

Arizona Health Care Cost Containment System



Contract Year Ending 2021 External Quality Review Annual Technical Report *for* **Arizona Long Term Care System**

April 2022



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Overview of the Contract Year Ending (CYE) 2021 External Review

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

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

- Validation of performance measures required in accordance with §438.330(b)(2).
- Validation of performance improvement projects (PIPs).
- An operational review (OR) conducted within the previous three-year period to determine the MCO's, PIHP's, or PAHP's compliance with the standards set forth in Subpart D of §438.
- Validation of network adequacy to comply with requirements set forth in §438.68.

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

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

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

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

AHCCCS contracted with Health Services Advisory Group, Inc. (HSAG), as its CMS-required EQRO, to prepare this annual EQR technical report.

This report presents:

- AHCCCS' findings from conducting each activity.
- HSAG's analysis and assessment of the reported results for each Contractor's performance.
- Recommendations to improve Contractors' performance, as applicable.

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

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

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

HSAG has prepared the annual technical report for AHCCCS for 18 consecutive years. The report complies with all requirements set forth at 42 CFR §438.364.

This executive summary includes an overview of AHCCCS' EQR activities as provided to HSAG and a high-level summary of the results. The results include a description of HSAG's findings with respect to

performance by the AHCCCS Contractors in complying with the AHCCCS contract requirements and the applicable federal 42 CFR §438 requirements for each activity. In addition, this executive summary includes an assessment of each Contractor's strengths and opportunities for improvement related to the quality and timeliness of, and access to healthcare services as well as HSAG's recommendations for improving the quality of services.

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

- **Introduction to the Annual Technical Report:** An introduction to the annual technical report, including a description of the EQR mandatory activities.
- **Overview of the Arizona Health Care Cost Containment System:** An overview of AHCCCS' background including the Medicaid managed care history, AHCCCS' Strategic Plan with key accomplishments for CYE 2021, AHCCCS' Quality Strategy, and waivers and legislative changes impacting AHCCCS' Medicaid programs.
- **Quality Initiatives:** An overview of AHCCCS' statewide quality initiatives across its Medicaid managed care program and those specific to the Arizona Long Term Care System (ALTCS) program for CYE 2021.
- **Contractor Best and Emerging Practices:** An overview of the Contractors' best and emerging practices for CYE 2021.
- **Performance Measure Results:** A presentation of results for select performance measures for each Contractor, as well as HSAG's associated findings and recommendations for calendar year (CY)/measurement year (MY) as appropriate, to reflect the change in approach for performance measure calculations starting with CY 2020 (i.e., moving from CYE to CY measurement period).
- **PIPs:** A presentation of results for the *Breast Cancer Screening* and *Back to Basics* PIPs that were initiated CYE 2019.
- **Organizational Assessment and Structure Performance:** A review of organization review methodology and processes.
- **Network Adequacy Update:** A presentation of results for the network adequacy validation (NAV) and analysis conducted in CYE 2021 and HSAG's associated findings.

Please see appendices A, B, and C for an overview of the AHCCCS methodology for the performance measure, PIP, and OR activities, including objectives, descriptions of data obtained, technical methods of data collection and analysis, scoring methodology, and corrective action statements. Appendix D includes the NAV study methodology and Contractor results by quarter and county. Appendix E includes the complete text of AHCCCS' CYE 2021 Network Adequacy Report.

Contractors Reviewed

During the CYE 2021 review cycle, AHCCCS contracted with the Contractors¹⁻² listed in Table 1-1 to provide services to members enrolled in the AHCCCS ALTCS Medicaid managed care program. Associated abbreviations are included.

Table 1-1—AHCCCS Contracted LTC Providers

ALTCS Contracted Providers	
Contractor Name	Contractor Abbreviation
Arizona Long Term Care System (ALTCS), Elderly and Physically Disabled (EPD)	ALTCS-EPD
Banner University Family Care	BUFC LTC
Mercy Care	Mercy Care LTC
UnitedHealthcare Community Plan	UHCCP LTC
Arizona Long Term Care System (ALTCS), Developmental Disabilities (DD)	ALTCS-DD
Department of Economic Security, Division of Developmental Disabilities	DES/DDD

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

The following section provides a high-level summary of HSAG’s findings and conclusions about the quality and timeliness of, and access to care furnished to AHCCCS members across activities. For each Contractor reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the Contractor’s performance, which can be found in sections 7–11 of this report.

Performance Measures

CYE 2021 Performance Measure Validation

During CYE 2021, HSAG validated and reported Contractor performance for a set of CY 2020/MY 2020 performance measures related to providing quality, timely, and accessible care and services to AHCCCS members. The purpose of performance measure validation (PMV) is to assess the accuracy of

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

performance measures reported by Contractors and to determine the extent to which performance measures reported by the Contractors follow State specifications and reporting requirements. According to the CMS publication, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019,¹⁻³ the mandatory PMV activity may be performed by the State Medicaid agency, an agent that is not an MCO, or an EQRO.

The following tables display the performance measure rates for measures that could be compared to the National Committee for Quality Assurance’s (NCQA’s) Quality Compass[®],¹⁻⁴ national Medicaid health maintenance organization (HMO) mean for Healthcare Effectiveness Data and Information Set (HEDIS[®])¹⁻⁵ MY 2020. Contractor-specific performance measure results, including an assessment of strengths, opportunities for improvement, and recommendations, are included in Section 8, with additional performance measures (i.e., measures that could not be compared to NCQA Quality Compass national Medicaid HMO means) and findings from the CYE 2021 PMV activity included in Appendix A of this report.

Of note, some access to care challenges may have been the result of the coronavirus disease 2019 (COVID-19) public health emergency (PHE), as some in-person services were temporarily suspended.

ALTCS-EPD Aggregate Findings

Table 1-2 presents the MY 2020 aggregate performance measure results for the ALTCS-EPD Contractors. Of note, the ALTCS-EPD Aggregate rates include all members who met the enrollment criteria within the ALTCS-EPD line of business (LOB). Performance measure rate cells shaded green indicate that aggregate performance met or exceeded NCQA’s Quality Compass national Medicaid HMO mean for HEDIS MY 2020. 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.

Table 1-2—MY 2020 Aggregate Performance Measure Results for the ALTCS-EPD Program

Performance Measure	MY 2020 Performance
Behavioral Health Care	
<i>Antidepressant Medication Management</i>	
<i>Effective Acute Phase Treatment</i>	72.6%
<i>Effective Continuation Phase Treatment</i>	63.0%
<i>Follow-Up After Hospitalization for Mental Illness</i>	
<i>7-Day Follow-Up—Total</i>	36.6%


¹⁻³ The Centers for Medicare & Medicaid Services. *CMS External Quality Review (EQR) Protocols*, October 2019. Available at: <https://www.medicare.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html>. Accessed on: Dec 7, 2021.

¹⁻⁴ Quality Compass[®] is a registered trademark of the NCQA.

¹⁻⁵ HEDIS[®] is a registered trademark of NCQA.

Performance Measure	MY 2020 Performance
<i>30-Day Follow-Up—Total</i>	49.7%
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment	
<i>Total Initiation of AOD—Total</i>	50.8%
<i>Total Engagement of AOD—Total</i>	4.3%
Care of Acute and Chronic Conditions	
Comprehensive Diabetes Care	
<i>Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*</i>	39.4%
Preventive Screening	
Breast Cancer Screening	
<i>Total</i>	36.3%

* A lower rate indicates better performance for this measure.

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

ALTCS-EPD Aggregate Conclusions and Recommendations

Table 1-3—AHCCCS 2021 Aggregate Performance Measurement Strengths, Opportunities for Improvement, and Recommendations for the ALTCS-EPD Program

Performance Measurement
Program Strengths
<p>1. For the <i>Antidepressant Medication Management</i> measure in the Behavioral Health Care domain, two of three (66.7 percent) ALTCS-EPD Contractors and the ALTCS-EPD Aggregate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 for the <i>Effective Acute Phase Treatment</i> measure indicator, and all three ALTCS-EPD Contractors and the ALTCS-EPD Aggregate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 for the <i>Effective Continuation Phase Treatment</i> measure indicator, indicating that most members with a diagnosis of major depression were 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.¹⁻⁶</p> <p>2. In the Care of Acute and Chronic Conditions domain, two of three (66.7 percent) ALTCS-EPD Contractors and the ALTCS-EPD Aggregate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 for the <i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)</i> measure indicator, indicating that members with diabetes were able to manage their condition according to evidence-based guidelines through the appropriate use of</p>

¹⁻⁶ National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: <https://www.ncqa.org/hedis/measures/antidepressant-medication-management/>. Accessed on: Jan 25, 2022.

Performance Measurement
<p>medications, diet and nutrition, or physical activity. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.¹⁻⁷</p>
Program Opportunities for Improvement and Recommendations
<p>1. In the Behavioral Health Care domain, all three ALTCS-EPD Contractors’ and the ALTCS-EPD Aggregate performance measure rates for <i>Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment—Engagement of AOD—Total—Total</i> did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and fell below the 25th percentile, indicating that members with a new episode of AOD dependence were not always accessing AOD services or medication-assisted treatment (MAT) within 34 days of the initiation visit. Treatment, including MAT, in conjunction with counseling or other behavioral therapies, has been shown to reduce AOD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.¹⁻⁸</p> <p>Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended</p> <p style="margin-left: 40px;">Recommendation: HSAG recommends that AHCCCS support the ALTCS-EPD Contractors in conducting a root cause analysis to determine why members were not receiving timely AOD services or MAT. The ALTCS-EPD Contractors should consider the nature and scope of the issue (e.g., are the issues related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). Additionally, the ALTCS-EPD Contractors should identify factors related to the COVID-19 PHE and how access to care was impacted. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, the ALTCS-EPD Contractors should implement appropriate interventions to improve the performance related to initiating and engaging in timely treatment following a new episode of AOD dependence.</p>
<p>2. In the Preventive Screening domain, all three ALTCS-EPD Contractors’ and the ALTCS-EPD Aggregate performance measure rates for <i>Breast Cancer Screening</i> did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and fell below the 25th percentile, indicating that women were not 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.¹⁻⁹</p>

¹⁻⁷ National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: <https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/>. Accessed on: Jan 25, 2022.

¹⁻⁸ National Committee for Quality Assurance. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET). Available at: <https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/>. Accessed on: Jan 25, 2022.

¹⁻⁹ National Committee for Quality Assurance. Breast Cancer Screening (BCS). Available at: <https://www.ncqa.org/hedis/measures/breast-cancer-screening/>. Accessed on: Jan 25, 2022.

Program Opportunities for Improvement and Recommendations

A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE.

Recommendation: HSAG recommends that AHCCCS support the ALTCS-EPD Contractors in conducting a root cause analysis or focused study to determine why its female members were not receiving timely screenings for breast cancer. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, the ALTCS-EPD Contractors should implement appropriate interventions to improve the performance related to preventive screenings.

ALTCS-DD Aggregate Findings

Table 1-4 presents the MY 2020 aggregate performance measure results for ALTCS-DD. Performance measure rate cells shaded green indicate that aggregate performance met or exceeded NCQA’s Quality Compass national Medicaid HMO mean for HEDIS MY 2020. 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.

Table 1-4— MY 2020 Performance Measure Results for the ALTCS-DD Program

Performance Measure	MY 2020 Performance ^A
Behavioral Health Care	
<i>Antidepressant Medication Management</i>	
<i>Effective Acute Phase Treatment</i>	72.9%
<i>Effective Continuation Phase Treatment</i>	69.7%
<i>Follow-Up After Hospitalization for Mental Illness</i>	
<i>7-Day Follow-Up—Total</i>	68.9%
<i>30-Day Follow-Up—Total</i>	87.3%
<i>Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment</i>	
<i>Initiation of AOD—Total—Total</i>	38.8%
<i>Engagement of AOD—Total—Total</i>	S
Care of Acute and Chronic Conditions	
<i>Comprehensive Diabetes Care</i>	
<i>Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*</i>	24.2%
Pediatric Health	
<i>Child and Adolescent Well-Care Visits</i>	
<i>Total</i>	47.9%

Performance Measure	MY 2020 Performance [^]
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>	26.2%
Preventive Screening	
Breast Cancer Screening	
<i>Total</i>	47.4%

[^] Caution should be exercised when comparing MY 2020 performance to national Medicaid means, given the differences in the DES/DDD population compared to the overall Medicaid population.

* A lower rate indicates better performance for this measure.

S indicates that fewer than 11 cases exist in the numerator of this measure; therefore, the rate was suppressed to satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule’s de-identification standard.

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

DES/DDD Conclusions and Recommendations

Table 1-5—AHCCCS 2021 Performance Measurement Strengths, Opportunities for Improvement, and Recommendations for the ALTCS-DD Program

Performance Measurement
Program Strengths
1. DES/DDD performed well within the Behavioral Health Care domain, with four of six (66.7 percent) measure rates meeting or exceeding the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020.
2. DES/DDD performed well within the Care of Acute and Chronic Conditions domain, as the measure rate for <i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)</i> met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020.
3. Overall, DES/DDD had six of 11 (54.5 percent) measure rates meet or exceed the 50th percentile, with five of these measure rates (<i>Antidepressant Medication Management—Effective Acute Phase Treatment</i> and <i>Effective Continuation Phase Treatment, Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total</i> and <i>30-Day Follow-Up—Total</i> , and <i>Comprehensive Diabetes Care—HbA1c Poor Control [>9.0%]</i>) meeting or exceeding the 90th percentile. The measure rates that met or exceeded the 50th percentile were in the Behavioral Health Care and Care of Acute and Chronic Conditions domains.
Program Opportunities for Improvement and Recommendations
1. In the Behavioral Health Care domain, DES/DDD’s performance measure rates for <i>Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment—Initiation of AOD—Total—Total</i> and <i>Engagement of AOD—Total—Total</i> fell below the 25th percentile, indicating that members with a new episode of AOD dependence were not always initiating treatment within 14 days of diagnosis or accessing AOD services or MAT within 34 days of the initiation visit. Treatment, including MAT, in conjunction with counseling or other behavioral

Program Opportunities for Improvement and Recommendations

therapies, has been shown to reduce AOD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.

Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended.

Recommendation: HSAG recommends that AHCCCS support DES/DDD in conducting a root cause analysis to determine why members were not initiating treatment or receiving timely AOD services or MAT. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. DES/DDD should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). Additionally, DES/DDD should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, DES/DDD should implement appropriate interventions to improve the performance related to initiating and engaging in timely treatment following a new episode of AOD dependence.

2. In the Pediatric Health domain, DES/DDD's performance measure rate for *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* fell below the 25th percentile, indicating that children were not always accessing well-child visits with a PCP or Obstetrics/Gynecology (OB/GYN) practitioner. Well-care visits provide an opportunity for providers to influence health and development and they are a critical opportunity for screening and counseling.¹⁻¹⁰

A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE.

Recommendation: HSAG recommends that AHCCCS support DES/DDD in conducting a root cause analysis to determine why children were not always accessing well-child visits. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. DES/DDD should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of PCP or OB/GYN service providers, or the need for community outreach and education). Upon identification of a root cause, DES/DDD should implement appropriate interventions to improve the performance related to well-care visits.

¹⁻¹⁰ National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: <https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/#:~:text=Well%2DChild%20Visits%20in%20the,first%2015%20months%20of%20life>. Accessed on: Jan 25, 2022.

Performance Improvement Projects (PIPs)

Breast Cancer Screening

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Breast Cancer Screening* PIP for ALTCS-EPD, due to the prevalence of breast cancer among women. 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. The objective of the *Breast Cancer Screening* PIP is to increase the number and percentage of breast cancer screenings. CY 2020 served as an intervention year for this PIP; as the PIP is in the early stages of implementation, repeated measurements are not yet available. Improvement for subsequent remeasurement years in comparison to the baseline year will be evaluated using Contractor-calculated performance measure rates that have undergone EQRO validation.

Table 1-6 provides a high-level overview of AHCCCS PIP strengths, opportunities for improvement, and recommendations for ALTCS-EPD for CYE 2021. A summary of activities, including individual plan overviews and comparative analysis is provided in Section 7.

Table 1-6—AHCCCS 2021 PIP Strengths, Opportunities for Improvement, and Recommendations for the ALTCS-EPD Program

Performance Improvement Projects	
Program Strengths	
1.	For CYE 2021, AHCCCS ensured that all Contractors had interventions in place that may lead to improvement in indicator outcomes. [Quality, Access, and Timeliness]
Program Opportunities for Improvement and Recommendations	
<p>Recommendation: CYE 2021 served as an intervention year for the <i>Breast Cancer Screening</i> PIP. HSAG recommends that AHCCCS continue to support the Contractors in the implementation of interventions for the <i>Breast Cancer Screening</i> PIP. Specific opportunities for improvement and additional recommendations will be provided after the first remeasurement year (CY 2022).</p>	

Back to Basics

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Back to Basics* PIP for the AHCCCS Complete Care (ACC)/KidsCare, Department of Child Safety Comprehensive Health Plan (DCS CHP) (formerly Comprehensive Medical and Dental Program [CMDP]), and Division of Developmental Disabilities (DDD) populations. Well-care and annual dental visits for children and adolescents aim to promote optimal health and development. Ensuring that children and adolescents receive regular well-care and dental visits is critical in disease prevention, early detection, and treatment. There are many benefits of well-child/well-care visits. The objective of the *Back to Basics* PIP is to increase the number of child and adolescent well-child/well-care visits, as well as increase the number of

children and adolescents receiving annual dental visits. CY 2020 served as an intervention year for this PIP; as the PIP is in the early stages of implementation, repeated measurements are not yet available. Improvement for subsequent remeasurement years in comparison to the baseline year will be evaluated using Contractor-calculated performance measure rates that have undergone EQRO validation.

Table 1-7 provides a high-level overview of AHCCCS PIP strengths, opportunities for improvement, and recommendations for DES/DDD for CYE 2021. A summary of activities, including individual plan overviews and comparative analysis is provided in Section 7.

Table 1-7—AHCCCS 2021 PIP Strengths, Opportunities for Improvement, and Recommendations for the ALTCS-DD Program

Performance Improvement Projects
Program Strengths
1. For CYE 2021, AHCCCS ensured that DES/DDD had interventions in place that may lead to improvement in indicator outcomes. [Quality, Access, and Timeliness]
Program Opportunities for Improvement and Recommendations
Recommendation: CYE 2021 served as an intervention year for the <i>Back to Basics</i> PIP. HSAG recommends that AHCCCS continue to support DES/DDD in the implementation of interventions for the <i>Back to Basics</i> PIP. Specific opportunities for improvement and additional recommendations will be provided after the first remeasurement year (CY 2022).

Organizational Assessment and Structure Standards

AHCCCS postponed its OR activities at the onset of the COVID-19 PHE to allow the Contractors the ability to focus on ensuring members received appropriate care and services during the PHE, in part through supporting their provider networks. AHCCCS resumed OR activities in June 2021.

The ALTCS-EPD Contractors were reviewed during the three-year cycle that started in CYE 2019. The findings for these Contractors’ ORs were included in the *Contract Year Ending 2019 External Quality Review Annual Report for Arizona Long Term Care System (ALTCS) Contractors*. Review of the EPD Contractors’ OR CAPs was put on hold due to the COVID-19 PHE. Review of the CAPs resumed in CYE 2021; however, final documentation was not available to include within this year’s report. Information pertaining to organizational reviews, including methodology, is included in Section 9.

Table 1-8—AHCCCS 2021 OR Strengths, Opportunities for Improvement, and Recommendations for the ALTCS-EPD Program

Operational Reviews
Program Strengths
Program strengths are not applicable as ORs were postponed during CYE 2021.

Program Opportunities for Improvement and Recommendations
<p>Program opportunities for improvement are not applicable, as ORs were postponed during CYE 2021.</p> <p>Recommendation: HSAG recommends that AHCCCS continue performing OR reviews with the ALTCS-EPD Contractors to ensure continuity with compliance.</p>

AHCCCS conducted the DES/DDD OR review in August 2021; however, final documentation was not available to include within this year's report. Information pertaining to organizational reviews, including methodology, is included in Section 9.

Table 1-9—AHCCCS 2021 OR Strengths, Opportunities for Improvement, and Recommendations for the ALTCS-DD Program

Operational Reviews
Program Strengths
<p>Program strengths are not applicable as ORs were postponed for CYE 2021.</p>
Program Opportunities for Improvement and Recommendations
<p>Program opportunities for improvement are not applicable, as ORs were postponed for CYE 2021.</p> <p>Recommendation: HSAG recommends that AHCCCS continue finalizing the OR review with the DES/DDD Contractor to ensure continuity with compliance.</p>

Network Adequacy Validation (NAV)

Biannually, each ALTCS-EPD Contractor and each DES/DDD subcontracted health plan submits its contracted network to AHCCCS along with its internal assessment of compliance with the applicable standards. HSAG’s NAV considered compliance with up to 12 AHCCCS-established time/distance standards for specific provider types and populations applicable to the ALTCS-EPD Contractors. HSAG assembled biannual analytical results for the CYE 2021 measurement period for all member coverage areas for each ALTCS-EPD Contractor and DES/DDD subcontracted health plan. Additionally, detailed time/distance results were presented to AHCCCS and each Contractor and subcontracted health plan in an interactive Tableau dashboard filterable by LOB, Contractor, urbanicity, county, and provider category.

ALTCS-EPD

HSAG’s biannual NAV determined that one ALTCS-EPD Contractor, Mercy Care LTC, met all requirements for all standards across all counties; also, all ALTCS-EPD Contractors met all minimum time/distance network standards in Apache, Cochise, Gila, Graham, Greenlee, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties during both quarters. Additionally, all the ALTCS-EPD Contractors met all minimum time/distance network standards in both quarters except for

Nursing Facility and Pharmacy. Due to data-related concerns, rather than network limitations, HSAG was unable to accurately validate and assess compliance for BUFC LTC’s reported Dentist, Pediatric provider category. Results are shown for informational purposes only.

Table 1-10—AHCCCS 2021 NAV Strengths, Opportunities for Improvement, and Recommendations for the ALTCS-EPD Program

Network Adequacy Validation
Program Strengths
<ol style="list-style-type: none"> ALTCS-EPD Contractors consistently met all time/distance network standards for both quarters in CYE 2021 for all counties, except for the Nursing Facility and Pharmacy provider categories.
Program Opportunities for Improvement and Recommendations
<ol style="list-style-type: none"> Isolated data issues may have contributed to specific instances affecting the ALTCS-EPD Contractors’ compliance with time/distance standards. <p style="margin-left: 40px;">Recommendation: HSAG recommends that AHCCCS support the ALTCS-EPD Contractors in continuing to monitor their processes for creating the Provider Affiliation Transmission (PAT) and review the PAT file for accuracy prior to submitting to AHCCCS.</p> Based on the quarterly NAV results, not all ALTCS-EPD contractors met all requirements for all standards across all quarters and counties. <p style="margin-left: 40px;">Recommendation: HSAG recommends that AHCCCS support the ALTCS-EPD Contractors in continuing to monitor and maintain existing provider network coverage, with specific attention to ensuring the availability of nursing facilities in Coconino County and pharmacies in La Paz County.</p>

DES/DDD

AHCCCS maintains a contract with DES/DDD to provide acute care, behavioral health, and long-term services and supports (LTSS). As of October 1, 2019, DES/DDD elected to subcontract the acute care and behavioral health services to two statewide Contractors, Mercy Care DD [Developmental Disabilities] and UHCCP DD. Biannually, DES/DDD submitted its subcontracted health plans’ contracted provider network data to AHCCCS along with its internal assessment of compliance with the applicable network standards for DES/DDD members. HSAG’s NAV considered biannual compliance with 11 AHCCCS-established time/distance standards specific provider types and populations applicable to the ALTCS-DD subcontracted health plans for the CYE 2021 measurement period.

Both ALTCS-DD subcontracted health plans met all minimum time/distance network standards during both quarters in Cochise, Gila, Graham, Maricopa, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. Both ALTCS-DD subcontracted health plans met the minimum time/distance network requirements in each quarter for Behavioral Health Residential Facility, Obstetrics/Gynecology (OB/GYN), and Primary Care Practitioner (PCP), Pediatric providers.

Table 1-11—AHCCCS 2021 NAV Strengths, Opportunities for Improvement, and Recommendations for the ALTCS-DD Program

Network Adequacy Validation	
Program Strengths	
1. Both statewide ALTCS-DD subcontracted health plans met minimum network standards in all quarters for the majority of counties in the Central and South regions.	
Program Opportunities for Improvement and Recommendations	
1. With both ALTCS-DD subcontracted health plans failing to meet standards for at least one quarter and/or county, ALTCS-DD subcontracted health plans commonly struggled to meet minimum time/distance network standards in North region counties.	
<p style="text-align: center;">Recommendation: HSAG recommends that AHCCCS support the ALTCS-DD and its subcontracted health plans in continuing to monitor and maintain existing provider network coverage, with specific attention to ensuring the availability of behavioral health outpatient and integrated clinics for adults and adult cardiologists in Apache County.</p>	

Refer to Appendix D for the complete study methodology, ALTCS-EPD Contractor and ALTCS-DD subcontracted health plan results by quarter and county.

Overall Assessment of Progress in Meeting EQRO Recommendations

During the previous year, HSAG made recommendations in the annual reports for each activity conducted. Section 3, under *AHCCCS Follow-Up on Prior Year Recommendations* includes summaries of AHCCCS’ follow-up actions per activity for the ALTCS LOB in response to HSAG’s recommendations. Section 5 includes the Contactors’ responses to HSAG’s recommendations.

2. Introduction to the Annual Technical Report

Description of EQR Activities

Mandatory Activities

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

- Validate Contractor PIPs—validation performed by AHCCCS.
- Validate Contractor performance measures—validation performed by HSAG.
- Provide summary and findings of Contractors’ performance in complying with the AHCCCS’ contract requirements and the federal Medicaid managed care regulations—review performed by AHCCCS.
- Validate Contractor network adequacy—validation performed by HSAG.

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

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

Optional Activities

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

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

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

information about the EQRO’s independent assessment process; results obtained from the assessment; and, as applicable to its findings, recommendations for improvement. AHCCCS uses the information to assess the effectiveness of its current strategic goals and related strategies and to provide a roadmap for potential changes and new goals and strategies.

Quality, Access, and Timeliness

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

CMS defines “quality” in the 2016 federal health care regulations at 42 CFR §438.320 as follows: Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM entity increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and through interventions for performance improvement.²⁻¹

CMS defines “access” in the 2016 regulations at 42 CFR §438.320 as follows: Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 42 CFR §438.68 (Network adequacy standards) and 42 CFR §438.206 (Availability of services).²⁻²

Federal managed care regulations at 42 CFR §438.206 require the state to define its standards for timely access to care and services. Timeliness standards must take into account the urgency of the need for services. HSAG extends the definition of “timeliness” to include other federal managed care provisions that impact services to enrollees and that require timely response by the MCO/PIHP—e.g., processing expedited member grievances and appeals and providing timely follow-up care. In addition, NCQA defines “timeliness” relative to utilization decisions as follows: “The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation.”²⁻³ It further discusses the intent of this standard to minimize any disruption in the provision of healthcare.

