysis and Interpretation of PIP Results
8. Assess the Improvement Strategies
9. Assess the Likelihood that Significant and Sustained Improvement Occurred

HSAG used the following methodology to evaluate PIPs conducted by the Contractors to determine PIP validity and to rate the compliance with the CMS EQR Protocol 1 for conducting PIPs.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as “critical elements.” For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall rating of *No Confidence* for the PIP. The Contractor is assigned two confidence levels, the overall confidence of adherence to acceptable methodology for all phases of the PIP and the overall confidence that the PIP achieved significant improvement.

In addition to the two overall confidence levels, HSAG assigns the PIP a percentage score for all evaluation elements (including critical elements) for each confidence level. HSAG calculates the percentage scores by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met* with *Not Assessed* and *Not Applicable* elements removed. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met* with *Not Assessed* and *Not Applicable* elements removed. HSAG assessed the PIP’s results for the two confidence levels using the following methods.

Confidence Levels for Acceptable PIP Methodology

- *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
- *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
- *Low Confidence*: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*, or one or more critical evaluation elements were *Partially Met*.
- *No Confidence*: No confidence in reported PIP results. Less than 65 percent of all evaluation elements were *Met* across all steps, or one or more critical evaluation elements were *Not Met*.

Confidence Levels for Significant Improvement

- *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.

- **Moderate Confidence:** To receive *Moderate Confidence* for significant improvement, one of the three scenarios below occurred:
 - All performance indicators demonstrated improvement over the baseline **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
 - All performance indicators demonstrated improvement over the baseline **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
 - Some but not all performance indicators demonstrated improvement over baseline **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
- **Low Confidence:** The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
- **No Confidence:** The remeasurement methodology differed from the baseline methodology for all performance indicators **or** none of the performance indicators demonstrated improvement over the baseline.

The Contractors had the opportunity to receive initial PIP validation scores and detailed feedback, request technical assistance and guidance from HSAG, make any necessary corrections, and resubmit the PIP for final validation. HSAG forwarded the completed validation tools to AHCCCS and the Contractors.

Table A-3 provides a general timeline of the PIP activities and milestones during CYE 2025.

Table A-3—CYE 2025 PIP Activities

PIP Activities and Milestones	Dates
Initial PIP submissions due to HSAG	8/29/2025
Initial PIP validation tools due to MCOs for review and approval	11/25/2025
PIP resubmissions due to HSAG	12/19/2025
Final PIP validation tools due to MCOs and AHCCCS	2/18/2026

Description of Data Obtained

For the CYE 2025 validation, the Contractors submitted Remeasurement 3 data for the *Back to Basics*, *Breast Cancer Screening*, and *Preventive Screening* PIPs. For the *Prenatal and Postpartum Care* PIP, Contractors submitted Remeasurement 1 data. Contractor-calculated indicator results were validated by the EQRO in alignment with the CMS EQR Protocol 1, and were utilized for PIP validation. The performance indicator measurement period dates for the PIPs are listed below.

Table A-4 presents the measurement periods for the *Back to Basics*, *Breast Cancer Screening*, and *Preventive Screening* PIPs.

Table A-4—Measurement Periods for *Back to Basics*, *Breast Cancer Screening*, and *Preventive Screening* PIPs

PIPs— <i>Back to Basics</i> , <i>Breast Cancer Screening</i> , and <i>Preventive Screening</i>					
CYE 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
Baseline Measurement (10/01/2018–09/30/2019)	Intervention Year 1 (01/01/2020–12/31/2020)	Intervention Year 2 (01/01/2021–12/31/2021)	Remeasurement Year 1 (01/01/2022–12/31/2022)	Remeasurement Year 2 (01/01/2023–12/31/2023)	Remeasurement Year 3 (01/01/2024–12/31/2024)

Table A-5 presents the measurement periods for the *Prenatal and Postpartum Care* PIP.

Table A-5—Measurement Periods for *Prenatal and Postpartum Care* PIPs

PIP— <i>Prenatal and Postpartum Care</i>			
CY 2022	CY 2023	CY 2024	CY 2025
Baseline Measurement (01/01/2022–12/31/2022)	Intervention Year 1 (01/01/2023–12/31/2023)	Remeasurement Year 1 (01/01/2024–12/31/2024)	Remeasurement Year 2 (01/01/2025–12/31/2025)

How Data Were Aggregated and Analyzed

For PIPs, performance indicator data were aggregated and analyzed by AHCCCS. AHCCCS-mandated PIPs typically begin on a date that corresponds with a calendar year. Baseline data are collected and analyzed at the beginning of the PIP. During the Intervention Year, 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 the shortest feasible time frame, based on the PIP topic. Contractors are expected to use several PDSA cycles within the PIP lifespan and include the PDSA in the annual and final PIP report submissions.

Annual measurements (Remeasurement Year 1, Remeasurement Year 2, as well as any subsequent remeasurement years necessary for the Contractor to meet the required criteria for PIP closure) are utilized to evaluate Contractor performance. AHCCCS may require interim measurements, depending on the resources required, to collect and analyze data. Annual measurements (rates and results) are used as the basis for quantitative and qualitative analyses and the selection/modification of interventions.

Contractors are required to submit a formal PIP report to AHCCCS in accordance with the contract. AHCCCS reviews and validates each Contractor PIP report submission to ensure alignment with

AHCCCS PIP policy and checklist requirements. Following this review, each AHCCCS Contractor is provided formal feedback and may be required to resubmit its PIP report if such requirements are not met.

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

How Conclusions Were Drawn

HSAG validated the PIPs to ensure the Contractor used a sound methodology in its design, implementation, analysis, and reporting of the PIP's findings and outcomes. The process assesses the validation findings on the likely validity and reliability of the results by assigning two confidence ratings, one for overall methodological soundness of the PIP design and the second for significant improvement achieved. The confidence levels assigned to the two ratings were either *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*.

To draw conclusions about the quality and timeliness of, and access to care and services provided by the Contractors, HSAG assigned each of the components reviewed for PIP validation to one or more of the three domains (i.e., Quality, Timeliness, and/or Access). While the focus of a Contractor's PIP may have been to improve performance related to healthcare Quality, Timeliness, or Access, PIP validation activities were designed to evaluate the validity and quality of the Contractor's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the Quality domain. In addition, the PIP topic was also assigned to other domains as appropriate. This assignment to domains is shown in Table A-6.

Table A-6—Assignment of PIPs to the Quality, Timeliness, and Access Domains

PIP	Quality	Timeliness	Access
<i>Back to Basics</i>	✓	✓	✓
<i>Breast Cancer Screening</i>	✓		✓
<i>Preventive Screening</i>	✓		✓
<i>Prenatal and Postpartum Care</i>	✓	✓	✓

Compliance Reviews Conducted by HSAG

In CYE 2025, AHCCCS transitioned the oversight and completion of compliance review activities to HSAG. AHCCCS continued to monitor corrective actions from compliance activities completed prior to CYE 2025. HSAG followed standardized processes for conducting the reviews for each of the MCOs,

and the methods were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023.²⁰³

Objectives

The primary objective for HSAG’s reviews was to provide meaningful information to AHCCCS and the MCOs regarding the MCOs’ compliance with requirements in 15 program areas, referred to as standards. HSAG assembled a team to:

- Collaborate with AHCCCS to determine the scope of the review, standards to be evaluated, scoring methodology, data collection methods, schedules for the desk review and on-site review activities, and the agenda for the on-site review.
- Provide technical assistance to the MCOs for participating in the OR process.
- Collect and review data and documents before and during the on-site review.
- Aggregate and analyze the data and information collected.
- Prepare the reports of its findings.

To accomplish its objective and based on the results of its collaborative planning with AHCCCS, HSAG developed and used a standardized data collection tool and processes to assess and document each MCO’s compliance with certain federal Medicaid managed care regulations, State rules, and the associated AHCCCS contract requirements. Table A-7 outlines the standards that were included in the CYE 2025 compliance review.

Table A-7—Compliance Review Standards

Standards	Associated Federal Citation ¹	
	Medicaid	CHIP
Disenrollment: Requirements and Limitations	438.56	457.1212
Member Rights and Member Information	438.10 438.100	457.1207 457.1220
Emergency and Poststabilization Services	438.114	457.1228
Availability of Services	438.206	457.1230(a)
Assurances of Adequate Capacity and Services	438.207	457.1230(b) 457.1218
Coordination and Continuity of Care	438.208	457.1230(c)
Coverage and Authorization of Services	438.210	457.1230(d)

²⁰³ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Feb 5, 2026.

Standards	Associated Federal Citation ¹	
	Medicaid	CHIP
Provider Selection	438.214	457.1233(a)
Confidentiality	438.224	457.1233(e)
Grievance and Appeal Systems	438.228	457.1260
Subcontractual Relationships and Delegation	438.230	457.1233(b)
Practice Guidelines	438.236	457.1233(c)
Health Information Systems	438.242	457.1233(d)
Quality Assessment and Performance Improvement Program	438.330	457.1240
Program Integrity	438.600	457.1201(o)

¹ The OR standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of 438.228 and all requirements under 42 CFR Subpart F).

Prior to the on-site portion of the review, HSAG also evaluated how each MCO implemented a number of the requirements for certain managed care administrative functions by reviewing the following:

- Physical health, behavioral health, dental, and medication service authorization denials
- Member grievances
- Member appeals
- Subcontractor/delegation contracts

The MCOs were asked to prepare and provide a demonstration of their tracking and reporting systems for a number of managed care administrative functions related to the standards under review. This allowed HSAG to evaluate the soundness of the MCOs' methods for data capture and reporting for select AHCCCS-required reports.