²⁻¹ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

²⁻² Ibid.

²⁻³ National Committee for Quality Assurance. 2013 Standards and Guidelines for the Accreditation of Health Plans.

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

This section of the report includes a brief history of the AHCCCS Medicaid managed care programs and a description of AHCCCS' Strategic Plan for State Fiscal Years (SFYs) 2018–2023 (Strategic Plan). The description of the Strategic Plan includes the four goals:³⁻¹

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

AHCCCS Medicaid Managed Care Program History

Since 1982, AHCCCS, the single state Medicaid agency for Arizona, has operated under the authority of the federal Medicaid Demonstration 1115 Waiver under Section 1115 of the Social Security Act, which has allowed for the operation of an integrated managed care model. AHCCCS uses State, federal, and county funds to administer pediatric, acute, long-term, and behavioral healthcare programs to the State's Medicaid members. AHCCCS has an appropriated budget of approximately \$18.3 billion to administer its programs, which provide services for over two million individuals and families in Arizona through a provider network credentialed and contracted by its Contractors. The AHCCCS Acute Care Program began in 1982 and in 1988, AHCCCS added the Arizona Long Term Care System (ALTCS) Program for individuals with developmental disabilities, and then expanded the program in January 1989 to include the elderly and physically disabled (EPD) populations. ALTCS provides acute care, behavioral health services, LTC, and case management to AHCCCS members who are elderly, physically disabled, or developmentally disabled and who meet the criteria for receiving care in a home and community based setting. Services for individuals with developmental disabilities in ALTCS are offered through the Arizona Department of Economic Security, Division of Developmental Disabilities (DES/DDD). The ALTCS members account for less than 4.0 percent of the AHCCCS population, with approximately 21.7 percent of the costs. American Indian/Alaskan Native (AI/AN) members may choose to receive services through the managed care structure or may opt to receive services through the fee-for-service program. Services for children in the foster care system are offered through DCS CHP (previously CMDP).

³⁻¹ Arizona Health Care Cost Containment System. AHCCCS Strategic Plan: State Fiscal Years 2014–2018. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan_14-18.pdf. Accessed on: Mar 10, 2021.

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. The Children's Health Insurance Program (CHIP) was incorporated in Arizona in 1998 and is known as KidsCare. In 2009, due to a persistently severe budget shortfall, a freeze was placed on enrollment in KidsCare. In 2016, Governor Ducey signed Senate Bill (SB) 1457 into law, ending the enrollment freeze on the KidsCare program. Children who qualify for this program receive care through AHCCCS Contractors. In October 2013, children enrolled in the Acute Care Program who had a Children's Rehabilitative Services (CRS) qualifying diagnosis were enrolled into one integrated CRS Contractor, UnitedHealthcare Community Plan (UHCCP). This was done to decrease fragmentation and reduce member confusion; ensure optimal access to primary, specialty, and behavioral care; enhance coordination of all service delivery; improve member outcomes and satisfaction; and streamline administration. At the same time, children with CRS qualifying conditions and enrolled in the ALTCS program, other than in DDD, were fully integrated into their ALTCS Contractors' provided services, including all primary, specialty, long-term, and behavioral healthcare related to the members' CRS conditions.

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

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

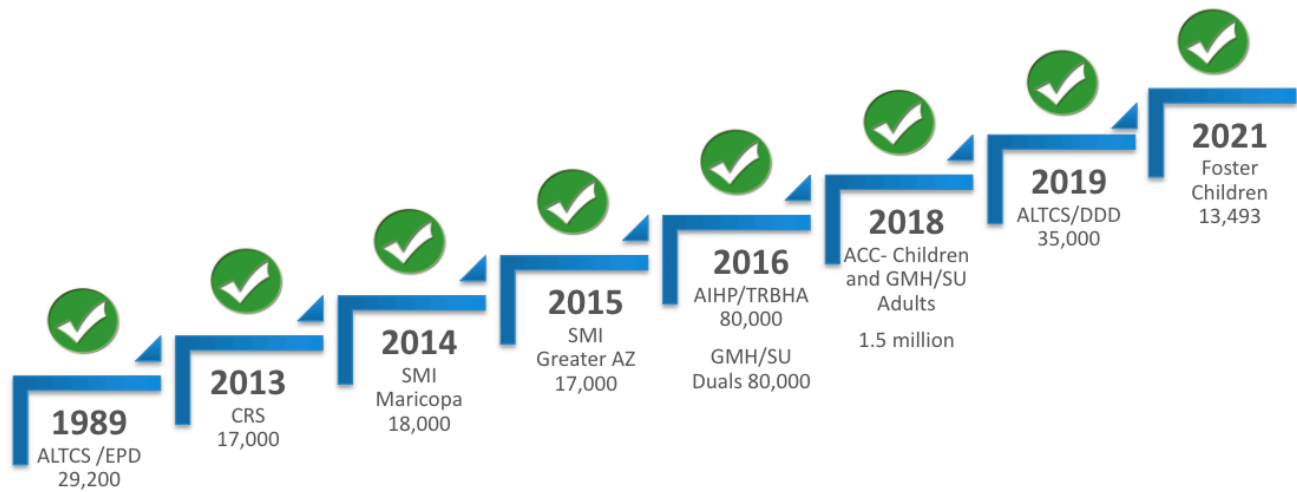
Beginning July 1, 2016, DBHS merged with AHCCCS, moving contractual oversight of the RBHAs to AHCCCS.

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

Effective October 1, 2018, AHCCCS implemented a delivery system reform that allows members who are not enrolled in an ALTCS-EPD program to also access physical and general mental health and substance use behavioral healthcare services through a single integrated delivery system model, ACC, with seven health plans. In addition, on October 1, 2018, service delivery was restructured into three geographic service areas (GSAs): North, Central, and South. Members continue to have a choice of health plans in their geographic service areas and to have access to a network of providers and the same array of covered services.

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

Integration Progress To Date



Effective October 1, 2022, AHCCCS expanded three ACC contracts to include RBHA services, thus furthering integration efforts.

American Indian members have the choice of enrolling in an ACC managed care plan or the American Indian Health Program (AIHP) and a Tribal RBHA when available. American Indian members have the same access to Indian Health Service (IHS) providers, Tribal 638 providers, and Urban Indian Health providers regardless of whether they are receiving services through managed care or the fee-for-service program.

AHCCCS Waiver Amendment Requests and Legislative Updates

COVID-19 PHE Flexibility

CMS approved components of Arizona’s requests under the 1135 Waiver, Appendix K, and the State Plan. Information regarding the status of AHCCCS Emergency Authority Requests (for the federally declared COVID-19 PHE) is available on the AHCCCS COVID-19 Federal Emergency Authorities Request web page.³⁻²

On March 17 and March 24, 2020, AHCCCS submitted requests to the CMS administrator to waive certain Medicaid and CHIP requirements in order to combat the continued spread of COVID-19. AHCCCS sought a broad range of emergency authorities, that include:

- Strengthen the provider workforce and remove barriers to care for AHCCCS members.
- Enhance Medicaid services and supports for vulnerable members for the duration of the emergency period.
- Remove cost sharing and other administrative requirements to support continued access to services.

1115 Waiver Update

CMS has extended AHCCCS’ 1115 Waiver Demonstration authority for a one-year period, through September 30, 2022, while CMS continues to review the agency’s full 1115 Waiver renewal application. The extension grants authority to continue specific programs for a sixth year, including the Targeted Investments (TI) Program.

The larger 1115 Waiver renewal package, submitted to CMS on December 22, 2020, and subject to negotiation, seeks to implement new initiatives such as:

- Coverage of traditional healing.
- Authority to allow for verbal consent in lieu of written signature for up to 30 days for all care and treatment documentation for ALTCS members.
- Authority to reimburse IHS and Tribal 638 facilities to cover the cost of adult dental services that are eligible for 100 percent federal financial participation (FFP), that are in excess of the \$1,000 emergency dental limit for adult members in Arizona’s State Plan, and \$1,000 dental limit for individuals ages 21 or older enrolled in the ALTCS program.
- TI 2.0.³⁻³

³⁻² Arizona Health Care Cost Containment System. COVID-19 Federal Emergency Authorities Request. Available at: <https://azahcccs.gov/Resources/Federal/PendingWaivers/1135.html>. Accessed on: Jan 10, 2022.

³⁻³ Arizona Health Care Cost Containment System. Target Investments (TI) 2.0 Concept Paper. Available at: <https://azahcccs.gov/Resources/Federal/PendingWaivers/TI2.html>. Accessed on: Jan 17, 2022.

- Housing and Health Opportunities (H2O) demonstration.³⁻⁴

If approved, in part or in full, the next five-year waiver will run from October 1, 2022, through September 30, 2027.

More details on Arizona’s 1115 Waiver renewal request (2021–2026), along with the proposal and supplemental documentation, are available on the AHCCCS Section 1115 Waiver Renewal Request (2021–2026) web page.³⁻⁵

The current demonstration exempts Arizona from particular provisions of the Social Security Act and also includes expenditure authority permitting FFP for State expenditures that would not otherwise qualify for federal participation. Moreover, demonstration projects must establish budget neutrality where Medicaid costs to the federal government are not expected to exceed costs to the federal government in the absence of the demonstration.

With CMS’ approval of its demonstration renewal application, Arizona will continue its successful Medicaid program and implement programs including, but not limited to:

- Mandatory managed care.
- Home and community-based services for individuals in the ALTCS program.
- Administrative simplifications that reduce inefficiencies in eligibility determination.
- Integrated health plans for AHCCCS members.

1115 Waiver Evaluation

In accordance with Special Terms and Conditions (STC) 69, AHCCCS must submit a draft Waiver Evaluation Design for its 1115 Waiver demonstration. In addition, AHCCCS is also required by CMS to submit an Interim Evaluation Report and a Summative Evaluation Report of the 1115 Waiver Demonstration by December 31, 2020, and March 30, 2024, respectively.

AHCCCS has contracted with the Health Services Advisory Group (HSAG) to serve as the independent evaluator for Arizona’s 1115 Waiver Demonstration. In SFY 2019, AHCCCS worked with HSAG to develop Evaluation Design Plans for the following programs:

- ACC Program
- ALTCS Program
- CMDP

³⁻⁴ Arizona Health Care Cost Containment System. AHCCCS Housing and Health Opportunities (H2O) Demonstration. Available at: <https://azahcccs.gov/Resources/Federal/HousingWaiverRequest.html>. Accessed on: Jan 17, 2022.

³⁻⁵ Arizona Health Care Cost Containment System. Arizona’s Section 1115 Waiver Renewal Request (2022-2026). Available at: <https://azahcccs.gov/Resources/Federal/waiverrenewalrequest.html>. Accessed on: Jan 10, 2022.

- RBHAs
- TI Program
- Waiver of Prior Quarter Coverage
- AHCCCS Works Program

On November 13, 2019, AHCCCS submitted an Evaluation Design Plan to CMS for Arizona’s demonstration components noted above, with the exception of AHCCCS Works. Additionally, HSAG later developed, and AHCCCS submitted, a separate evaluation design plan to CMS for the AHCCCS Works program. Arizona’s waiver evaluation design plan was approved by CMS on November 19, 2020.

As required by the STCs of Arizona’s approved demonstration, an Interim Evaluation Report must be submitted and discuss the evaluation progress and findings-to-date, in conjunction with Arizona’s demonstration renewal application. Arizona’s interim evaluation report was submitted with the waiver renewal application on December 22, 2020.

Due to data limitations and operational constraints imposed by the COVID-19 PHE, Arizona’s previous interim evaluation report did not include data from all sources described in Arizona’s evaluation design plan. Qualitative data based on key informant interviews and focus groups, as well as member survey data, were not collected.

For this reason, an updated interim evaluation report was developed and completed by August 30, 2021. HSAG’s updated report contains results for additional years and includes findings-to-date from focus groups and qualitative interviews. In addition, the report used statistical techniques, where possible, to control for confounding factors and identify the impact of Arizona’s demonstration initiatives on access to care, quality of care, and member experience with care. Once approved by CMS, AHCCCS intends to post the updated interim evaluation report to its website.

Additionally, AHCCCS worked with HSAG on developing an Evaluation Design Plan for the COVID-19 section of Arizona’s 1115 Waiver, in accordance with the guidance issued by CMS on COVID-19 Section 1115 Waiver Monitoring and Evaluation. AHCCCS submitted the design plan to CMS on July 31, 2021. The COVID-19 Evaluation Design Plan was approved by CMS on February 1, 2022.

Legislative Updates

The legislature passed a number of bills in the 2021 legislative session that will impact the agency, including:

- HB 2392 (AHCCCS, graduate medical education, reimbursement) establishes a community health center graduate medical education (GME) program.
- HB 2521 (long-term care, health aides) creates a licensed health aide program to allow relatives to provide care to their family members with complex health conditions.

- SB 1505 (health information, disclosures, prohibition) allows State, county, or local health departments to disclose communicable disease and immunization-related information to the State’s health information exchange (HIE).
- SB 1824/SB 1823 (budget bills) contain appropriations for State agencies and programs. Specific to the AHCCCS administration, the budget included the following items:
 - Secured authorization to spend federal funds tied to approval of the AHCCCS Housing and Health Opportunities (H2O) waiver proposal.
 - Funding for critical IT projects.
 - Additional funding for providers of services for elderly and physically disabled individuals.

The Arizona Legislature adjourned *sine die* on June 30, 2021; the general effective date for legislation is September 29, 2021.

AHCCCS’ Strategic Plan

AHCCCS’ Strategic Plan for SFY 2022 presents the strategy and direction for AHCCCS, including new programs, initiatives, and past accomplishments. The Strategic Plan identifies AHCCCS’ mission, vision, and core values:³⁻⁶

- AHCCCS Vision: Shaping tomorrow’s managed healthcare...from today’s experience, quality, and innovation.
- AHCCCS Mission: Reaching across Arizona to provide comprehensive quality healthcare to those in need.

The Strategic Plan offers four multi-year strategies:

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

- Increase school safety
- Reduce health disparities

2. Pursue continuous quality improvement

- Increase use of AHCCCS’ automated provider enrollment platform
- Ensure seamless experience for individuals applying for AHCCCS benefits
- Address the behavioral health needs of uninsured and underinsured children
- Standardize treatment planning and placement for individuals with substance use disorders

³⁻⁶ Arizona Health Care Cost Containment System. Fiscal Year 2022 Strategic Plan. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/Plans/FY2022_2-Page_StrategicPlan.pdf. Accessed on: Jan 10, 2022.

3. Reduce fragmentation driving toward an integrated sustainable healthcare system

- Improve AHCCCS member connectivity to critical social services
- Provide a comprehensive resource for accessing treatment for opioid use disorder

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

- Maximize use of remote work options
- Prepare for anticipated staff retirements/departures

Key Accomplishments for AHCCCS

Following are key AHCCCS accomplishments related to the AHCCCS SFY 2020 Strategic Plan:

- Submitted proposal to CMS, outlining how AHCCCS intends to reinvest approximately \$1.5 billion in funding over the next 2.5 years, available to states through the home and community-based services provision of the American Rescue Plan Act (ARPA). AHCCCS received partial approval of the proposal from CMS on September 28, 2021.
- Released a request for proposal (RFP), soliciting bids from managed care organizations interested in serving individuals determined to have a serious mental illness under a Regional Behavioral Health Agreement.
- Received a one-year extension of AHCCCS' 1115 waiver from CMS.
- Implemented Housing Administrator contract, allowing for the streamlined distribution of \$30 million in rental subsidy funds to nearly 2,400 individuals each year.
- Implemented expanded Medicaid School Based Claiming Program, allowing all students to access school-based services (currently limited to students with an Individualized Education Program).

AHCCCS Quality Strategy and Quality Strategy Evaluation

AHCCCS enhanced the Quality Strategy by evaluating the report's structure, content, and data analysis. Part of the approach was to incorporate synchronized reporting processes to ensure alignment across various AHCCCS reports that relate to quality (e.g., Strategic Plan, Quality Strategy, and External Quality Review Organization Report). The AHCCCS Quality Strategy, Assessment, and Performance Improvement report is a coordinated, comprehensive, and proactive approach to drive improved health outcomes by utilizing creative initiatives, ongoing assessment and monitoring, and result-based performance improvement. Members, the public, and stakeholders provide input and recommendations regarding the content and direction of the Quality Strategy through stakeholder presentations and public comments. The AHCCCS Quality Strategy Evaluation is a companion document to the Quality Strategy for the purpose of evaluating the effectiveness of the AHCCCS Quality Strategy.

AHCCCS’ enhanced Quality Strategy was submitted to CMS in July 2018 for review and approval. In June 2020, AHCCCS began efforts to update its Quality Strategy to reflect changes within the Arizona Medicaid delivery system as well as incorporate the feedback received from CMS, in alignment with the required elements outlined in 42 CFR §438.340. AHCCCS’ Quality Strategy updates were posted to the AHCCCS website on June 30, 2021, and were submitted to CMS on July 1, 2021.

AHCCCS continues to demonstrate innovative and collaborative approaches to managing costs while improving the quality of systems, care, and services.

The targeted goals for AHCCCS’ quality strategy include:

- Quality Goal 1: Improve the member’s experience of care, including quality and satisfaction.
- Quality Goal 2: Improve the health of the AHCCCS population.
- Quality Goal 3: Reduce the growth in healthcare costs and lower costs per person.
- Quality Goal 4: Enhance data system and performance measure reporting capabilities.

Quality Strategy Strengths, Opportunities for Improvement, and Recommendations for Targeted Goals and Objectives to Improve Quality, Access, and Timeliness

Table 3-1 outlines Quality Strategy strengths and opportunities for improvement, as well as HSAG’s recommendations to AHCCCS for improving quality, timeliness, and access pertaining to the Quality Strategy.

Table 3-1—Quality Strategy Strengths, Opportunities for Improvement, and Recommendations to Improve Quality, Access, and Timeliness

Quality Strategy
Strengths
AHCCCS maintains a multi-faceted Quality Strategy that aims to improve health outcomes for members by utilizing creative initiatives, ongoing assessment and monitoring, and results-based performance improvement. [Quality, Access, and Timeliness]
Opportunities for Improvement and Recommendations
<p>HSAG recommends that AHCCCS:</p> <ul style="list-style-type: none"> • Persist in its efforts to improve the member experience of care, improve the health of populations, and reduce the per-capita growth of the cost of healthcare services. • Continue its efforts to evaluate and further expand data system capabilities in order to better understand and serve the member population. • Continue to monitor Contractor performance and adjust goals to encourage a positive trend in performance

Opportunities for Improvement and Recommendations

- Encourage and support each Contractor to continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations.

Follow-up to the prior year’s Quality Strategy recommendations is not included within the report as no recommendations were provided in the CYE 2020 EQR Technical Reports specific to the AHCCCS Quality Strategy. AHCCCS will provide a response to these recommendations, which will be published in the annual technical report released in April of 2023.

AHCCCS Follow-Up on Prior Year Recommendations

HSAG made recommendations to AHCCCS for improving the quality of healthcare services furnished to AHCCCS members. The recommendations provided to AHCCCS in the *Contract Year Ending 2020 External Quality Review Annual Report for AHCCCS Arizona Long Term Care System (ALTCS)*³⁻⁷ are summarized below for ALTCS-EPD (Table 3-2) and ALTCS-DD (Table 3-3), along with each along with AHCCCS’s response.

Table 3-2—AHCCCS Follow-Up on Prior Year Recommendations for ALTCS-EPD Program

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
<p>HSAG recommended that AHCCCS work with the ALTCS-EPD Contractors to increase rates for both measure indicators in the Behavioral Health Care domain that failed to meet the CYE 2019 MPS.</p> <p>AHCCCS Response: <i>(Note—The narrative within the response section was provided by AHCCCS and has not been altered by HSAG except for minor formatting)</i></p> <p>AHCCCS transitioned from utilizing External Quality Review Organization (EQRO) calculated rates to measure and report MCO level data to utilizing MCO-calculated performance measure rates that have undergone EQRO validation starting with its 2020 performance measures. Beginning with its CYE 2021 contract amendments, AHCCCS transitioned from its use of internally established Minimum Performance Standards (MPS) to the use of national benchmark data (i.e., NCQA HEDIS Medicaid Mean and CMS Medicaid Median) to evaluate Contractor performance. AHCCCS also intends to utilize line of business specific historical performance data to evaluate MCO, line of business, and agency performance.</p> <p>AHCCCS requires all Contractors to submit quarterly Performance Measure Monitoring Reports (PMMR). The PMMR deliverable submissions were suspended due to the COVID-19 PHE; however, during CYE 2021, AHCCCS worked with its Contractors to update and streamline the reporting template so it can be utilized for both the quarterly PMMR submissions and the annual Quality Management/Performance Improvement (QM/PI) Work Plan/Work Plan Evaluation submissions.</p>

³⁻⁷ Arizona Health Care Cost Containment System. *Contract Year Ending 2020 External Quality Review Annual Report for Arizona Long Term Care System*, July 2021.

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:

HSAG recommended AHCCCS partner with ALTCS-EPD to increase preventive screenings for women.

AHCCCS Response: *(Note—The narrative within the response section was provided by AHCCCS and has not been altered by HSAG except for minor formatting)*

AHCCCS implemented a Breast Cancer Screening Performance Improvement Project (PIP) for the ALTCS-EPD population (Baseline Measurement Year: CYE 2019) with the goal of demonstrating a statistically significant increase in the number and percentage of women receiving Breast Cancer Screenings, followed by sustained improvement for one consecutive year. As part of the PIP, Contractors are required to conduct a root cause and barrier analysis, examining and reporting potential barriers to women receiving breast cancer and implement interventions to promote screenings. Calendar Year 2021 served as an intervention year for this PIP (to account for the impact of COVID-19, this PIP includes two intervention years within its design.).

Beginning CYE 2021, the Breast Cancer Screening measure was included as a value based purchasing withhold measure for the ALTCS-EPD line of business.

In CYE 2021, AHCCCS implemented its Health Disparity Summary & Evaluation deliverable to be submitted as part of the MCO Quality Management/Performance Improvement (QM/PI) Program Plan submissions. The Health Disparity Summary & Evaluation will be utilized for MCOs to provide (1) an analysis of the effectiveness of implemented strategies and interventions in meeting its health equity goals and objectives during the previous Calendar Year, (2) a detailed overview of the MCO's identified health equity goals/objectives for the upcoming Calendar Year, and (3) targeted strategies/interventions planned for the upcoming Calendar Year to achieve its goals.

3. Prior Year Recommendation from the EQR Technical Report for Operational Reviews:

HSAG recommended AHCCCS consider distributing technical assistance documents to all Contractors and holding meetings with Contractors who scored lowest in the ALTCS OR standards, including guidance on how to complete a CAP.

HSAG recommended AHCCCS consider using the quarterly meetings with Contractors as forums in which to share lessons learned from both the State and Contractor perspectives. AHCCCS should present identified best practices on the predominant issues for ALTCS Contractors' issues and facilitate a group discussion on Contractors' policies and procedures. In addition, AHCCCS should consider conducting a root cause analysis with the Contractors to determine why they continue to have difficulty complying with specific standards.

AHCCCS Response: *(Note—The narrative within the response section was provided by AHCCCS and has not been altered by HSAG except for minor formatting)*

AHCCCS offers technical assistance sessions for any findings in the OR that may be of concern. The Contractor may request the technical assistance session or AHCCCS staff may offer based upon the outcomes of the OR. Guidance on how to complete a CAP is provided to all MCOs during the kickoff meeting held with the Contractor s prior to initiating an OR cycle.

3. Prior Year Recommendation from the EQR Technical Report for Operational Reviews:
AHCCCS has a number of venues to share lessons learned with Contractors. OR lessons learned are often discussed at each Contractor's exit interview upon completion of the onsite portion of the OR.
4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
HSAG recommended that AHCCCS continue its oversight of the Contractors as they continue to monitor and maintain existing provider networks.
<p>AHCCCS Response: <i>(Note—The narrative within the response section was provided by AHCCCS and has not been altered by HSAG except for minor formatting)</i></p> <p>Due to the delay experienced in finalizing and publishing the CYE 2020 EQR reports, AHCCCS included a summary of activities related to the recommendations included within these reports that occurred during the current reporting period (CYE 2021). AHCCCS anticipates continued follow-up to further address these recommendations during CYE 2022.</p>

Table 3-3—AHCCCS Follow-Up on prior Year Recommendations for ALTCS-DD Program

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended AHCCCS partner with DES/DDD to increase preventive screenings for women.
<p>AHCCCS Response: <i>(Note—The narrative within the response section was provided by AHCCCS and has not been altered by HSAG except for minor formatting)</i></p> <p>In CYE 2021, AHCCCS implemented its Health Disparity Summary & Evaluation deliverable to be submitted as part of the MCO Quality Management/Performance Improvement (QM/PI) Program Plan submissions. The Health Disparity Summary & Evaluation will be utilized for MCOs to provide 1.) an analysis of the effectiveness of implemented strategies and interventions in meeting its health equity goals and objectives during the previous Calendar Year, 2.) a detailed overview of the MCO's identified health equity goals/objectives for the upcoming Calendar Year, and 3.) targeted strategies/interventions planned for the upcoming Calendar Year to achieve its goals.</p>
2. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
HSAG recommended that AHCCCS continue its oversight of the Contractors as they continue to monitor and maintain existing provider networks.
<p>AHCCCS Response: <i>(Note—The narrative within the response section was provided by AHCCCS and has not been altered by HSAG except for minor formatting)</i></p> <p>Due to the delay experienced in finalizing and publishing the CYE 2020 EQR reports, AHCCCS included a summary of activities related to the recommendations included within these reports that occurred during the current reporting period (CYE 2021). AHCCCS anticipates continued follow-up to further address these recommendations during CYE 2022.</p>

4. Quality Initiatives

AHCCCS continued to demonstrate innovative and collaborative approaches to managing costs while improving the quality of systems, care, and services. The July 2021 enhanced Quality Strategy and Quality Strategy Evaluation, the 2018–2023 strategic plan, and the quarterly quality assurance/monitoring activity reports provided compelling evidence of AHCCCS’ vision and leadership in identifying and proactively pursuing opportunities to improve access to, and the quality and timeliness of care and services, as well as improve member health outcomes.

Quality Initiative Selection and Initiation

AHCCCS has several initiatives and best practices underway 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 to the greatest extent.