The information and findings that resulted from HSAG's review of standards and files were used by AHCCCS and each MCO to:

- Evaluate the degree to which the MCO's operations were in compliance with the State contract and federal managed care requirements.
- Evaluate MCO organizational strengths and identify areas for improvement.
- Identify, implement, and monitor interventions to improve MCO compliance and the quality, accessibility, and timeliness of its services.

Technical Methods of Data Collection

Before beginning the compliance review, HSAG developed a standardized data collection tool to conduct the reviews. The requirements included in the tool were selected based on applicable federal and State regulations and laws, and on the requirements set forth in the contract agreement between AHCCCS and each MCO, as they related to the scope of the review.

Pre-on-Site Review Activities included:

- Using information obtained from the NCQA Accreditation Standards, NCQA Medicaid Managed Care Toolkit, and documentation from the Arizona Association of Health Plans (AzAHP) to develop a nonduplication matrix to assess the comparability of NCQA standards to federal regulations.
- Identifying the compliance review elements that were eligible to be deemed compliant.
- Developing the compliance review tool, checklists, and file review tools.
- Scheduling the on-site reviews and sending an introductory letter with a schedule of key dates to each MCO.
- Generating file review samples based on data universes submitted by each MCO.
- Developing and forwarding to each MCO the on-site review agenda.
- Preparing and forwarding to each MCO a customized desk review form and instructions for submitting the requested documentation to HSAG for its desk review.
- Reviewing scoring for each MCO's NCQA accreditation and prepopulating a score of *Deemed* for any deemable element in which the MCO obtained a *Met* score from NCQA.
- Providing the data collection tool to each MCO to help facilitate its preparation for HSAG's review.
- Conducting technical assistance via webinar for the MCOs. The assistance included a Microsoft PowerPoint presentation outlining the documentation submission processes, HSAG's desk review and on-site review processes, submission of documents for the file reviews, and expectations for logistics during the on-site review. HSAG answered questions during and after the technical assistance session and was available for further assistance via telephone and email up to the date of each MCO's on-site review.
- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of key documents obtained from the MCOs. This desk review process enabled HSAG reviewers to increase their knowledge and understanding of each MCO's operations, identify areas needing further clarification, and begin compiling interview questions before the on-site review.
- Conducting a pre-on-site review of the selected service authorization denial, member grievance, and member appeal files, and subcontractor/delegation contracts.

On-Site Activities during the reviews included:

- An opening session, with introductions and a review of the agenda and logistics.
- Interviews with the MCOs' key administrative and program staff members.

- Observation of the select tracking and reporting systems the MCOs were requested to demonstrate.
- A closing conference during which HSAG summarized its preliminary findings from the review.

HSAG reviewers documented their observations and findings for each MCO in the data collection tool. HSAG then analyzed the information to determine the MCO's performance for each of the individual requirements in the standards. HSAG rated each element as *Met*, *Not Met*, or *Not Applicable* to document whether the MCO complied with the requirements. HSAG documented the opportunities for performance improvement based on its findings. Areas that were *Not Met* were also included in a required CAP template for use by the MCO. HSAG prepared a draft report for each MCO that described the results of the compliance review. The reports were forwarded to AHCCCS and the applicable MCO for their review and comment. Following AHCCCS' approval of each draft report, HSAG issued the final reports to AHCCCS and the applicable MCO.

Table A-8 provides a general timeline of the compliance review activities and milestones during CYE 2025.

Table A-8—CYE 2025 Compliance Review Activities

Compliance Review Activities and Milestones	Dates
Conduct compliance review overview meeting with MCOs.	12/09/2024
Send “Here We Come” letter to MCOs.	01/27/2025
Post Document Request Form, Operational Review Evaluation Tool, Site Review Agenda, and File Review Samples for MCOs.	03/03/2025
Conduct compliance review technical assistance webinar with MCOs.	03/10/2025
Receive completed Desk Review Form, Operational Review Evaluation Tools, and record review files from MCOs.	04/07/2025
Conduct desk review of submitted documentation.	04/08/2025–05/02/2025
Conduct on-site reviews of MCOs.	05/06/2025–07/15/2025
Submit final reports and CAP templates to MCOs.	07/25/2025–09/26/2025
Receive completed CAPs from MCOs and review and evaluate sufficiency of plan and implementation.	09/01/2025–ongoing

Description of Data Obtained

To assess the MCOs' compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by each MCO, including the following:

- Committee meeting agendas, minutes, and handouts
- Written policies and procedures

- Program descriptions, work plans, and annual evaluations
- Management/monitoring reports related to the areas for review
- Provider and delegate contracts
- Provider manual
- Member handbook and other member communications
- Subcontractor/delegation contracts
- Staff training materials and attendance logs
- Records and files related to service authorization denials, member grievances, and member appeals processed by the MCOs

Additional information for the compliance review was obtained through interaction, discussions, observations, and interviews with each MCO’s key staff members, and through demonstrations and presentations provided by the MCOs.

Table A-9 lists the major data sources HSAG used in determining compliance with requirements by each MCO and the period to which the data applied.

Table A-9—Description of Data Sources

Data Obtained	Period to Which the Data Applied
Documentation submitted for HSAG’s desk review and additional documentation and interview information available to HSAG during the on-site review	October 1, 2024–March 31, 2025
Service authorization denial, member grievance, and member appeal files	October 1, 2024–December 31, 2024
Information obtained from subcontractor/delegation contracts	October 1, 2024–March 31, 2025

How Data Were Aggregated and Analyzed

Compliance Review Standards

HSAG reviewers used the following scoring methodology for each requirement in the compliance review tool.

Met indicates full compliance, defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, must be present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

- Documentation, staff responses, case file reviews, and system demonstrations confirmed implementation of the requirement.

Not Met indicates noncompliance, defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- Documentation, staff responses, case file reviews, and system demonstrations did not demonstrate adequate implementation of the requirement.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any findings of *Not Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

Not Applicable indicates an element that is specific to an AHCCCS program or service (e.g., LTSS) and is not applicable for an MCO that is not contracted for that program or to provide that service.

Not reviewed by HSAG is selected when an element is deemed compliant.

From the scores that it assigns for each of the requirements, HSAG calculates a total percentage-of-compliance score for each standard and an overall percentage-of-compliance score across the standards. HSAG calculates the total score for each standard by totaling the number of *Met* (1 point) elements and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard.

HSAG determined the overall percentage-of-compliance score across the areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

HSAG conducted file reviews of MCO service authorization denials (denial types include physical health, behavioral health, dental, medication), member grievances, and member appeals to verify that the MCO has implemented what the MCO has documented in its policy and for compliance with federal and State contract requirements. For service authorization denials, HSAG generated a sample of 10 files plus an oversample of five files for each denial type from the full universe provided by the MCO. For both member grievances and member appeals, HSAG generated a sample of 10 files plus an oversample of five files from the full universe provided by the MCO. The oversampled files were only reviewed in cases where any of the initial 10 files that were reviewed did not meet the requirements of the file universe (e.g., non-Medicaid member, outside the review time period). The file reviews were not intended to be a statistically significant representation of all the MCO's files. Rather, the file reviews highlight instances in which practices described in policy were not followed by the MCO staff members.

Based on the results of the file reviews, the MCO must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the compliance review tool.

While select elements in the compliance review tool were eligible for deeming, some deemable elements corresponded to requirements within the file review tools. HSAG conducted the file reviews regardless of the MCO's scoring of deemed elements.

Nonduplication and Deeming

To avoid duplication of mandatory EQR activities, 42 CFR 438.360 allows the State to use information from a private accreditation review of an MCO for the annual EQR if the following conditions are met:

1. The MCO, PIHP, or PAHP is in compliance with the applicable Medicare Advantage standards established by CMS, as determined by CMS or its contractor for Medicare, or has obtained accreditation from a private accrediting organization recognized by CMS.
 - AHCCCS requires that the MCOs obtain and maintain NCQA health plan accreditation.
2. The Medicare or private accreditation review standards are comparable to standards established through the EQR protocols.
 - AHCCCS contracted with HSAG to use information obtained from NCQA Accreditation Standards, the NCQA Medicaid Managed Care Toolkit, and documentation from AzAHP to develop a nonduplication matrix to assess the comparability of NCQA standards to federal regulations. The nonduplication matrix identified the OR elements that were eligible to be deemed compliant.
3. The MCO, PIHP, or PAHP provides to the State all the reports, findings, and other results of the Medicare or private accreditation review activities applicable to the standards for the EQR activities.
 - AHCCCS obtained all NCQA accreditation reports, findings, and other results from the MCOs and provided the documents to HSAG.

For CYE 2025, AHCCCS exercised the nonduplication option to meet a portion of the EQR compliance review requirements. The MCO must have achieved NCQA health plan accreditation, inclusive of the NCQA MED Module, within the previous three years to be eligible for deeming. If an MCO had provisional or denied NCQA accreditation status, deeming as a whole was not allowed for the MCO. The MCOs were not required to submit evidence of compliance for elements that were identified as deemable if the MCO was accredited and received a score of *Met* for the corresponding NCQA standards and elements during its most recent accreditation survey. Table A-10 lists the compliance review standards and federal citations for deemable elements.

Table A-10—Federal Citations for Deemable Elements

Standards	Federal Citations for Deemable Elements
Disenrollment: Requirements and Limitations	Not applicable.