Systemwide Quality Initiatives/Collaboratives

Accessing Behavioral Health Services in Schools⁴⁻¹

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.

The Arizona Department of Education (ADE) and AHCCCS created the Behavioral Health 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.

Jake’s Law Covers Students Without Insurance

In 2020, the Arizona State Legislature allocated \$8 million for behavioral health services in school settings for students who are underinsured or uninsured. Known as the Children’s Behavioral Health Services Fund (or Jake’s Law), schools must develop a policy to refer students for behavioral health services, and to allow families to opt-in or opt-out of the referral process each year. This funding is available through June 2022.

⁴⁻¹ Arizona Health Care Cost Containment System. Accessing Behavioral Health Services in Schools. Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/BehavioralHealthServices/>. Accessed on: Jan 10, 2022.

Behavioral health services under this funding are provided to students by participating health care providers contracted with the three Regional Behavioral Health Authorities (RBHAs): Mercy Care (in Central Arizona), Arizona Complete Health Complete Care (in Southern Arizona), and Health Choice Arizona (in Northern Arizona).

Project AWARE

Project AWARE is a federal initiative funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) to build and expand the partnership between education and mental health systems at both the state and local levels. The Arizona Project AWARE team is a partnership between ADE, AHCCCS, and three local school districts. Project AWARE is focused on ensuring access to behavioral health services for students by establishing referral pathways and formal communication between schools, parents, and behavioral health providers. Project AWARE also works to support the implementation of suicide prevention trainings as required by the Mitch Warnock Act.

***Building A Health Care System: Care Coordination and Integration*⁴⁻²**

AHCCCS has various initiatives designed to improve care coordination and communication while reducing fragmentation to create a healthcare system with more effective outcomes. AHCCCS continues to integrate the care delivery systems and align incentives that are designed to transform the structure of the Medicaid program, improve health outcomes, and better manage limited resources.

ALTCS EPD Members

ALTCS EPD has been integrated since its inception in 1989. Individuals covered under an ALTCS EPD plan have always received integrated physical, behavioral health, and long term-services and support through one health plan. Additionally, each individual enrolled in one of AHCCCS' ALTCS EPD plans is assigned a dedicated case manager at the health plan level who provides care coordination and advocacy for the member.

Medicare and Medicaid Dual Eligibles

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 170,000 Arizonians who are eligible for both Medicare and Medicaid, navigating these two separate systems of care can be overwhelming. Under these circumstances, individuals “fall through the cracks,” inefficient care is provided, and optimal health outcomes are not achieved.

⁴⁻² Arizona Health Care Cost Containment System. Building an Integrated Health Care System. Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/>. Accessed on: Feb. 23, 2022.

AHCCCS continues developing integration initiatives to increase alignment and improve service delivery for individuals covered by both Medicare and Medicaid. AHCCCS moved toward increasing the coordination of health service delivery between the two health programs by contracting with Medicare Advantage Dual Special Needs Plans (D-SNPs) that are affiliated with its partner Medicaid health plan. Requiring each Medicaid health plan to offer a partner Medicare D-SNP promotes the enrollment or alignment of dual-eligible members in the same health plan for both Medicare and Medicaid services to the greatest possible extent. Enrolling in specialized Medicare plans allows dual-eligible members to receive all their healthcare services, including prescription drug benefits, from a single, integrated health plan.

Persons with an SMI Designation

In Arizona, behavioral health has historically been a carved-out benefit separately managed by RBHAs. As such, a person with an SMI designation could navigate up to four different healthcare systems to get care. Navigating the healthcare system is one of the greatest barriers to accessing care. The results for Arizonians with an SMI designation were less than optimal. Concerns around poor medication management and stigma caused many people to forgo physical healthcare. Because many persons with SMI also experience comorbidities, management of chronic diseases like diabetes or hypertension was also poor.

The RBHAs play a critical role in providing integrated physical and behavioral health services for members with an SMI designation. Enrollment in each geographic service area (GSA) as of September 1, 2021, for Title XIX/XXI covered members determined to have an SMI designation:

- North GSA: 6,272.
- Central GSA: 26,822.
- South GSA: 14,305.

The RBHAs provide crisis services including telephone, community-based mobile, and facility-based stabilization (including observation not to exceed 24 hours), and SAMHSA grants and other services, including housing. Effective October 1, 2021, Arizona Behavioral Health Corporation began administering the AHCCCS Housing Program to provide a housing support program for individuals with mental health issues who are experiencing homelessness.

On October 1, 2022, AHCCCS is updating its contracts with MCOs for health insurance coverage for individuals with an SMI designation. Select ACC Contractors will have expanded responsibilities as an ACC Contractor with a Regional Behavioral Health Agreement (ACC-RBHA). The ACC-RBHAs will be responsible for the provision of integrated care addressing physical health and behavioral health 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.

Beginning October 1, 2018, ACC plans became the integrated health plans for the majority of AHCCCS members. This transition affected approximately 1.5 million members. Through this major system initiative, AHCCCS has streamlined the service delivery system for members who had previously needed to coordinate physical and behavioral health benefits through two separate health plans while also simplifying the payment streams for the services received by members. This transition also included the flexibility for individuals designated to Children’s Rehabilitative Services (CRS) to choose their ACC plan.

Children with Special Health Care Needs (SHCN): CRS

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

Beginning October 1, 2018, members that qualify for a CRS designation and are not enrolled with DES/DDD have a choice of ACC plans in their area. The ACC plan manages care for all services (including CRS, other non-CRS physical health services, and all covered behavioral health services). Effective October 1, 2019, members enrolled with DES/DDD use their assigned DES/DDD plan for all of their CRS and non-CRS physical health and behavioral health services. DES/DDD continues to provide long-term care services for these members. On April 1, 2021, CMDP changed to DCS CHP. American Indian and Alaska Native members with a CRS designation have a choice of an ACC plan or the American Indian Health Program, thus minimizing the need for members to navigate multiple systems for care.

ALTCS DD Members

DES/DDD serves as the ALTCS Contractor for members with intellectual and developmental disabilities. Beginning October 1, 2019, for its membership, DES/DDD assumed the responsibility of covering behavioral health services and services for those with qualifying CRS conditions. DES/DDD delegated this responsibility to two integrated subcontracted health plans—Mercy Care Plan and UnitedHealthcare Community Plan. ALTCS DD enrollment as of September 2021 was 37,072.

Integrating Services for Children and Youth in the Foster Care System

On April 1, 2021, CMDP changed to DCS CHP. Children in foster care are able to get physical health, including CRS services, and behavioral health services from one health plan, through a subcontracted health plan named Mercy Care DCS CHP. Covered services for children in foster care remain the same. Enrollment as of September 2021 was 13,657.

Justice System Transitions

AHCCCS has partnered with state and county governments to improve coordination within the justice system and create the most cost-effective and efficient ways to transition individuals leaving the criminal justice system. A significant number of men, women, and children transitioning out of jail and prison into communities are in need of services for behavioral and physical health conditions. Many of these individuals are eligible for Medicaid.

To facilitate the transition, AHCCCS is engaged with the Arizona Department of Corrections Rehabilitation and Reentry (ADCRR), the Arizona Department of Juvenile Corrections (ADJC), and most Arizona counties covering the majority of the State's population, including the two largest—Maricopa and Pima—in a data exchange process that allows AHCCCS to suspend eligibility upon incarceration, rather than terminate coverage. This exchange allows ADCRR, ADJC, and county jails to electronically send discharge dates, which simplifies the process of transitioning directly into care. Through this enrollment suspension process, care can be coordinated by county jails or prisons upon discharge. To support this, AHCCCS Contractors are required to have a justice systems liaison that can ensure a connection to needed behavioral health services following release. In addition, AHCCCS medical management coordinates with counties to facilitate a transition of care into ACC health plans for persons being discharged with serious physical illnesses, such as cancer or other illnesses, that present public health concerns or require immediate attention.

Electronic Visit Verification⁴⁻³

Pursuant to Section 1903 of the Social Security Act (42 U.S.C. 1396b), AHCCCS mandated Electronic Visit Verification (EVV) for nonskilled (attendant care, personal care, homemaker, habilitation, respite) and in-home skilled nursing services (home health) services on January 1, 2021. In addition to the legislative intent of EVV to prevent, detect, and recover improper payments due to fraud, waste, and abuse, AHCCCS is using EVV to ensure, track, and monitor timely service delivery and access to care for members receiving services in their homes or community.

Emergency Triage, Treat and Transport to Transform EMS Delivery⁴⁻⁴

The Emergency Triage, Treat and Transport initiative (ET3) is a voluntary, five-year CMS Innovation Center Payment Model designed to provide greater flexibility to ambulance care teams addressing emergency healthcare needs. The goal of this program is to decrease unnecessary transports to emergency departments and reduce hospital admissions, while simultaneously connecting members with the appropriate level of care, at the right time and at the right place, in order to improve quality and

⁴⁻³ Arizona Health Care Cost Containment System. Electronic Visit Verification. Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/EVV/>. Accessed on: Feb 22, 2022.

⁴⁻⁴ Arizona Health Care Cost Containment System. Emergency Triage, Treat and Transport (ET3). Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/ET3/>. Accessed on: Feb 22, 2022.

reduce costs. AHCCCS began reimbursing qualified emergency transportation providers for providing ET3 services on and after October 1, 2021.

AHCCCS Housing Programs⁴⁻⁵

The AHCCCS Housing Programs (AHP) provide Non-Title XIX/XXI State General Funded permanent supportive housing (PSH) programs to assist members with a designation of SMI or with a general mental health and/or substance use disorder (GMHSUD) who are experiencing homelessness or housing instability. AHP follows the SAMHSA community-based permanent supportive housing standards that specify that members should have a renewable lease, the right of entry and exit (not restricted by program), and can voluntarily select services. Housing subsidies are provided for permanent supportive housing in scattered unit sites (Scattered Site Program) and dedicated site-based units (Community Living Program). All units must meet minimum health and safety standards set forth by Federal Housing Quality Standards (HQS) and have a reasonable rent based on market standards. AHP also provides housing-related supports and payment such as deposits, move-in assistance, eviction prevention, and damage(s) related to member occupancy.

PSH related Medicaid reimbursable wrap-around supportive housing services not only help AHCCCS members obtain and maintain housing, but also help lower utilization of emergency and crisis services.

Health Equity Committee⁴⁻⁶

Formally established in July 2020, the Health Equity Committee is tasked with understanding health disparities and developing strategies to ensure health equity for all AHCCCS-eligible individuals and members. This committee is responsible for overseeing and managing recommendations as they relate to policy, data, health plan oversight, and emerging healthcare innovation strategies for over 2 million Arizonians.

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

This committee is responsible for identifying health disparities among AHCCCS-eligible individuals and members by using AHCCCS utilization and quality improvement data to advance policy and/or contracting strategies to improve the health equity of AHCCCS’ populations and programs. This committee will communicate existing health equity strategies currently being implemented by the

⁴⁻⁵ Arizona Health Care Cost Containment System. AHCCCS Housing Programs. Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/AHP/>. Accessed on: Jan 10, 2022.

⁴⁻⁶ Arizona Health Care Cost Containment System. Health Equity Committee. Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/HEC/index.html>. Accessed on: Jan 10, 2022.

agency, identify needed improvements to existing strategies (if appropriate), develop and/or evaluate key metrics, and articulate future interventions aimed at eliminating health disparities.

Committee goals:

- Understand health disparities among AHCCCS members.
- Effectuate policy changes and support the implementation of strategies for positive improvement where known disparities exist, creating opportunities for the more equitable provision of services and supports.
- Raise the visibility of AHCCCS' commitment to health equity and the strategies in place to ensure the equitable provision of services and supports.
- Improve health outcomes for AHCCCS members.
- Identify challenges and barriers that AHCCCS members have in accessing covered services.

Incentivizing Quality: Payment Modernization⁴⁻⁷

Modernizing the way healthcare services are purchased means rethinking the end product. Traditional reimbursement structures favor the provider with higher production numbers (i.e., performs more services without regard to outcome). 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.

To that end, 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 Contractor and provider partners, and there is a commitment to continuous quality improvement and learning.

Strategies

- **Align Payer & Provider Incentives:** Establish payment systems that encourage collaboration to improve affordability, access, and quality results for individuals.
- **Payment and Care Delivery Transformation:** Transform the healthcare delivery system and achieve the three-part aim outlined by the Institute of Medicine (IOM): better care, healthy people/healthy communities, and affordable care.
- **Innovate through Competition:** Enact performance expectations that reward innovation and results.
- **Pay for Value:** Pay for outcomes of care rather than quantity of care.

⁴⁻⁷ Arizona Health Care Cost Containment System. AHCCCS Payment Modernization. Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/PaymentModernization/>. Accessed on: Jan 10, 2022.

- Collaborative Learning: AHCCCS is a committed partner in the Health Care Payment Learning and Action Network (LAN). The goal of the LAN is to accelerate the healthcare system's adoption of effective alternative payment models (APMs). AHCCCS will work to continue to shift an increasing percentage of payments into Categories 3 and 4 value-based structures. The LAN also has a compendium of APM resources for healthcare providers and payers.

Improving Communications: Health Information Technology⁴⁻⁸

Since 2006, AHCCCS providers and Contractors have been supporting a single statewide HIE, Health Current, a Contexture organization. AHCCCS encourages providers to adopt health information technology tools that help store and share member health records, streamline the delivery of healthcare services, and improve member healthcare outcomes.