Standards	Federal Citations for Deemable Elements
Member Rights and Member Information	438.100(a)(1), 438.10(f)(1), 438.10(f)(3), 438.10(g)(4), 438.10(h)(4), 438.10(i)(1-3)
Emergency and Poststabilization Services	Not applicable.
Availability of Services	438.206(b)(1-5), 438.206(c)(1)(ii-iii)
Assurances of Adequate Capacity and Services	Not applicable.
Coordination and Continuity of Care	438.208(b)(1-6), 438.208(c)(2), 438.208(c)(3), 438.208(c)(3)(i-iv), 438.208(c)(4)
Coverage and Authorization of Services	438.210(b)(2)(i), 438.210(c), 438.210(d)(1), 438.210(d)(2)(i), 438.210(d)(3), 438.404(c)(1), 438.404(c)(3), 438.404(c)(6)
Provider Selection	438.214(b)(1-2), 438.214(d)(1), 438.214(e)
Confidentiality	438.224
Grievance and Appeal Systems	438.406(a), 438.406(b)(3)
Subcontractual Relationships and Delegation	438.230(b)(2), 438.230(c)(1)
Practice Guidelines	438.236(b)(1-4), 438.236(c)
Health Information Systems	Not applicable.
Quality Assessment and Performance Improvement Program	438.330(b)(3-4)
Program Integrity	Not applicable.

Within the compliance review tool, HSAG included the following scoring options for deemable elements:

Deemed indicates that the MCO received a score of *Met* for the corresponding NCQA standard(s) and element(s) during its NCQA accreditation survey. If more than one NCQA standard and/or element is identified in the scoring section of the compliance review tool, the MCO must have received a score of *Met* for all referenced standards and/or elements for the requirement to be *Deemed*. The scoring for a deemed element was considered the same score as *Met* (1 point).

Not Deemed indicates that the MCO was not NCQA accredited or did not receive a score of *Met* for the corresponding NCQA standard(s) and element(s) during its NCQA accreditation survey. Any element not deemed was reviewed by HSAG for compliance with the requirement.

As part of the pre-on-site activities, HSAG reviewed the reports and findings from the MCO's most recent NCQA health plan accreditation survey, inclusive of the MED Module, and populated a score of *Deemed* or *Not Deemed*.

Aggregating the Scores

To draw conclusions about each MCO's strengths and opportunities for improvement related to the quality and timeliness of, and access to, the care and service provided to members, HSAG aggregated and analyzed the data resulting from its desk and on-site review activities. The data that HSAG aggregated and analyzed included for each MCO:

- Observations, demonstrations, interview responses, and file and document review findings regarding each MCO's performance in complying with the requirements.
- The scores assigned to the MCO's performance for each requirement.
- The MCO's total percentage-of-compliance score for each of the 15 standards.
- The MCO's overall percentage-of-compliance score calculated across the 15 standards.
- The actions required to bring the MCO's performance into compliance with the requirements that received a score of *Not Met*.

How Conclusions Were Drawn

To draw conclusions about the quality of, timeliness of, and access to care and services provided by the MCOs, HSAG assigned each of the standards reviewed in CYE 2025 to one or more of those domains of care. Each standard may involve the assessment of more than one domain of care due to the combination of individual requirements within each standard. Table A-11 depicts the assignment of the standards to the domains of care.

Table A-11—Assignment of Operational Standards to the Quality, Timeliness, and Access Domains

Compliance Review Standard	Quality	Timeliness	Access
Disenrollment: Requirements and Limitations	✓		
Member Rights and Member Information	✓	✓	✓
Emergency and Poststabilization Services	✓	✓	✓
Availability of Services		✓	✓
Assurances of Adequate Capacity and Services		✓	✓
Coordination and Continuity of Care	✓	✓	✓
Coverage and Authorization of Services	✓	✓	✓
Provider Selection		✓	✓
Confidentiality	✓		

Compliance Review Standard	Quality	Timeliness	Access
Grievance and Appeal Systems	✓	✓	✓
Subcontractual Relationships and Delegation	✓		
Practice Guidelines	✓		
Health Information Systems	✓		
Quality Assessment and Performance Improvement Program	✓	✓	
Program Integrity	✓		

Compliance Reviews Conducted by AHCCCS

Objectives

AHCCCS' objectives for conducting compliance reviews are as follows:

- Determine if the Contractor satisfactorily met AHCCCS' requirements as specified in its contract, AHCCCS policies, Arizona Revised Statutes, the Arizona Administrative Code (AAC), and Medicaid managed care regulations (42 CFR 438).
- Provide technical assistance and identify areas in which the Contractor can improve as well as areas of noteworthy performance and accomplishments.
- Review the Contractor's progress in implementing recommendations that AHCCCS made during prior compliance reviews.
- Determine if the Contractor complied with its own policies and evaluate the effectiveness of those policies and procedures.
- Determine Contractor compliance with commitments made during the RFP process.
- Perform oversight of the Contractor as required by CMS in accordance with AHCCCS' 1115 Waiver.
- Provide information to HSAG as AHCCCS' EQRO to use in preparing the annual EQR technical report as described in 42 CFR 438.364.

Technical Methods of Data Collection

AHCCCS conducts compliance reviews on a three-year cycle. During the first year of the compliance review cycle, AHCCCS conducts the compliance review of all standards. During the second and third years of the cycle, Contractors submit proposed CAPs and evidence of compliance to AHCCCS for approval.

To assess the Contractors' compliance with regulations, AHCCCS conducted the five activities described in the CMS EQR Protocol 3 cited above. Table A-12 describes the five protocol activities and the specific tasks that AHCCCS performed to complete each activity.

Table A-12—Protocol Activities Performed for Assessment of Compliance With Regulations

For this protocol activity,	AHCCCS completed the following activities:
Activity 1:	Establish Compliance Thresholds
	- AHCCCS determined the timing and scope of the reviews, as well as scoring strategies. - AHCCCS developed monitoring tools and templates, agendas, and set review dates. - AHCCCS conducted training for all reviewers to ensure consistency in scoring across the Contractors.
Activity 2:	Perform Preliminary Review
	- AHCCCS notified the Contractors in writing of the request for desk review documents via email delivery of the compliance monitoring tool and an agenda. The desk review request included instructions for organizing and preparing the documents to be submitted. - Prior to the review, the Contractors provided data files from which AHCCCS chose samples to be reviewed, including grievance, appeal, and denial cases. AHCCCS provided the final samples to the Contractors via AHCCCS' SFTP site. Prior to the scheduled review, the Contractors provided documentation for the desk review, as requested. - Examples of documents submitted for the desk review and compliance review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. - The AHCCCS review team reviewed all documentation submitted prior to the scheduled webinar and prepared a request for further documentation, as needed, and an interview guide to use during the webinar.
Activity 3:	Conduct the Review
	- During the review, AHCCCS met with groups of the Contractors' key staff to obtain a complete picture of the Contractors' compliance with Medicaid and CHIP managed care regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the Contractors' performance. - AHCCCS requested, collected, and reviewed additional documents, as needed. - At the close of the review, AHCCCS may provide the Contractors' staff with a high-level overview of how the overall review process went.
Activity 4:	Compile and Analyze Findings
	AHCCCS used a compliance report template to compile the findings and incorporate information from the compliance review activities.

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

Table A-13 provides a general timeline of the compliance review activities and milestones during CYE 2025.

Table A-13—CYE 2025 Compliance Review Activities

Compliance Review Activities and Milestones	Dates
AHCCCS conducted compliance review of the ALTCS-DD Contractor.	08/12/2024–08/15/2024
AHCCCS finalized the compliance review report of findings for the ALTCS-DD Contractor.	10/31/2024
AHCCCS reviewed and accepted the ALTCS-DD Contractors' CAPs.	01/17/2025
AHCCCS conducted ongoing reviews of all Contractors' outstanding CAP items for required revisions or successful closure.	2025–ongoing

Description of Data Obtained

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

- Committee meeting agendas, minutes, and reports
- Policies and procedures
- Management/monitoring reports
- Quarterly reports

- Provider manual and directory
- Member handbook and informational materials
- Staff training materials and documentation of training attendance
- Applicable correspondence or template communications
- Records or files related to administrative tasks (grievances and appeals)
- Interviews with the Contractors' key staff

How Data Were Aggregated and Analyzed

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

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

AHCCCS included the following focus areas in its compliance review. Table A-14 includes a list of each focus area crosswalked with the related federal requirements found in 42 CFR Part 438.

Table A-14—Crosswalk of AHCCCS Focus Areas and Federal Requirements

Focus Areas	Federal Requirements Included
Corporate Compliance	438.242, 438.608, 438.610, 455.1, 455.17, 455.100–106, 455.436
Claims and Information Standards	433.135, 434.6, 438.242, 438.600
Case Management*	438.208, 438.608, 440.70, 440.169, 440.180, 441.18, 441.400, 441.468, 441.725, 441.730
Delivery Systems	438.12, 438.102, 438.206, 438.207, 438.214, 438.242
General Administration	164.530, 438.3, 438.224
Grants Management**	This focus area reflects the Contractor's fulfillment of State requirements or regulations outside of CFR 438.
Grievance Systems	438.10, 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.420, 438.424
Adult; EPSDT; and Maternal Child Health	441.56, 441.58
Medical Management	438.62, 438.114, 438.208, 438.210, 438.228, 438.230, 438.236, 438.330, 438.404, 456.125–133
Member Information	438.10, 438.100, 438.206, 438.207, 438.208, 438.406
Quality Management	438.3, 438.66, 438.206, 438.214, 438.228, 438.230, 438.402, 438.406, 438.408, 438.416, 438.330, 476.160

Focus Areas	Federal Requirements Included
Quality Improvement	438.330, 438.242
Reinsurance	This focus area reflects the Contractor's fulfillment of State requirements or regulations outside of CFR 438.
Third-Party Liability	This focus area reflects the Contractor's fulfillment of State requirements or regulations outside of CFR 438.
Integrated Systems of Care	This focus area reflects the Contractor's fulfillment of State requirements or regulations outside of CFR 438.

*The Case Management Focus Area does not apply to ACC Program Contractors.

**The Grants Management Focus Area is only applicable to ACC-RBHA Contractors.

IS review is part of the PMV process for AHCCCS; therefore, there is no IS component in the compliance review. In addition to the PMV process, AHCCCS evaluates the Contractors' IS through ongoing monthly deliverables, encounter editing processes, and data validation processes. Further, as of CY 2020, AHCCCS transitioned to using Contractor-calculated performance measure rates that are validated by HSAG.

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

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

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

- *The Contractor must* This statement indicates a critical noncompliant area that must be corrected as soon as possible to comply with the AHCCCS contract.
- *The Contractor should* This statement indicates a noncompliant area that must be corrected to comply with the AHCCCS contract but is not critical to the day-to-day operations 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.

In years 2 and 3 of the compliance review cycle, AHCCCS reviews Contractors' proposed CAPs and either approves or requests more information. Once approved, Contractors must provide AHCCCS with evidence of compliance. AHCCCS reviews the evidence of compliance, and if sufficient, accepts and closes the Contractor's CAP.

HSAG reviewed AHCCCS' assessment of CAPs and assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable* for each focus area reviewed:

- *Not Applicable:* A CAP was not required as the score was 95 percent or greater.
- *Partially Met:* AHCCCS approved the Contractor's proposed CAP. The Contractor must submit evidence of compliance.
- *Met:* AHCCCS accepted and closed the Contractor's CAP.

How Conclusions Were Drawn

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

Table A-15 depicts assignment of the standards to the domains of care.

Table A-15—Assignment of Focus Areas to the Quality, Timeliness, and Access Domains

Focus Areas	Quality	Timeliness	Access
Corporate Compliance	✓		✓
Claims and Information Standards			✓
Case Management*	✓		✓
Delivery Systems		✓	✓
General Administration		✓	✓
Grants Management**	✓		✓
Grievance Systems	✓	✓	✓
Adult; EPSDT; and Maternal Child Health		✓	✓
Medical Management	✓	✓	✓
Member Information	✓		
Quality Management	✓		
Quality Improvement	✓		✓
Reinsurance	✓		
Third-Party Liability	✓	✓	✓
Integrated Systems of Care	✓		✓

*The Case Management Focus Area does not apply to ACC Program Contractors.

**The Grants Management Focus Area is only applicable to ACC-RBHA Contractors.

Network Adequacy Validation

AHCCCS contracted with HSAG to support the validation of its healthcare provider networks subcontracted to AHCCCS' Contractors. HSAG's validation of managed care network adequacy considered each Contractor's compliance with all applicable AHCCCS-established standards²⁰⁴ for specific provider categories and populations within the Contractors' provider networks.

Objectives

As guided by the CMS EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023,²⁰⁵ HSAG conducted the following tasks during the NAV activity:

- **Defined the scope of the validation of the quantitative network adequacy standards:** HSAG obtained needed information from the State, identified and defined network adequacy indicators for validation, identified and defined provider categories subject to standards, and established a timeline for activities.
- **Identified data sources for validation:** HSAG worked with AHCCCS and the Contractors to identify NAV-related data sources and to answer clarifying questions regarding the data sources.
- **Reviewed the information systems underlying network adequacy monitoring:** HSAG developed NAV document request materials and an ISCAT, reviewed each Contractor's ISCA, and assessed systems and processes for collecting and maintaining network adequacy data used to inform the calculation and reporting of network adequacy standards and indicators in scope of review.
- **Validated network adequacy assessment data, methods, and results:** HSAG assessed the reliability and validity of each Contractor's network adequacy data, methods, and results; performed an independent calculation of the percentage of members with access within time/distance standards; and calculated validation ratings for all indicators and summarized validation findings.

Table A-16 lists the Contractors that HSAG included in the NAV activity, as well as the LOB and geographic region(s) associated with each Contractor. Each Contractor may serve members living in Arizona's Central, North, and/or South Geographic Service Areas (GSAs).²⁰⁶

²⁰⁴ The ACOM, Section 417—Appointment Availability, Transportation Timeliness, Monitoring, and Reporting and Section 436—Network Standards defines time/distance standards. The ACOM is available at: <https://www.azahcccs.gov/shared/ACOM/>. Accessed on: Jan 22, 2026.

²⁰⁵ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Jan 22, 2026.

²⁰⁶ The Arizona counties associated with the Central, North, and South GSAs for all LOBs are as follows:

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

Table A-16—AHCCCS Contractors by LOB and GSA

Contractor Name	Contractor Abbreviation	LOB and GSA				
		ACC	ACC-RBHA	ALTCS-DD	ALTCS-EPD	DCS CHP
Arizona Complete Health—Complete Care Plan	AzCH-CCP	Central South	South			
Banner—University Family Care	BUFC	Central South			Central South	
Care1st Health Plan ¹	Care1st	North	North			
Health Choice Arizona	HCA	Central North				
Mercy Care	Mercy Care	Central	Central	Statewide	Central South (Pima only)	Statewide
Molina Healthcare	Molina	Central				
UnitedHealthcare Community Plan	UHCCP	Central South (Pima Only)		Statewide	Central North	

¹ As of October 1, 2024, Care1st transferred network responsibilities to AzCH-CCP.

Scope of Validation of Quantitative Network Adequacy Standards

The NAV included study indicators from the following domains, described in further detail below:

- **Time and Distance Validation:** HSAG’s validation of results for all applicable AHCCCS-established time/distance standards by Contractor, LOB, and county, using PMMIS and PAT data.
 - Study indicators will show the percentage of members assigned by AHCCCS to the specified county, with access to any provider location serving the LOB within the time/distance standard.
- **Appointment Access and Availability Validation:** HSAG’s validation of results for all applicable AHCCCS-established appointment access and availability standards by Contractor and LOB using provider directory source data.

Time and Distance Validation

The PMMIS and PAT data were used to calculate the percentage of members within the time/distance standards described in Table A-17.

Table A-17—Time and Distance Network Standards for AHCCCS Contractors by Provider Type and County

Provider Category	Member Population	Network Standard Maricopa and Pima Counties	Network Standard All Other Arizona Counties
Behavioral Health Outpatient and Integrated Clinic, Adult ^{5,6}	Members ages 18 years and older	90 percent of members within 15 minutes or 10 miles	90 percent of members within 60 miles
Behavioral Health Outpatient and Integrated Clinic, Pediatric ^{4,6}	Members younger than 18 years of age	90 percent of members within 15 minutes or 10 miles	90 percent of members within 60 miles
BHRF ¹	All members	90 percent of members within 15 minutes or 10 miles	Not Applicable
Cardiologist, Adult ^{5,6}	Members ages 21 years and older	90 percent of members within 30 minutes or 20 miles	90 percent of members within 75 minutes or 60 miles
Cardiologist, Pediatric ⁶	Members younger than 21 years of age	90 percent of members within 60 minutes or 45 miles	90 percent of members within 110 minutes or 100 miles
Crisis Stabilization Facility ²	All members	90 percent of members within 15 minutes or 10 miles	90 percent of members within 45 miles
Dentist, Pediatric	Members younger than 21 years of age	90 percent of members within 15 minutes or 10 miles	90 percent of members within 40 minutes or 30 miles
Hospital	All members	90 percent of members within 45 minutes or 30 miles	90 percent of members within 95 minutes or 85 miles
Nursing Facility ³	All members currently residing in their own home	90 percent of members within 45 minutes or 30 miles	90 percent of members within 95 minutes or 85 miles
OB/GYN	Female members ages 15 to 45 years	90 percent of members within 45 minutes or 30 miles	90 percent of members within 90 minutes or 75 miles
Pharmacy	All members	90 percent of members within 12 minutes or 8 miles	90 percent of members within 40 minutes or 30 miles
PCP, Adult ^{5,6}	Members ages 21 years and older	90 percent of members within 15 minutes or 10 miles	90 percent of members within 40 minutes or 30 miles
PCP, Pediatric ⁶	Members younger than 21 years of age	90 percent of members within 15 minutes or 10 miles	90 percent of members within 40 minutes or 30 miles

¹ Applies only to Maricopa and Pima counties.

² Applies only to ACC-RBHA Contractors.

³ Applies only to ALTCS Contractors.

⁴ Applies to all Contractors except ACC-RBHA Contractors.

⁵ Calculations for DCS CHP do not include standards applicable only to adults (i.e., Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult; or PCP, Adult).

⁶ Services identified as eligible for a telehealth standard modification only require 80 percent of a county's membership to meet the time/distance standards where telehealth services are available for that provider category.

Additionally, HSAG mapped providers to a provider category consistent with AHCCCS' ACOM 436 requirements by using a combination of provider type and/or provider specialty codes. Table A-18 provides a network crosswalk for each provider category in the time/distance analyses.