Between 2011 and 2021, AHCCCS and CMS administered an electronic health record (EHR) incentive program that awarded \$691 million to Arizona providers for installing EHR systems. To help healthcare providers move from paper-based records to electronic health records to be able to easily retrieve and transfer data, AHCCCS implemented the Arizona Medicaid Electronic Health Record Incentive Program. The incentive payment program was designed to support qualified providers with health information technology transition and instill the use of EHRs in meaningful ways to improve the quality, safety, and efficiency of patient healthcare.

Benefits of adopting EHR technology include:

- More real-time clinical information to better inform provider care planning.
- Increased administrative efficiencies.
- Potential to reduce repeated health-related testing.
- Improved communication between providers.

December 31, 2021, was the final day that states could make Medicaid Promoting Interoperability Program payments to Medicaid eligible professionals (EPs) and hospitals.

Connecting Communities: The Importance of Private Sector Partners⁴⁻⁹

The AHCCCS program was founded on a competitive, public/private partnership model. AHCCCS began in 1982 as the first statewide mandatory managed care program, placing all enrollees (except American Indians/Alaska Natives) in health plans for acute care, long-term care, and behavioral health

⁴⁻⁸ Arizona Health Care Cost Containment System. Using Technology to Improve Patient Care. Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/HIT/>. Accessed on: Jan 10, 2022.

⁴⁻⁹ Arizona Health Care Cost Containment System. Connecting Communities: The Importance of Private Sector Partners. Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/PrivateSectorPartners/>. Accessed on: Jan 10, 2022.

(known as RBHAs). Medicaid managed care has evolved and answered the call toward continued innovation and population health strategies.

These Contractors do far more than simply pay claims. Today’s health plans use sophisticated data analytics tools to assess member risk and develop innovative intervention protocols. In addition, health plans engage their members in person-centered approaches. This often means engaging families and communities, too, so that members have the tools they need to manage their own health. This level of engagement also assists the health plan in developing strategies that respond to community needs. The connection, relationship, and transparency between AHCCCS and the health plans as well as the community, providers, and members served is integral to a successful public/private partnership.

Telehealth Services⁴⁻¹⁰

Delivering healthcare services through telehealth provides an alternative way for AHCCCS members to see their healthcare providers. AHCCCS covers all major forms of telehealth technologies and holds ongoing discussions with contracted managed care health plans, providers including Indian Health Services (IHS)/ Tribal (638) facilities, and members to determine how telehealth should be leveraged to serve AHCCCS members and improve health outcomes.

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 can use these devices from their homes to attend healthcare appointments with their healthcare providers. Telehealth can make access to healthcare 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 are uploaded by providers and retrieved, perhaps to an online portal. Telephonic services (audio-only) use a traditional telephone to conduct healthcare appointments. Telemedicine involves interactive audio and video, in a real-time, synchronous conversation. AHCCCS also covers telehealth for remote patient monitoring and teledentistry.

During the COVID-19 PHE, AHCCCS added flexibilities to telehealth coverage to promote physical distancing and limit the spread of COVID-19 while also promoting access to healthcare; these flexibilities are posted in the AHCCCS COVID-19 FAQs on telehealth.⁴⁻¹¹

⁴⁻¹⁰ Arizona Health Care Cost Containment System. Telehealth Services. Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/Telehealth/>. Accessed on: Jan 11, 2022.

⁴⁻¹¹ Arizona Health Care Cost Containment System. Frequently Asked Questions (FAQs) Regarding Coronavirus Disease 2019 (COVID-19). Telehealth Delivery and Billing. Available at: <https://www.azahcccs.gov/AHCCCS/AboutUs/covid19FAQ.html#telehealth>. Accessed on: Jan 11, 2022.

Transforming Healthcare Delivery: Targeted Investments (TI) Program⁴⁻¹²

The TI Program provides financial incentives to eligible AHCCCS providers to develop systems that integrate and coordinate physical and behavioral healthcare. The TI Program aims to reduce fragmentation that occurs between acute care and behavioral healthcare, increase efficiencies in service delivery for members with behavioral health needs, and improve health outcomes for the affected populations.

In accordance with 42 CFR §438.6(c) and the 1115 Waiver, managed care plans will provide financial incentives to eligible Medicaid providers who meet certain benchmarks for integrating and coordinating physical and behavioral healthcare for Medicaid members.

AHCCCS 2021 Year in Review⁴⁻¹³

The COVID-19 PHE continued to be an overarching priority in 2021. AHCCCS also achieved significant innovations in technology, policy, and service delivery that streamlined business processes and improved care coordination.

Innovations in Service Delivery and Technology

- Awarded Competitive Contract Expansion contracts to three AHCCCS ACC Contractors to serve individuals with a SMI designation.
- Submitted the AHCCCS Housing and Health Opportunities (H2O) demonstration waiver request to CMS, aimed at enhancing the availability of housing-related services and support for individuals experiencing homelessness or at risk of homelessness.
- Expanded the existing Medicaid School Based Claiming program to allow all Medicaid-enrolled children to access health care services on school campuses (not just those students with an Individualized Education Program).
- Implemented the ET3 program to reduce unnecessary transports to emergency departments and allow members to be transported to alternate destinations.
- Launched the Opioid Services Locator tool and fostered increased community opioid and stimulant primary prevention efforts; developed a toolkit on psychostimulants, fentanyl, and targeted strategies on counterfeit pills.
- With the State's HIE, launched a closed loop referral system to make it easier for clinicians to connect members to needed social services.

⁴⁻¹² Arizona Health Care Cost Containment System. Targeted Investments Program Overview. Available at: <https://www.azahcccs.gov/PlansProviders/TargetedInvestments/>. Accessed on: Jan 11, 2022.

⁴⁻¹³ Arizona Health Care Cost Containment System. 2021 Year in Review. Available at: <https://www.azahcccs.gov/shared/Downloads/News/2022/2021YearInReview.pdf>. Accessed on: Jan 17, 2022.

- Implemented Arizona’s EVV program to ensure access to care for members who receive in-home services and supports.
- Provided behavioral health services to 6,000 students either on school campuses or in established clinics in response to referrals for services.
- In alignment with the Home and Community Based Services (HCBS) Enhanced Federal Match provision allowing states to supplement existing funding, AHCCCS submitted a spending plan for more than \$1 billion detailing how the agency will use additional federal funding to strengthen and enhance the HCBS system of care for seniors, individuals with disabilities, individuals with a SMI designation, and children with behavioral health needs.

Response to the COVID-19 Public Health Emergency

- Maintained coverage for all members enrolled during the federally declared public health emergency; enrollment increased nearly 24 percent over the last 22 months.
- Implemented strategies to increase COVID-19 vaccination rates among vulnerable AHCCCS members, including mobile-based vaccine distribution for members enrolled in ALTCS. Achieved ALTCS vaccine rates as high as 78 percent.
- Maintained the Crisis Counseling Program to help individuals and communities recover from the PHE; served more than 17,000 unique individuals statewide with crisis counseling and group counseling/public education.
- Distributed over \$18 million in additional COVID-19 relief funding to nursing facilities.

Other Systemwide Quality Initiatives/Collaboratives⁴⁻¹⁴

Promoting Access in Medicaid and CHIP Managed Care

Published by CMS in June 2021, the Promoting Access in Medicaid Managed Care: Behavioral Health Provider Network Adequacy Toolkit highlights AHCCCS’ efforts to integrate physical and behavioral health services for Medicaid members in Arizona.⁴⁻¹⁵ By integrating physical and behavioral health services it made it easier for the AHCCCS to require managed care plans to cover primary and behavioral health care integration and to coordinate services between the two. Arizona used the TI Program to promote the integration and coordination of physical and behavioral healthcare for Medicaid

⁴⁻¹⁴ Arizona Health Care Cost Containment System. Awards, Studies, and Highlights. Available at: <https://www.azahcccs.gov/AHCCCS/AboutUs/awardsandstudies.html>. Accessed on: Jan 17, 2022.

⁴⁻¹⁵ Center for Medicare & Medicaid Services. *Promoting Access in Medicaid and CHIP Managed Care: Behavioral Health Provider Network Adequacy Toolkit*, June 2021. Available at: <https://www.azahcccs.gov/shared/Downloads/News/2021/CMSPromotingAccessinMedicaidandCHIPManagedCareJune2020.pdf>. Accessed on: Jan 27, 2022.

members. Arizona also includes a differential adjusted payment to increase services in rural and remote areas, such as tribal lands. Through this payment program, managed care plans provide a rate increase to eligible providers for all claims and encounters with AHCCCS across the state.

Arizona enhanced access to services by approving asynchronous technologies, such as store-and-forward, which allows for the electronic transmission of medical information. This supports clinical decision making for providers and increases efficiency.

During the COVID-19 PHE, AHCCCS added flexibilities to telehealth coverage to promote physical distancing and limit the spread of COVID-19 while also promoting access to healthcare; these flexibilities are posted in the AHCCCS COVID-19 FAQs on telehealth.

Arizona Paid Caregiver Survey Report

In Arizona, paid caregivers—including direct care workers, paid family caregivers, and direct support professionals, among others—provide critical daily support to thousands of older adults and people with disabilities. As the need for these essential workers escalates, the state faces a pressing question: what can be done to improve paid caregiving jobs and enhance the supports that these workers deliver? To help address this question, the organization, PHI, partnered with four AHCCCS managed care organizations to survey the paid caregiver workforce about their experiences and insights. The survey findings revealed the following recommendations and opportunities for improvement:

- Support paid caregivers during the COVID-19 PHE.
- Promote diversity, equity, and inclusion.
- Improve access to additional hours and full-time schedules.
- Recruit new workers online while also leveraging personal connections.
- Implement supportive supervisory practices.
- Promote existing advancement opportunities and create new career pathways.
- Expand training opportunities for paid caregivers.
- Include paid caregivers' voices when evaluating interventions.

MACPAC June 15, 2021, Report to Congress

The Medicaid and CHIP Payment and Access Commission (MACPAC) highlighted Arizona's Non-Emergency Medical Transportation (NEMT) benefit, integrated benefit for dually eligible populations, and crisis system in its June 15, 2021, report to Congress.

The NEMT benefit allows members to access secure, comfortable, and reliable transportation for nonemergent need, if they are not able to provide, secure, or pay for transportation on their own, and free transportation is not available. Additionally, the state is maximizing its Medicare Improvement for

Patients and Provider Act (MIPPA) authority by providing fully integrated care for dually eligible members. Furthermore, Arizona provides crisis services including three regional 24-hour hotlines, mobile crisis response teams, and facility-based crisis stabilization. The crisis system in Maricopa County, Arizona which provides these three core components, led to an estimated \$260 million reduction in inpatient spending by providing crisis services.

Spotlight on Member Engagement and Elevating the Consumer Voice

States and MCOs use member advisory councils to shape Medicaid strategy, service design, delivery, and program structure at the state and plan level. Elevating the consumer voice through advisory councils ensures that the experiences of Medicaid members inform program design and policy decisions and improve access to care. However, while advisory councils are a mechanism for elevating member voice and input on Medicaid and health plan service delivery, consumer engagement and retention within these advisory structures is often very challenging. This study completed by the nonpartisan and objective research organization NORC at the University of Chicago details how Banner Health and AHCCCS are working together to engage Medicaid members in advisory councils. Strategies to support more effective member engagement in advisory councils include:

- Train members in leadership, policy, and governance structures.
- Offer incentives to demonstrate to members that their time and input is valued.
- Leverage data to inform issue areas.
- Develop and formalize clear processes for raising issues within the plan and to the state.
- Establish close Contractor-state collaboration.
- Establish a feedback loop that communicates changes or results back to the community.
- Work closely with community-based organizations.

Social Determinants of Health (SDOH) and Risk Adjustment: Arizona Medicaid Innovations

AHCCCS recently updated the methodology for risk adjusting the capitation rates paid to ACC Contractors. With the recent recognition of the impact that socio-economic factors have on an individual's well-being, health outcomes, and health care costs, several state Medicaid programs have begun to incorporate a limited number of social risk factors (commonly referred to as social determinants of health [SDOH]) into their risk adjustment methodologies.

Medicaid Forward: Behavioral Health

AHCCCS was highlighted for its crisis services in Medicaid Forward: Behavioral Health, a report published by the National Association of Medicaid Directors that provides examples of evidence-backed, sustainable policy and program solutions that states are implementing to improve Medicaid members' mental health and well-being. AHCCCS' programs and policies include:

- Forming a task force to address behavioral health concerns arising due to the COVID-19 PHE.
- Providing peer support to members with an addiction and supporting a training academy for peers.
- Operating regional 24-hour crisis telephone lines to respond to individuals in need and dispatch mobile response teams, if necessary.
- Directing plans to cover services provided by 24-hour crisis stabilization/observation and detox facilities, 24-hour outpatient clinics, and crisis response.
- Supporting information exchange between Medicaid and the corrections department.

5. Assessment of Contractor Follow-Up to Prior Year Recommendations

From the findings of each Contractor performance for the CYE 2021 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to AHCCCS members. The recommendations provided to each Contractor for the EQR activities in the *Contract Year Ending 2020 External Quality Review Annual Report for Arizona Long Term Care System*, July 2021 are summarized below, along with each Contractor’s response and HSAG’s assessment of the degree to which the response was addressed, partially addressed, or not addressed. HSAG may have made minor edits to enhance readability. Some of the Contractors may have included rates in their responses to the recommendations. Please note that these are self-reported rates and are not validated by AHCCCS or the EQRO.

BUFC LTC

Table 5-1—Prior Year Recommendations and Responses for BUFC LTC

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
<p>HSAG recommended that AHCCCS work with the ALTCS-EPD Contractors to increase rates for both measure indicators in the Behavioral Health Care domain that failed to meet the CYE 2019 MPS. The ALTCS-EPD Contractors should conduct root cause analyses for the low rates of follow-up visits after hospitalization for mental illness to determine the nature and scope of the issue (e.g., barriers to care, lack of continuity of care, transportation issues, ineffective communication).</p> <p>Additionally, HSAG recommended that AHCCCS partner with ALTCS-EPD and DES/DDD to increase preventive screenings for women. To understand the cause of the low rates, ALTCS-EPD and DES/DDD should examine potential barriers to women receiving breast cancer and cervical cancer screenings (e.g., provider misconceptions, lack of education, member anxiety) and implement multicomponent interventions to reduce structural barriers. ALTCS-EPD and DES/DDD should ensure that members receive screenings in accordance with the United States (U.S.) Preventive Services Task Force (USPSTF) screening recommendations for breast cancer and cervical cancer.</p>
<p>BUFC LTC’s Response:</p> <p>BUFC LTC had the following interventions in place to facilitate performance measure improvement:</p> <p>Follow-up after hospitalization for mental health: ALTCS case managers conduct a post-discharge call and assessment within 72 hours of discharge. They ensure that a follow-up visit is scheduled, and if not scheduled, offer assistance with scheduling one. Behavioral Health case managers also do a follow-up call to the member to ensure an appointment has been made and offer any behavioral health specific assistance. This measure has been improving for the last several years and is the focus measure for an internal work group attempting to improve rates and reduce barriers.</p>

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

Ambulatory care—ED visits: BUFC LTC performance rates demonstrate that emergency department visit rates continue to improve year over year. For those BUFC LTC members identified as visiting an ED 4 or more times in a rolling 6-month period, the ALTCS RN team will attempt phone contact to determine reason for the multiple visits and assist with any care gaps they may identify. Also, the RN team will send educational letters outlining when it is appropriate for PCP visit, Urgent Care visit, and ED visits. In CYE 2020, COVID also affected the rates as many people avoided going to provider offices and the ED unless necessary.

Breast cancer screening: In CYE 2020, AHCCCS mandated a breast cancer screening PIP, and several internal interventions were started. Case managers targeted female members in the appropriate age group for outreach and assistance with scheduling a mammogram. BUFC LTC also partnered with Banner Imaging to have slots open for BUFC LTC members to schedule mammograms quickly. Mobile mammogram units are also being contracted. Rates declined slightly for CYE 2020 due to COVID-19, causing members to avoid provider offices for all but emergencies, lowering preventive screening rates.

Use of Opioids at High Dosage in Persons Without Cancer: This measure has been holding steady over the last two years. Prescription fill reports are monitored monthly. Members are referred to Behavioral Health case managers, if necessary, for assistance with addiction.

HSAG Assessment: HSAG has determined that BUFC LTC has addressed the prior year recommendation.

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:

HSAG did not provide recommendations for BUFC LTC for PIPs in CYE 2020.

BUFC LTC’s Response:

This section is not applicable, as no recommendations were provided in CYE 2020.

HSAG Assessment: Not applicable

3. Prior Year Recommendation from the EQR Technical Report for Operational Review:

HSAG did not provide recommendations for BUFC LTC for ORs in CYE 2020, as the activity was postponed due to the COVID-19 PHE.

BUFC LTC’s Response:

AHCCCS conducted an OR in CYE 2018. All CAPs opened as a result of that OR have been completed and closed. BUFC LTC is currently preparing for an NCQA accreditation audit scheduled for fall 2022. There are no current CAPs open.

HSAG Assessment: Not applicable.

4. Prior Year Recommendation from the EQR Technical Report for Network Analysis:

HSAG recommended each ALTCS-EPD Contractor should continue to monitor and maintain its existing provider network, based on the following validation conclusions:

- BUFC LTC identified errors in the submission of Quarter 2 and Quarter 3 CYE 2020 PAT files but was unable to correct the numbers until its final CYE 2020 submission. As such, BUFC LTC should continue to review quarterly PAT data files for accuracy prior to submitting the files to AHCCCS.

BUFC LTC’s Response:

BUFC LTC conducts a quarterly network analysis, which includes time and distance, minimum network requirements, and appointment availability. BUFC LTC will continue to implement improvements in this area as necessary to meet the needs of the population served.

HSAG Assessment: HSAG has determined that BUFC LTC has not addressed the prior year recommendation, as BUFC LTC’s response did not address the review of PAT data files for accuracy.

Mercy Care LTC

Table 5-2—Prior Year Recommendations and Responses for Mercy Care LTC

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

HSAG recommended that AHCCCS work with the ALTCS-EPD Contractors to increase rates for both measure indicators in the Behavioral Health Care domain that failed to meet the CYE 2019 MPS. The ALTCS-EPD Contractors should conduct root cause analyses for the low rates of follow-up visits after hospitalization for mental illness to determine the nature and scope of the issue (e.g., barriers to care, lack of continuity of care, transportation issues, ineffective communication).

Additionally, HSAG recommended that AHCCCS partner with ALTCS-EPD and DES/DDD to increase preventive screenings for women. To understand the cause of the low rates, ALTCS-EPD and DES/DDD should examine potential barriers to women receiving breast cancer and cervical cancer screenings (e.g., provider misconceptions, lack of education, member anxiety) and implement multicomponent interventions to reduce structural barriers. ALTCS-EPD and DES/DDD should ensure that members receive screenings in accordance with the USPSTF screening recommendations for breast cancer and cervical cancer.

Mercy Care LTC’s Response:

Interventions and activities in place to increase compliance with *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-up—Total* and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total* include:

- All LTC case managers will be expected to contact a member within 3 days of discharge, and coordinate/ensure that a visit occurs within 7 days.
- Readmission Intervention Assessment is completed by assigned case manager.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

- Referral (as needed) and coordination with behavioral health provider after discharge.
- Inter-Disciplinary Team (IDT) meetings held weekly to review high utilizing/high need members.
- Inter-Disciplinary Team—Behavioral Health (IDT-BH) meetings held every two weeks to review high utilizing/high need BH members.
- Digital outreach to members after hospitalization (text messaging, email, IVR [interactive voice response] calls).
- IVR calls to members post-discharge to ensure members are aware of the importance of post-discharge follow-up visits.
- Value-based program incentives for members receiving FUH visit within 3 days of discharge.
- Tableau inpatient census report shared with ACOs and providers to ensure they are aware of member discharges and can assist with coordinating a follow-up visit.

Interventions and activities in place to increase compliance with breast cancer screening and cervical cancer screening include:

- Digital outreach to members in need of a well woman visit (text messaging, email, IVR calls).
- Written educational outreach.
- Partnership with SimonMed imaging to close gaps in care.
- Coordination with providers who are due for a mammogram to sign an order form which Mercy Care LTC then utilizes to contact the member and assist with scheduling mammogram.
- Member financial incentives.
- Electronic provider gaps in care notifications.
- Provider site visits.
- Implementation of the AHCCCS-mandated Performance Improvement Project (PIP).

HSAG Assessment: HSAG has determined that Mercy Care LTC has addressed the prior year recommendation.

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:

HSAG did not provide recommendations for Mercy Care LTC for PIPs in CYE 2020.

Mercy Care LTC’s Response:

In CYE 2019, AHCCCS implemented a new PIP, *Breast Cancer Screening*, for ALTCS-EPD. As a result, no recommendations have been made by HSAG at this time.

HSAG Assessment: Not applicable.

3. Prior Year Recommendation from the EQR Technical Report for Operational Reviews:

HSAG did not provide recommendations for Mercy Care LTC for ORs in CYE 2020, as the activity was postponed due to the COVID-19 PHE.

Mercy Care LTC’s Response:

This section is not applicable, as no recommendations were provided in CYE 2020.

HSAG Assessment: Not applicable.

4. Prior Year Recommendation from the EQR Technical Report for Network Analysis:

HSAG recommended that each ALTCS-EPD Contractor should continue to monitor and maintain its existing provider network, based on the following validation conclusions:

- As of CYE 2020, Quarter 3, Mercy Care LTC met all standards and did not receive saturation analysis results.

Mercy Care LTC’s Response:

Mercy Care met all standards; no updates to report.

HSAG Assessment: HSAG has determined that Mercy Care LTC has addressed the prior year recommendation.

UHCCP LTC

Table 5-3—Prior Year Recommendations and Responses for UHCCP LTC

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

HSAG recommended that AHCCCS work with the ALTCS-EPD Contractors to increase rates for both measure indicators in the Behavioral Health Care domain that failed to meet the CYE 2019 MPS. The ALTCS-EPD Contractors should conduct root cause analyses for the low rates of follow-up visits after hospitalization for mental illness to determine the nature and scope of the issue (e.g., barriers to care, lack of continuity of care, transportation issues, ineffective communication).

Additionally, HSAG recommended that AHCCCS partner with ALTCS-EPD and DES/DDD to increase preventive screenings for women. To understand the cause of the low rates, ALTCS-EPD and DES/DDD should examine potential barriers to women receiving breast cancer and cervical cancer screenings (e.g., provider misconceptions, lack of education, member anxiety) and implement multicomponent interventions to reduce structural barriers. ALTCS-EPD and DES/DDD should ensure that members receive screenings in accordance with the USPSTF screening recommendations for breast cancer and cervical cancer.

UHCCP LTC’s Response:

UHCCP LTC outlined the following member and provider related initiatives designed to ensure LTC members receive behavioral health services following discharge from a hospital for mental illness:

- Facilities to schedule appointments within seven days of discharge. UM team to assist facilities in finding follow up appointments as needed.
- BH Quality collaborate with Provider Relations to outreach to higher-volume, lower-performing facilities to discuss/address barriers to finding aftercare appointments, provide resources.
- Case Management (CM) outreach to members post-discharge to discuss importance of aftercare and ensure appointment scheduled. If no timely appointment scheduled, CM will assist in locating an appointment.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

- Post measure education on provider website to promote role of PCP in members being compliant with behavioral health aftercare.
- Incentivize BH outpatient providers and community mental health centers (CMHCs) through value-based contracts.
- Contracted with a provider group to assist in case management and aftercare (COVID restricted all but telehealth interactions).
- Maintain Express Access program (providers with five day availability).
- Practitioners to offer telemental health appointments.
- Promote telemental health in provider newsletter.
- Distributed best practices email blast.
- Review additional opportunities to educate providers.
- Update a reference guide on HEDIS measures on UHC website for medical providers.
- Share daily inpatient admission and discharge data with providers.
- UHCCP’s performance on this measure will be measured monthly via various established reports.

UHCCP’s CYE 2019 Breast Cancer Screening rate of 34.1% failed to meet the AHCCCS minimum performance standard of 55%. UHCCP calculated the CYE 2020 LTC Breast Cancer rate and realized a slight improvement to 37.2%. The current level of performance is below the NCQA national average of 53.7%.

AHCCCS has initiated an ALTCS PIP—Breast Cancer Screening. The baseline measurement year was October 1, 2018, through September 30, 2019. The current contract year represents Intervention year 2 and the first re-measurement period is January 1, 2022, through December 31, 2022.

UHCCP formed a work group comprised of Long Term Care and Quality Management staff, tasked to problem-solve the health plan’s current level of performance and identify and implement strategies designed to improve performance on the breast cancer screening measure. The team developed various member and provider interventions to be initiated in CYE 2022 to improve performance.

HSAG Assessment: HSAG has determined that UHCCP LTC has addressed the prior year recommendation.

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:

HSAG did not provide recommendations for UHCCP LTC for PIPs in CYE 2020.

UHCCP LTC’s Response:

This section is not applicable, as no recommendations were provided in CYE 2020.

HSAG Assessment: Not applicable.

3. Prior Year Recommendation from the EQR Technical Report for Operational Reviews:

HSAG did not provide recommendations for UHCCP LTC for ORs in CYE 2020, as the activity was postponed due to the COVID-19 PHE.

3. Prior Year Recommendation from the EQR Technical Report for Operational Reviews:

UHCCP LTC’s Response:

UnitedHealthcare Community Plan adopts policies on an as-needed basis and reviews said policies and procedures annually or as often as business or regulatory requirements dictate. UnitedHealthcare Community Plan policies and procedures are instrumental in translating the company’s strategies, mission and values as well as laws and regulations into documented guidelines for management and staff to follow and act upon.

New and substantially revised policies and procedures for UnitedHealthcare Community Plan are presented to and approved by the Policy Committee. The Policy Committee recommends approval or denial to health plan management. If approved by health plan management, the Policy Committee finalizes approval of the policy and procedure. Policies and procedures are reviewed annually or as often as business needs or regulatory requirements dictate. The Policy Committee is comprised of a cross-functional team designated to provide oversight and to ensure that communication to all areas directly and indirectly impacted by these updates is provided and documented. Policies are then converted to PDF’s and uploaded to the UnitedHealthcare Community Plan HEART SharePoint, where they can be accessible.

HSAG Assessment: Not applicable.

4. Prior Year Recommendation from the EQR Technical Report for Network Analysis:

HSAG recommended each ALTCS-EPD Contractor should continue to monitor and maintain its existing provider network, based on the following validation conclusions:

- UHCCP LTC failed to meet the pediatric dentist standard for all applicable counties in CYE 2020 Quarter 3 and should review the validation results from AHCCCS to identify and address any concerns with its PAT data file.