Table A-18—Provider Category Crosswalk

Provider Type/Provider Specialty Codes	
Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric	
Provider Type Code: • 77–Behavioral Health Outpatient Clinic • IC–Integrated Clinics	
BHRF	
Provider Type Code: • B8–Behavioral Health Residential Facility	
Cardiologist, Adult	
Provider Type Code: • 08–MD–Physician • 31–DO–Physician Osteopath	with a Provider Specialty Code: • 062–Cardiovascular Medicine • 927–Cardiologist
Cardiologist, Pediatric	
Provider Type Code: • 08–MD–Physician • 31–DO–Physician Osteopath	with a Provider Specialty Code: • 062–Cardiovascular Medicine • 151–Pediatric Cardiologist • 927–Cardiologist
Crisis Stabilization Facility	
Provider Type Code: • 02–Hospital • 71–Psychiatric Hospital • 77–Behavioral Health Outpatient Clinic	• B5–Subacute Facility • B6–Subacute Facility • B7–Crisis Services Provider
<i>or</i>	
Provider Type Code: • IC–Integrated Clinics that are authorized to provide behavioral health observation/stabilization in accordance with A.A.C. 9-10-1012	
Dentist, Pediatric	
Provider Type Code: • 07–Dentist	with a Provider Specialty Code: • 800–Dentist-General • 804–Dentist-Pediatric Dentist
<i>or</i>	
Provider Type Code: • C2–Federally Qualified Health Centers (FQHCs) identified by AHCCCS	

Provider Type/Provider Specialty Codes	
Hospital	
Provider Type Code:	
• 02–Hospital • C4–Specialty Per Diem Hospitals	
Nursing Facility	
Provider Type Code:	
• 22–Nursing Home	
Obstetrician/Gynecologist (OB/GYN)	
Provider Type Code:	with a Provider Specialty Code:
• 08–MD-Physician • 19–Registered Nurse Practitioner • 31–DO-Physician Osteopath • CN–Clinical Nurse Specialist	• 089–OB/GYN • 090–Gynecologist • 091–Obstetrician • 095–Women’s Health Care-OB/GYN Nurse Practitioner • 181–Surgery-Obstetrical • 219–Surgery-Gynecological
Pharmacy	
Provider Type Code:	
• 03–Pharmacy • 05–Clinic	
PCP, Adult	
Provider Type Code:	with a Provider Specialty Code:
• 08–MD-Physician • 31–DO-Physician Osteopath	• 050–Family Practice • 055–General Practice • 060–Internal Medicine • 089–OB/GYN • 091–Obstetrician
<i>or</i>	
Provider Type Code:	with a Provider Specialty Code:
• 19–Registered Nurse Practitioner • CN–Clinical Nurse Specialist	• 084–RN-Family Nurse Practitioner • 095–Women’s Health Care-OB/GYN Nurse Practitioner • 097–RN-Adult Nurse Practitioner
<i>or</i>	
Provider Type Code:	with a Provider Specialty Code:
• 18–Physician Assistant	• 798–Physician Assistant

Provider Type/Provider Specialty Codes	
PCP, Pediatric	
Provider Type Code: • 08–MD-Physician • 31–DO-Physician Osteopath	with a Provider Specialty Code: • 050–Family Practice • 150–Pediatrician • 176–Adolescent Medicine
<i>or</i>	
Provider Type Code: • 19–Registered Nurse Practitioner • CN–Clinical Nurse Specialist	with a Provider Specialty Code: • 084–Family Nurse Practitioner • 087–RN-Pediatric Nurse Practitioner • 097–RN-Adult Nurse Practitioner
<i>or</i>	
Provider Type Code: • 18–Physician Assistant	with a Provider Specialty Code: • 798–Physician Assistant

Appointment Access and Availability Validation

The provider directory data were used to ensure providers were meeting the appointment access and availability standards described in Table A-19.

Table A-19—Appointment Access and Availability Standards for AHCCCS Contractors by Provider Category and LOB

Provider Category	Appointment Type	Appointment Standard
General Appointment Standards for All LOBs		
Primary Care	Urgent	no later than 2 business days of request ¹
	Routine	within 21 calendar days of request
Specialty Physician, Including Dental Specialists	Urgent	no later than 2 business days of request ¹
	Routine	within 45 calendar days of referral
Dental	Urgent	no later than 3 business days of request ¹
	Routine	within 45 calendar days of request ²
Maternity Care ³	First Trimester	within 14 calendar days of request
	Second Trimester	within 7 calendar days of request

Provider Category	Appointment Type	Appointment Standard
	Third Trimester	within 3 business days of request
	High Risk Pregnancy	no later than 3 business days of identification of high risk ^{1,4}
Psychotropic Medication Appointment Standards for All LOBs		
Behavioral Health	Referral for Psychotropic Medications	Provide an appointment, if clinically indicated, with a practitioner who can prescribe psychotropic medications within a time frame that ensures the member: • Does not run out of needed medications, or • Does not decline in their behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need
Behavioral Health Appointment Standards for ACC, ACC-RBHA, ALTCS-DD, and ALTCS-EPD LOBs		
Behavioral Health	Urgent	no later than 24 hours from identification of need ¹
	Routine: Initial Assessment	within 7 calendar days after the initial referral or request
	Routine: First Service Following Initial Assessment (Adult)	no later than 23 calendar days after the initial assessment
	Routine: First Service Following Initial Assessment (Child)	no later than 21 days after the initial assessment
	Routine: Subsequent Services	no longer than 45 calendar days from identification of need ⁵
Behavioral Health Appointment Standards for DCS CHP LOB		
Behavioral Health	Rapid Response When a Child Enters Out-of-Home Placement	no later than 72 hours after notification by the DCS that a child has been or will be removed from their home
	Initial Assessment	within 7 calendar days after the initial referral or request for behavioral health services
	Initial Appointment	no later than 21 calendar days after the initial assessment ⁵
	Subsequent Services	no longer than 21 calendar days from the identification of need ⁵

¹ As expeditiously as the member's health condition requires

² For DCS CHP only, routine care appointments within 30 calendar days of request

³ For initial prenatal care appointments with the provider for enrolled pregnant members

⁴ Within 3 days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists

⁵ Within time frames indicated by clinical need

Technical Methods of Data Collection

The CMS EQR Protocol 4 identifies key activities and data sources needed for NAV. The following describes the types of data collected and how HSAG conducted an analysis of these data.

Review Information Systems Underlying Network Adequacy Monitoring

HSAG completed a desk review of the submitted ISCAT, followed by virtual interviews that included Contractor network-related information systems demonstrations and discussion of data management processes described in the ISCAT submission.

HSAG conducted an ISCA using each Contractor's completed ISCAT and relevant supplemental documentation to understand the processes for maintaining and updating provider data, including how the Contractor tracks providers over time, across multiple office locations, and through changes in participation in the Contractor's network. The ISCAT was used to assess the ability of the Contractor's information systems to collect and report accurate data related to each network adequacy indicator. To do so, HSAG sought to understand the Contractor's information technology (IT) system architecture, file structure, information flow, data processing procedures, and completeness and accuracy of data related to current provider networks. HSAG thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.

Validate Network Adequacy Assessment Data, Methods, and Results

Validate Network Adequacy Data and Methods

HSAG assessed data and documentation from each Contractor including, but not limited to, network data files or directories, member enrollment data files, and/or provider and member handbooks. HSAG assessed all data files used for network adequacy calculation at the indicator level for validity and completeness. HSAG required each Contractor to submit its methodology for calculating each indicator within the scope of the validation. HSAG identified whether the required variables were present and required each Contractor to submit documentation describing the steps the Contractor followed for indicator calculation.

Validate Network Adequacy Results

HSAG assessed each Contractor's ability to collect reliable and valid network adequacy reporting data, use sound methods to assess the adequacy of its managed care provider networks, and produce accurate results to support network adequacy reporting. HSAG validated network adequacy reporting against state-defined standards and against the most recent network adequacy reports (i.e., ACOM 417 and ACOM 436 submissions) to assess reasonability of reported indicator-level results. HSAG assessed whether the results were valid, accurate, and reliable, and whether the Contractor's interpretation of the data was accurate.

HSAG conducted an independent review of the time/distance network requirements wherein HSAG calculated the percentage of members with required access according to standards using Quest Analytics

software to calculate the travel time and driving distance between the addresses of specific members and the addresses of their nearest provider for all applicable provider categories identified in the analysis. All study results were stratified by Contractor, as well as by LOB and county. HSAG’s results were compared to the results submitted by the Contractors. Additionally, HSAG performed a saturation analysis and assessed the degree to which each Contractor’s provider network reflected available AHCCCS-contracted providers for indicators that failed to meet the minimum network standards.

Provide Validation Ratings for Network Adequacy Results Submitted by the Contractor

HSAG used the CMS EQR Protocol 4 Worksheet 4.6 as a guide to systematic assessment of the quality of Contractor network adequacy data, methods, and results. The worksheet was completed for each network adequacy indicator for each Contractor. The worksheet consisted of 10 questions regarding data collection procedures, 16 questions regarding network adequacy methods, and four questions regarding results. For each question, a “Yes” response indicated that the Contractor met quality expectations, a “No” response indicated that the Contractor fully or partially failed to meet expectations, and an “N/A” response indicated that the question did not apply to the Contractor or the specific indicator. For each indicator, HSAG calculated a validation score equal to the number of “Yes” responses divided by the total number of “Yes” and “No” responses. Based on where the score fell within ranges defined by CMS, the Contractor received a rating for the indicator of *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*.

Table A-20 provides a general timeline of the NAV activities and milestones.

Table A-20—NAV Activities

NAV Activities and Milestones	Dates
Study Design (Develop and finalize workplan and methodology)	04/09/24–04/30/24
Data Collection	10/01/24–12/17/24
NAV Analysis (Conduct time/distance analysis and provider saturation analysis)	12/18/24–01/8/25
Tableau Dashboard (Validate and deploy CYE 2024 S2 Tableau dashboard)	01/09/25–01/13/25
ISCA (Collect ISCAT, review ISCAT, conduct virtual review sessions with the Contractors, and complete Worksheet 4.6)	07/08/25–12/04/25
Report (Draft and finalize report)	12/05/25–12/19/25

Description of Data Obtained

HSAG identified the data sources needed for NAV which included the following data and documentation from AHCCCS and the Contractors: (1) provider and member data (2) Contractor-specific ACOM 417 and 436 submissions (3) Contractor-submitted ISCATs and documentation, and (4) information gathered in subsequent communication and interviews with the Contractors.

For each semiannual measurement period, AHCCCS and the Contractors supplied HSAG with the following data files to conduct the time/distance and appointment access and availability validations, as well as perform supplemental analyses (i.e., provider saturation):

- PMMIS provider data—Data files maintained by AHCCCS that list all AHCCCS-contracted providers and their corresponding addresses.
- AHCCCS member data—A data file compiled by AHCCCS from the PMMIS and Client Assessment and Tracking System (CATS) data. PMMIS data elements include the addresses and other necessary demographic information on AHCCCS members. Specific data elements from CATS identify all AHCCCS members who live in their own homes for calculation of the Nursing Facility time/distance standard.
- Contractor-specific PAT files—An aggregated data file listing each Contractor’s network providers, as identified to AHCCCS by each Contractor.
- Contractor-specific internal provider directories—An aggregated data file listing each Contractor’s network providers along with provider contact information.
- Contractor-specific ACOM 436 submissions—Microsoft Excel workbook(s) for each Contractor and LOB with a tab listing the Contractor’s results for compliance with county-level time/distance standards.
- Contractor-specific ACOM 417 submissions—Microsoft Excel workbook(s) for each Contractor and LOB with a tab listing the Contractor’s results for compliance with appointment access and availability standards.
- DCS CHP member data—A data file identifying the place of residence for DCS CHP members.

How Data Were Aggregated and Analyzed

HSAG used the Quest Analytics Suite software, version 2024.2 (QAS) to geocode the PAT and PMMIS addresses for members and providers, assigning each address to an exact geographic location (i.e., latitude and longitude). To facilitate geocoding, HSAG standardized member and provider address data to align with the United States Postal Service Coding Accuracy Support System (USPS CASS) to ensure consistent address formatting across data files.

HSAG assembled the geocoded member (PMMIS) and provider (PAT) addresses into datasets that were used with QAS to calculate the percentage of members meeting the time/distance standards described in Table A-17. County-specific time/distance calculations were conducted separately for each Contractor’s LOB and county. HSAG’s time/distance calculations considered the driving time/distance between a member and the nearest provider (i.e., the time or distance for the member to reach the provider using established roadways). Driving time calculations assumed 30 miles per hour (mph) for Maricopa and Pima counties and 55 mph for all other counties.

How Conclusions Were Drawn

HSAG calculated county-specific time/distance results for each provider category, LOB, and Contractor. HSAG then compared these analytic results to AHCCCS’ minimum network standards and identified the Contractors that failed to meet the minimum network standards. HSAG determined each Contractor’s substantial strengths and weaknesses by considering the degree to which the Contractor met minimum network standards for its GSA(s).

This report presents ISCA findings for CYE 2025. The accompanying analytic results are based on data from the 2024 S2 measurement period (July 1–September 30, 2024). Based on the data integrity and methodological framework established during the ISCA process, the analyses conducted using 2024 S2 data are considered representative of the full calendar year.

Detailed time/distance results were presented to AHCCCS and the Contractors as interactive Tableau dashboards containing the following information:

- Network Adequacy Assessment Comparison—Time and Distance: A dashboard assessing the differences between Contractors’ network adequacy results and HSAG’s results calculated for the time and distance standards.
- Network Adequacy Assessment Trending—Time and Distance: A dashboard comparing Contractor and HSAG Network Adequacy Assessment results across reporting periods by county, urbanicity, and provider category.
- Time and Distance Standards Assessment: A dashboard assessing Contractors’ compliance with time and distance standards by county, urbanicity, and provider category.

Additionally, HSAG evaluated each Contractor’s ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support the Contractor’s and AHCCCS’ network adequacy reporting efforts.

HSAG used the CMS EQR Protocol 4 indicator-specific worksheets to generate a validation rating that reflects HSAG’s overall confidence that the Contractor used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated each network adequacy indicator’s validation score by identifying the number of *Met* and *Not Met* elements recorded in HSAG’s CMS EQR Protocol 4 Worksheet 4.6, noted in Table A-21.

Table A-21—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of <i>Met</i> elements
B. Total number of <i>Not Met</i> elements
Validation Score = $A / (A + B) \times 100\%$
Number of <i>Not Met</i> elements determined to have significant bias on the results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the Contractor’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG’s overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. The CMS EQR Protocol 4 defines validation rating designations at the indicator level, which are defined in Table A-22. HSAG assigns a rating once it has calculated the validation score for each indicator.

Table A-22—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	<i>High Confidence</i>
50.0% to 89.9%	<i>Moderate Confidence</i>
10.0% to 49.9%	<i>Low Confidence</i>
Less than 10% and/or any <i>Not Met</i> element has significant bias on the results	<i>No Confidence</i>

If applicable, significant bias was determined based on the magnitude of errors detected and not solely based on the number of elements *Met* or *Not Met*. HSAG determined that a *Not Met* element had significant bias on the results by:

- Requesting that the Contractor provide a root cause analysis of the finding.
- Working with the Contractor to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- Tasking HSAG’s NAV Oversight Review Committee with reviewing the root cause, proposed corrective action, timeline for corrections, and estimated impact to determine the degree of bias.
- Tasking HSAG’s NAV Oversight Review Committee with finalizing a bias determination based on the following threshold:
 - The impact biased the reported network adequacy indicator result by more than 5 percentage points, the impact resulted in a change in network adequacy compliance (i.e., the indicator result changed from compliant to noncompliant or changed from noncompliant to compliant), or the impact was unable to be quantified and therefore was determined to have the potential for significant bias.

Analytic Considerations

AHCCCS does not define the software or process by which each Contractor calculates the semiannual ACOM 436 time/distance results. HSAG uses QAS to calculate time/distance results based on driving

distances, and additional discrepancies may result if Contractors use different versions of QAS during each of the different data network validations.²⁰⁷

AHCCCS members may seek care from network providers practicing outside of the member's county of residence. As such, HSAG considered all applicable provider locations within a program when calculating time/distance results. However, HSAG's time/distance calculations included all available provider locations noted in Contractors' PAT data files, without considering potential barriers to new patient acceptance or appointment availability at individual provider locations.

Additionally, HSAG's time/distance calculations did not include some facilities available to American Indian members enrolled with an MCO. American Indian members, Title XIX and Title XXI, on- or off-reservation, and eligible to receive services may choose to receive services at any time from an American Indian Health Facility—Indian Health Service (IHS) Facility, a Tribally-Operated 638 Health Program, or an Urban Indian Health Program (I/T/U) (American Reinvestment and Recovery Act of 2009 [ARRA] Section 5006[d], and State Medicaid Director Letter [SMDL] 10-001). These facilities are not included in the calculations in this report. As a result, member access may be underreported, particularly in areas with high concentrations of these facilities.

Similarly, HSAG's validation included time/distance standards that do not reflect all potential healthcare needs or service delivery options for members. Selected time/distance standards may be addressed through mobile service providers, mail delivery for prescriptions, or other emerging service delivery approaches that may be evaluated using metrics other than time/distance calculation results.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

Objectives

The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information and gain understanding about the healthcare experience of adult members and parents/caretakers of child patients. These surveys cover topics important to members, such as communication skills of providers and accessibility of services.

Technical Methods of Data Collection

To support the reliability and validity of the findings, standardized sampling and data collection procedures were followed for member selection and survey distribution. These procedures were

²⁰⁷ AHCCCS' member address data may not always reflect a member's place of residence (e.g., use of post office boxes) or be identifiable with mapping software (e.g., addresses reflecting local place designations, rather than street addresses). While mapping software may assign members to geographic coordinates, these coordinates may not align with the member's exact residential location for records that do not use a standard street address.

designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data.

The technical method of data collection for the child ACC Program, KidsCare, and DCS CHP was the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the children with chronic conditions (CCC) measurement set. Child members included as eligible for the surveys were 17 years of age or younger (less than 18 years of age) as of December 31, 2024. Parents/caretakers of child members as part of the child ACC Program, KidsCare, and DCS CHP completed the surveys from March to June 2025.

The technical method of data collection for the adult population as part of the adult ACC Program and ACC-RBHA SMI-Designated Program was the CAHPS 5.1 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set. Adult members included as eligible for surveys were 18 years of age or older as of December 31, 2024. Adult members completed surveys from March to June 2025.

The survey process allowed two methods by which a survey could be completed in English or Spanish: (1) complete the paper-based survey and return it using the pre-addressed, postage-paid return envelope, or (2) complete the web-based survey through the survey website with a designated login. Members who were identified as Spanish speaking through administrative data were mailed a Spanish version of the cover letter, with an English backside, and a Spanish survey. Members who were not identified as Spanish speaking received an English version of the cover letter, with a Spanish backside, and an English survey. The English and Spanish versions of the survey included a toll-free number that members and parents/caretakers of child members could call to request a survey in another language (i.e., English or Spanish). The first survey mailing was followed by a reminder postcard. A second survey mailing was sent to all non-respondents, which was followed by a second reminder postcard. Finally, a third survey mailing was sent to all non-respondents.

The surveys included a set of standardized items that assess respondents' perspectives on care as follows:

- Seventy-six items for the CAHPS 5.1 Child Medicaid Health Plan Survey yielded 14 measures of member experience.
- Thirty-nine items for the CAHPS 5.1 Adult Medicaid Health Plan Survey with the HEDIS supplemental item yielded 12 measures of member experience.

These measures included four global ratings, four composite scores, one individual item measure, three medical assistance with smoking and tobacco use cessation measure items (adult population only), and five CCC composites/items (CCC population only). The global ratings reflected respondents' overall experience with their/their child's health plan, health care, personal doctors, and specialists. The composite scores were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *Getting Care Quickly*). The individual item measure is an individual question that looks at coordination of care. The medical assistance with smoking and tobacco use cessation measure items assess the various aspects of providing medical assistance with smoking and tobacco use cessation for the adult population. The CCC composites and items are sets of questions and individual questions

that look at different aspects of care for the CCC population (e.g., *Access to Prescription Medicines* and *Access to Specialized Services*). If a minimum of 100 respondents for a measure was not achieved, the result of the measure was denoted with a cross (+).

Table A-23 provides a general timeline of the CAHPS activities and milestones during CYE 2025.

Table A-23—CYE 2025 CAHPS Activities

CAHPS Activities and Milestones	Dates
Survey Administration	03/28/25–06/20/25
HSAG submitted weekly disposition reports in Microsoft Excel format while the surveys were in the field to AHCCCS	04/11/25–06/20/25
HSAG submitted draft (D1) Statewide CAHPS Reports (unsuppressed and suppressed), respondent-level data files, and crosstabulations to AHCCCS	09/02/25
AHCCCS submitted feedback on draft (D1) Statewide CAHPS Reports to HSAG	09/25/25
HSAG submitted draft (D2) Statewide CAHPS Reports to AHCCCS for review and feedback	10/09/25
AHCCCS submitted feedback on draft (D2) Statewide CAHPS Reports to HSAG	10/20/25
HSAG submitted final draft (FD1) Statewide CAHPS Reports to AHCCCS for review and feedback	10/27/25
AHCCCS submitted feedback on final draft (FD1) Statewide CAHPS Reports to HSAG	11/07/25
HSAG submitted final Statewide CAHPS Reports to AHCCCS	11/17/25

Description of Data Obtained

HSAG aggregated data from survey respondents into a database for analysis. Results of the CAHPS surveys are found in [Section 4. ACC Program-Level Comparative Results](#), [Section 6. ACC-RBHA SMI-Designated Program-Level Comparative Results](#), and [Section 8. DCS CHP Program Results](#).

For each of the global ratings, composite measures, individual item measure, and CCC composites/items, the percentage of respondents who chose a positive or top-box response was calculated. Response choices for the CAHPS global ratings in the adult and child Medicaid surveys ranged from 0 to 10, where 0 is the worst rating possible and 10 is the best rating possible. A positive or top-box response for these measures was defined as a response of “9” or “10.” Response choices for the CAHPS composite questions, individual item, and CCC composites/items (i.e., child Medicaid only) in the adult and child Medicaid surveys were (1) “Never,” “Sometimes,” “Usually,” and “Always” and (2) “Yes” and “No.” A positive or top-box response for these measures was defined as a response of (1) “Usually” or “Always” and (2) “Yes.” For the three medical assistance with smoking and tobacco use cessation items, the percentages of smokers or tobacco users who were advised to quit, were

recommended cessation medications, and where provided cessation methods or strategies were calculated. Response choices of the CAHPS medical assistance with smoking and tobacco use cessation items in the adult Medicaid survey were “Sometimes,” “Usually,” and “Always,” which were used to determine if the member qualified for inclusion in the numerator.

How Data Were Aggregated and Analyzed

HSAG performed national comparisons of the results to NCQA’s Quality Compass Benchmark and Compare Quality Data to derive the overall member experience ratings.²⁰⁸ Ratings of one (★) to five (★★★★★) stars were determined for each measure using the percentile distributions shown in Table A-24.

Table A-24—Star Rating Percentile Distributions

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★★ Very Good	At or between the 75th and 89th percentile
★★★ Good	At or between the 50th and 74th percentile
★★ Fair	At or between the 25th and 49th percentile
★ Poor	Below the 25th percentile

National Average Comparisons

For the national average comparisons, HSAG performed a *t* test to determine whether the 2025 scores were statistically significantly different from the 2024 NCQA adult Medicaid, general child Medicaid, and CCC Medicaid national averages for these populations: the child and adult ACC Program, KidsCare, the ACC KidsCare Contractors, the adult ACC-RBHA SMI-Designated Program, and DCS CHP. A difference was considered statistically significant if the two-sided *p* value of the *t* test was less than 0.05. An H indicates a 2025 score that was statistically significantly higher than the 2024 national average. An L indicates a 2025 score that was statistically significantly lower than the 2024 national average. Scores in 2025 that were not statistically significantly higher or lower than the 2024 national averages are not denoted.

²⁰⁸ National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2024*. Washington, DC: NCQA, September 2024.

Trend Analysis

HSAG performed a trend analysis by performing a t test that determined whether 2025 scores were statistically significantly different (i.e., p value < 0.05) from the 2024 scores for these populations: KidsCare, the child and adult ACC Program, the adult ACC-RBHA SMI-Designated Program, and DCS CHP. Scores that were statistically significantly higher in 2025 than the trend year are denoted with black upward triangles (▲). Scores that were statistically significantly lower in 2025 than the trend year are denoted with black downward triangles (▼). Scores in 2025 that were not statistically significantly different from the trend year scores are not denoted with triangles. A trend analysis was not performed for the ACC Contractors since this was the first year this population was surveyed.

Program Comparisons

HSAG applied two types of hypothesis tests to the ACC KidsCare Contractor's scores. First, HSAG calculated a global F test, which determined whether the difference between the KidsCare ACC/ACC-RBHA MCO scores was significant. If the F test demonstrated MCO-level differences (i.e., $p < 0.05$), then HSAG performed a t test for each health plan. The t test determined whether each MCO's score was statistically significantly different from the KidsCare MCO Aggregate. MCO scores that were statistically significantly higher than the KidsCare MCO Aggregate are denoted with black upward arrows (↑). MCO scores that were statistically significantly lower than the KidsCare MCO Aggregate are denoted with black downward arrows (↓). MCO scores that were not statistically significantly different than the KidsCare MCO Aggregate are not denoted with arrows.

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to services provided by KidsCare, child and adult ACC Program, ACC KidsCare Contractors, DCS CHP, and ACC-RBHA SMI-Designated Program, HSAG assigned each of the measures to one or more of the three domains (i.e., Quality, Timeliness, and/or Access). The assignment to domains is depicted in Table A-25.

Table A-25—Assignment of CAHPS Measures to the Quality, Timeliness, and Access Domains

CAHPS Topic	Quality	Timeliness	Access
<i>Rating of Health Plan</i>	✓		
<i>Rating of All Health Care</i>	✓		
<i>Rating of Specialist Seen Most Often</i>	✓		
<i>Rating of Personal Doctor</i>	✓		
<i>Getting Needed Care</i>	✓		✓
<i>Getting Care Quickly</i>	✓	✓	
<i>How Well Doctors Communicate</i>	✓		
<i>Customer Service</i>	✓		
<i>Coordination of Care</i>	✓		

CAHPS Topic	Quality	Timeliness	Access
<i>Advising Smokers and Tobacco Users to Quit</i>	✓		
<i>Discussing Cessation Medications</i>	✓		
<i>Discussing Cessation Strategies</i>	✓		
<i>Access to Specialized Services</i>	✓		✓
<i>FCC: Personal Doctor Who Knows Child</i>	✓		
<i>Coordination of Care for Children with Chronic Conditions</i>	✓		
<i>Access to Prescription Medicines</i>	✓		✓
<i>FCC: Getting Needed Information</i>	✓		

Aggregating and Analyzing Program-Level Data

HSAG follows a four-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the quality and timeliness of, and access to care furnished by each Contractor, as well as the program overall. To produce AHCCCS' annual technical reports, HSAG performed the following steps to analyze the data obtained and draw program-level conclusions about the quality and timeliness of, and access to care and services provided by the Contractors:

Step 1: HSAG analyzed the quantitative results obtained from each EQR activity for each Contractor to identify strengths and opportunities for improvement in each domain of Quality, Timeliness, and Access to services furnished by the Contractor for the EQR activity.

Step 2: From the information collected, HSAG identified common themes and the salient patterns that emerged across EQR activities for each domain and drew conclusions about the overall quality and timeliness of, and access to care and services furnished by the Contractor.

Step 3: From the information collected, HSAG identified common themes and the salient patterns that emerged across all EQR activities related to strengths and opportunities for improvement in one or more of the domains of Quality, Timeliness, and Access to care and services furnished by the Contractor.

Step 4: HSAG identified any patterns and commonalities that exist across the program to draw conclusions about the quality and timeliness of, and access to care for the program.

Appendix B. Combined Performance Measure Results for AzCH-CCP ACC-RBHA and Care1st ACC-RBHA

Care 1st ACC-RBHA members fully transitioned to AzCH-CCP ACC-RBHA on October 1, 2024. For MY 2024, AHCCCS required performance measure rates for AzCH-CCP ACC-RBHA, Care1st ACC-RBHA, and combined AzCH-CCP/Care1st ACC-RBHA performance measure rates. Combined AzCH-CCP/Care1st ACC-RBHA performance measure rates presented in the tables below are reflective of AzCH-CCP ACC-RBHA members and Care1st ACC-RBHA members who transitioned to AzCH-CCP ACC-RBHA effective October 1, 2024, with continuous enrollment based on meeting the enrollment criteria (as outlined within the measure’s technical specifications and AHCCCS guidance) with either (or a combination of both) of the two plans during CY 2024.

Table B-1—CY 2024 AzCH-CCP and Care1st ACC-RBHA Performance Measure Aggregate Results

Performance Measure	CY 2024 Performance	2024 Performance Level ¹
Maternal and Perinatal Care		
Prenatal and Postpartum Care		
<i>Timeliness of Prenatal Care</i>	83.94% ⁺	★★
<i>Postpartum Care</i>	72.26% ⁺	★
Behavioral Health		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
<i>18+ Years</i>	49.39%	★
Antidepressant Medication Management		
<i>Effective Acute Phase Treatment—Total (18+ Years)</i>	63.77%	★★
<i>Effective Continuation Phase Treatment—Total (18+ Years)</i>	44.83%	★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
<i>18–64 Years</i>	82.55% [^]	★★
Follow-Up After ED Visit for Mental Illness		
<i>7-Day Follow-Up—Total (6+ Years)</i>	47.59% [^]	★★★★
<i>30-Day Follow-Up—Total (6+ Years)</i>	59.09% [^]	★★★★
Follow-Up After ED Visit for Substance Use		
<i>7-Day Follow-Up—Total (13+ Years)</i>	31.30% [^]	★★★★
<i>30-Day Follow-Up—Total (13+ Years)</i>	40.72% [^]	★★★★

Performance Measure	CY 2024 Performance	2024 Performance Level ¹
<i>Follow-Up After Hospitalization for Mental Illness</i>		
7-Day Follow-Up—Total (6+ Years)	46.30% [^]	★★★
30-Day Follow-Up—Total (6+ Years)	64.34% [^]	★★★
<i>Follow-Up Care for Children Prescribed ADHD Medication (ECDS)</i>		
Initiation Phase (6–12 Years)	60.65% [^]	★★★★★
Continuation and Maintenance Phase (6–12 Years)	69.32% [^]	★★★★★
<i>Initiation and Engagement of Substance Use Disorder Treatment</i>		
Initiation of SUD Treatment—Total—Total (13+ Years)	48.17% [^]	★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	18.52% [^]	★★★
<i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</i>		
Total (1–17 Years)	72.19% [^]	★★★★★
<i>Use of Opioids at High Dosage</i>		
18+ Years*	5.85%	★★
<i>Care of Acute and Chronic Conditions</i>		
<i>Glycemic Status Assessment for Patients With Diabetes</i>		
Glycemic Status <8.0%—Total (18–75 Years)	65.69% ^{+^}	★★★★★
Glycemic Status >9.0%—Total (18–75 Years)*	26.03% ^{+^}	★★★★★
<i>Pediatric Health</i>		
<i>Child and Adolescent Well-Care Visits</i>		
Total (3–21 Years)	56.34% [^]	★★★
<i>Childhood Immunization Status**</i>		
Combination 3	69.83% ^{+^}	★★★
Combination 7	60.83% ^{+^}	★★★
Combination 10	26.52% ⁺	★★
<i>Childhood Immunization Status (ECDS)**</i>		
Combination 3	64.77% [^]	★★★
Combination 7	57.50% [^]	★★★★★
Combination 10	23.98%	★★★

Performance Measure	CY 2024 Performance	2024 Performance Level ¹
Developmental Screening in the First Three Years of Life		
Total (0–3 Years)	24.82% ⁺	NC [±]
Immunizations for Adolescents**		
Combination 1 (Meningococcal, Tdap)	86.86% ⁺⁺	★★★★
Combination 2 (Meningococcal, Tdap, HPV)	40.63% ⁺⁺	★★★
Immunizations for Adolescents (ECDS)**		
Combination 1 (Meningococcal, Tdap)	82.61% [^]	★★★
Combination 2 (Meningococcal, Tdap, HPV)	39.98% [^]	★★★
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	45.36% [^]	★★★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total (3–17 Years)	82.48% ⁺⁺	★★
Counseling for Nutrition—Total (3–17 Years)	80.29% ⁺⁺	★★★
Counseling for Physical Activity—Total (3–17 Years)	77.13% ⁺⁺	★★★
Well-Child Visits in the First 30 Months of Life		
First 15 Months—Six or More Well-Child Visits	68.93% [^]	★★★★
15 Months–30 Months—Two or More Well-Child Visits	70.96%	★★
Preventive Screening		
Breast Cancer Screening		
Total (50–74 Years)	54.85%	NC [±]
Breast Cancer Screening (ECDS)		
Total (50–74 Years)	54.57%	★★
Cervical Cancer Screening		
21–64 Years	60.10% ⁺⁺	★★★
Cervical Cancer Screening (ECDS)		
21–64 Years	47.94%	★★
Colorectal Cancer Screening (ECDS)		
Total (45–75 Years)	39.30%	★★

Performance Measure	CY 2024 Performance	2024 Performance Level ¹
Appropriate Utilization of Services		
Plan All-Cause Readmissions		
Observed/Expected (O/E) Ratio—Total (18–64 Years)*	1.1753	★★
Oral Health		
Oral Evaluation, Dental Services		
Total (0–20 Years)	51.68% [^]	★★★★

* A lower rate indicates better performance for this measure.

** Table A-2 in [Appendix A. Methodology](#) outlines which immunizations are included within each combination.

NC[±] indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

+ Indicates the measure was reported using hybrid methodology.

 and [^] indicates that the rate met or exceeded the MY 2024 national Medicaid mean.

¹ Performance Levels for CY 2024 were based on comparisons of the HEDIS MY 2024 measure rates to national Medicaid Quality Compass HEDIS MY 2024 benchmarks.

Performance Levels for 2024 represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

**Table B-2—CY 2024 AzCH-CCP and Care1st ACC-RBHA SMI-Designated Program Performance Measure
Aggregate Results**

Performance Measure	CY 2024 Performance	2024 Performance Level ¹
Maternal and Perinatal Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	77.38% ⁺	★
Postpartum Care	64.29% ⁺	★
Behavioral Health		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
18+ Years	64.81%	★★
Antidepressant Medication Management		
Effective Acute Phase Treatment—Total (18+ Years)	55.83%	★
Effective Continuation Phase Treatment—Total (18+ Years)	40.99%	★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		

Performance Measure	CY 2024 Performance	2024 Performance Level ¹
18–64 Years	85.27% [^]	★★★★
Follow-Up After ED Visit for Mental Illness		
7-Day Follow-Up—Total (6+ Years)	62.40% [^]	★★★★★
30-Day Follow-Up—Total (6+ Years)	78.07% [^]	★★★★★
Follow-Up After ED Visit for Substance Use		
7-Day Follow-Up—Total (13+ Years)	54.05% [^]	★★★★★
30-Day Follow-Up—Total (13+ Years)	69.94% [^]	★★★★★
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up—Total (6+ Years)	61.63% [^]	★★★★★
30-Day Follow-Up—Total (6+ Years)	79.47% [^]	★★★★★
Initiation and Engagement of Substance Use Disorder Treatment		
Initiation of SUD Treatment—Total—Total (13+ Years)	49.94% [^]	★★★
Engagement of SUD Treatment—Total—Total (13+ years)	15.70%	★★★
Use of Opioids at High Dosage		
18+ Years*	7.79%	★
Care of Acute and Chronic Conditions		
Glycemic Status Assessment for Patients With Diabetes		
Glycemic Status <8.0%—Total (18–75 Years)	67.88% ^{+^}	★★★★★
Glycemic Status >9.0%—Total (18–75 Years)*	23.84% ^{+^}	★★★★
Pediatric Health		
Child and Adolescent Well-Care Visits		
Total (3–21 Years)	32.88%	★
Preventive Screening		
Breast Cancer Screening		
Total (50–74 Years)	45.47%	NC [±]
Breast Cancer Screening (ECDS)		
Total (50–74 Years)	45.38%	★
Cervical Cancer Screening		
21–64 Years	47.69% ⁺	★
Cervical Cancer Screening (ECDS)		

Performance Measure	CY 2024 Performance	2024 Performance Level ¹
21–64 Years	41.93%	★
Colorectal Cancer Screening (ECDS)		
Total (45–75 Years)	33.04%	★
Appropriate Utilization of Services		
Plan All-Cause Readmissions		
Observed/Expected (O/E) Ratio—Total (18–64 Years)*	1.7042	★
Oral Health		
Oral Evaluation, Dental Services		
Total (0–20 Years)	23.93%	★

* A lower rate indicates better performance for this measure.

NC[±] indicates the measure has no NCQA Medicaid mean and/or no NCQA Quality Compass National Medicaid HEDIS MY 2024 benchmarks for comparison, the CY 2023 rate was not presented, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

+ Indicates the measure was reported using hybrid methodology.

 and ^ indicates that the rate met or exceeded the MY 2024 national Medicaid mean.

¹ Performance Levels for CY 2024 were based on comparisons of the HEDIS MY 2024 measure rates to national Medicaid Quality Compass HEDIS MY 2024 benchmarks.

Performance Levels for 2024 represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Appendix C. Acknowledgements and Copyrights

CAHPS® refers to the Consumer Assessment of Healthcare Providers and Systems and is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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