UHCCP LTC’s Response:

UHCCP evaluates the contracted network on a quarterly basis. When gaps in the network are identified, UHCCP conducts a review of the area and category that has underperformed. A thorough audit of the provider community is conducted to include noncontracted providers and any new providers that enter the county. Our review also includes research through various public resources, such as the internet and phone book directories. These reviews are conducted monthly to ensure any new or expanding providers are approached and brought into the network.

HSAG Assessment: HSAG has determined that UHCCP LTC has partially addressed the prior year recommendation, as UHCCP LTC’s response did not address the review of PAT data files for accuracy.

DES/DDD

Table 5-4—Prior Year Recommendations and Responses for DES/DDD

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
<p>HSAG recommended that AHCCCS partner with DES/DDD to increase preventive screenings for women. To understand the cause of the low rates, DES/DDD should examine potential barriers to women receiving breast cancer and cervical cancer screenings (e.g., provider misconceptions, lack of education, member anxiety) and implement multicomponent interventions to reduce structural barriers. DES/DDD should ensure that members receive screenings in accordance with the USPSTF screening recommendations for breast cancer and cervical cancer.</p> <p>DES/DDD’s Response:</p> <p>The following paragraphs include interventions and action plans presented to DES/DDD by the subcontracted health plans, UHCCP and Mercy Care. Each subcontracted entity has developed individual strategies to improve performance in breast cancer screening, cervical cancer screening, and behavioral health follow-up visits after hospitalizations for mental illness.</p> <p>Mercy Care has current interventions and activities in place to increase compliance with breast cancer screening and cervical cancer screening, which include:</p> <ul style="list-style-type: none"> • Digital outreach to members in need of a well woman visit (text messaging, email, IVR calls). • Written educational outreach. • Partnership with SimonMed imaging to close gaps in care. • Coordination with providers with members who are due for a mammogram to sign an order form which Mercy Care then utilizes to contact the member and assist with scheduling mammograms. • Member financial incentives. • Electronic provider gaps in care notifications. • Provider site visits. <p>UHCCP outlined in the CYE 2022 Work Plan submitted to DES/DDD a series of actions designed to increase the percentage of DES/DDD members receiving a mammogram, including:</p> <ul style="list-style-type: none"> • Live member calls: live outbound calls to members encouraging the member to schedule a mammogram and assist the member with finding a provider if needed. • Provider Gaps in Care Mailing: quarterly mailing to providers listing members in need of a mammogram. • Patient Care Opportunity Report (PCOR): members in need of a mammogram. Report is furnished to the group monthly. • Additional live outbound call by UHC outreach staff during the months of August and September to encourage the member to obtain a mammogram. • Nominal member incentive to obtain a mammogram. • Measure included in provider incentive programs for 2022.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
To further improve UHCCP’s performance on the <i>Cervical Cancer Screening</i> measure, in CYE 2021 initiated a new member outreach initiative. UHCCP sent a biannual Cervical Cancer Screening Flyer & Cover Letter to members who had not received this preventative healthcare service.
HSAG Assessment: HSAG has determined that DES/DDD has addressed the prior year recommendation.
2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG did not provide recommendations for DES/DDD for PIPs in CYE 2020.
DES/DDD’s Response: This section is not applicable, as no recommendations were provided in CYE 2020.
HSAG Assessment: Not applicable.
3. Prior Year Recommendation from the EQR Technical Report for Operational Reviews:
HSAG did not provide recommendations for DES/DDD for ORs in CYE 2020, as the activity was postponed due to the COVID-19 PHE.
DES/DDD’s Response: This section is not applicable, as no recommendations were provided in CYE 2020.
HSAG Assessment: Not applicable.
4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy:
<p>HSAG recommended DES/DDD’s subcontracted health plan Mercy Care continue to monitor and maintain its existing provider networks while working to assure the availability of:</p> <ul style="list-style-type: none"> Behavioral health outpatient and integrated clinics for adults in Apache and Coconino counties. Cardiologists for adults in Apache and Coconino counties. Pediatric dentists in Gila, Apache, Graham, Greenlee, and La Paz counties. PCPs for adults in Apache and Coconino counties. <p>HSAG recommended DES/DDD’s subcontracted health plan UHCCP continue to monitor and maintain its existing provider networks while working to assure the availability of:</p> <ul style="list-style-type: none"> Behavioral health outpatient and integrated clinics for adults or children in Apache County. Cardiologists for adults or children in Apache County. Pediatric dentists in Apache and Greenlee counties. PCPs for adults in Apache County. Pharmacies in Apache County.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy:

DES/DDD's Response:

Mercy Care continues to actively recruit for specialty providers including behavioral health outpatient and integrated clinics for adults in Apache and Coconino counties; cardiologists for adults in Apache and Coconino counties; pediatric dentists in Gila, Apache, Graham, Greenlee, and La Paz counties; and PCPs for adults in Apache and Coconino counties.

While counts for members without access are low in these groups, Mercy Care is committed to the ongoing recruitment of these specialty providers, including routine review of AHCCCS-registered providers not currently contracted with Mercy Care and the assessment of geo-analyses to identify newly registered providers.

Apache County has a limited provider community. With that understanding, UHCCP continues to research and develop relationships with all providers who enter the county. When new or existing gaps are identified, our contracting team is immediately notified which, in turn, begins the process of contracting to resolve any gaps in the network. UHCCP's research includes a review of all providers, contracted and noncontracted, within our system of providers. A review of various public resources, such as the internet and phone directories. These reviews are conducted monthly to ensure any new or expanding providers are approached and brought into the Network. This process applies to any gaps within our network, to include all lines of business.

HSAG Assessment: HSAG has determined that DES/DDD has addressed the prior year recommendation.

6. Contractor Best and Emerging Practices

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

BUFC LTC

- **A1c Testing:** In CYE 2020, BUFC LTC worked to get the A1c testing scores to the goal of 86% for members. BUFC LTC coordinated with Sonora Quest to track and monitor A1c tests and values and conduct outreach to members without a test on record or those with A1c values >9%. BUFC LTC case managers assisted members with high A1c levels (>9) by following up with providers and care givers so interventions can be done to quickly lower levels and will continue to follow-up to ensure A1c levels are in the appropriate range. The Clinical Performance team loads quarterly A1c gap in care data alerts into the BUHP Call Center system (Siebel) and call center representatives reach out to members through telephonic outreach to remind them they are due for A1c testing. BUFC LTC is continuing to make intervention improvements to detect and address high A1c scores through 2022.
- **Annual Dental Visits 2–20 Years:** BUFC LTC recognizes the importance of oral health during childhood and prevention of more serious dental issues. To increase the number of children ages 2–20 years receiving preventative dental service(s), BUFC LTC ensures that all dental referrals are attended to. Their Quality Department conducts telephonic outreach to non-compliant members/caregivers to assist them in scheduling preventative dental visits. Dental educational materials are provided to members through the member newsletter and social media. BUFC LTC partnered with a dental vendor (DentaQuest) to identify members who are due for preventative treatment and provide educational materials and appointment reminders. The BUFC LTC Quality Outreach team, targeted members who missed two preventative dental visits to schedule a dental visit. Additionally, BUFC LTC increased claims ingestion to include all claims status. Due to the COVID-19 PHE, there was an unfortunate decline in rates as dental visits have been affected. However, BUFC LTC will continue to work with DentaQuest and ALTCS case managers to get children in for their appointments and preventative care.
- **Breast Cancer Screening:** With the increasing rate of breast cancer, BUFC LTC distributes annual mailings to non-compliant members regarding mammography and the importance of screenings. Additional interventions such as educating members on the important of cancer screenings and helping with scheduling at an image facility are provided. BUFC LTC has a partnership with the American Cancer Society, they provide BUFC LTC with cancer screening member and provider material that we then implement into our workflow and key phrases. Another partnership is with Banner Imaging, who conducts monthly outreach and schedule mammograms for our dual members who are due to breast cancer screenings. Additionally, Banner Imaging contracted with mobile mammogram providers to serve rural members and members in facilities. In 2021 and 2022, breast cancer screening is a focus for BUFC LTC and plan to implement several new initiatives to ensure screenings. BUFC LTC will be working with ALTCS case managers to outreach members missing services and will utilize more mobile mammogram units.

- Long-Term Services and Supports (LTSS) Comprehensive Assessment Update: New in 2022, the Comprehensive Assessment and Update measure is designed to ensure BUFC LTC 18 years and older members have comprehensive LTSS assessments. The LTSS assessments include nine core elements and at least twelve supplemental elements that require documentation through Case Management Record Review within 90 days of enrollment for new BUFC LTC members or annually for existing members

Mercy Care LTC

- Permanent Supportive Housing: With the significant increase in unsheltered persons experiencing homelessness in Maricopa County, permanent supportive housing (PSH) services are designed to assist Mercy Care LTC members in obtaining and/or maintaining independent housing in the community of their choice. PSH services are offered to members to maximize housing stability, prevent returns to homelessness, connect members to health care and treatment, and employment opportunities. During CYE 2021, four providers were reviewed for fidelity to the Substance Abuse and Mental Health Services Administration (SAMHSA) model of PSH and scored an average of 79%. This average represents a 20% increase of fidelity from the first-year providers that were reviewed in 2014–2015. Additionally, PSH service providers reported a housing retention rate of 93% for 2021, demonstrating that Mercy Care LTC members engaged in PSH services are maintaining housing in their community.

UHCCP LTC

- Behavioral Health (BH) Diabetic Education – In an increasing effort to educate UHCCP LTC members about the increased risk of diabetes with taking antipsychotic medication and importance of annual HbA1c tests, UHCCP LTC implemented the BH Diabetic Education behavioral health and clinical initiative for CYE 2021. The LTC BH quarterly review/consultation process is managed by two full-time licensed Behavioral Health Professionals (BHPs). During the reviews, the BHPs provides education about the increased risk of diabetes when taking antipsychotic medication, encouraged members to speak with their physician about their risk, and about the importance of annual HbA1c tests to screen members for diabetes. During 2021, BHPs have provided education to 55 UHCCP LTC members and their case managers (CMs) during BH quarterly reviews.
- AZ Provider Scorecard: UHCCP’s AZ Provider Scorecard supports primary care practice improvement by providing the practice information about their performance on quality measures (behavioral health, diabetes/hypertension, women’s health, maternity care, and pediatric prevention) compared to other practices. The AZ Provider Scorecard rates are reflected of UHCCP members across all lines of business, including UHCCP LTC members. The AZ Provider Score Card helps identify potentially unwarranted variations in care and provides an opening for discussions on how UHCCP can support their efforts to achieve the Triple Aim of better care, better outcomes, and better costs for the members. To increase quality measure rates, interventions included live and interactive voice response (IVR) reminder calls to members, reminder mailings to members,

provider gaps in care mailers, provider education materials, and provider incentive programs. UHCCP Clinical Practice Consultants (CPCs) also share Patient Care Opportunity Reports (PCOR) which shows quality measure gaps in care with providers groups each month. The AZ Provider Scorecard has been available to share with provider groups since July 2021 and has had positive provider feedback since this type of information was not previously made available. Moving forward, UHCCP will continue to provide the AZ Provider Scorecard to providers.

- **Pacific Dental Services Foundation:** UHCCP partnered with Pacific Dental Services Foundation to provide dental services to members with special needs enrolled in LTC lines of business. Pacific Health Care Services Foundation is a special care dental provider that understands the unique needs of these populations. The goal is to improve oral health for members with special needs by providing access to special care dental providers. Interventions to achieve this goal include:
 - Early and Periodic Screening, Diagnostic and Treatment (EPSDT) referral calls to members’ guardians, reminder mailers and postcards to member’s guardians, and provider education materials and training videos.
 - Differential adjusted payments for dentists with weekend hours and/or who apply sealants to members 5–15 years of age.
 - Monthly meetings between UHCCP CPCs, primary care and dental providers to share gaps in care reports for dental quality measures. CPCs include Pacific Dental Care Services Foundation as an agenda topic when meeting with providers and distribute referral forms.
 - Due to the COVID-19 public health emergency, the LTC ‘annual dental visit (ADV)’ measure rate had dropped in measurement year (MY) 2020 with a rate of 47.5% compared to 52% in CYE 2019. However, UHCCP still exceeded the NCQA 2020 National Average rate of 42.79% by 4.1 percentage points for MY 2020. The current MY 2021 prospective rate is less than two percentages points from this at 41.4%.

DES/DDD

- **Improving Access to Dental Services:** UHCCP provides dental services to DES/DDD members as a subcontracted health plan. In partnership with Pacific Dental Services Foundation, this partnership was established to provide dental services to members with special needs enrolled in LTC and DES/DDD lines of business. Pacific Health Care Services Foundation is a special care dental provider that understands the unique needs of these populations. The goal is to improve oral health for members with special needs by providing access to special care dental providers. Interventions to achieve this goal include:
 - EPSDT referral calls to members’ guardians, reminder mailers and postcards to member’s guardians, and provider education materials and training videos.
 - Differential adjusted payments for dentists with weekend hours and/or who apply sealants to members 5–15 years of age.
 - Monthly meetings between UHCCP CPCs, primary care and dental providers to share gaps in care reports for dental quality measures. CPCs include Pacific Dental Care Services Foundation as an agenda topic when meeting with providers and distribute referral forms.

- Due to the COVID-19 public health emergency, the DES/DDD ‘annual dental visit (ADV)’ measure rate had a significant drop in MY 2020 with a rate of 49.3% compared to 58.0% in CYE 2019. However, UHCCP still exceeded the NCQA 2020 National Average rate of 42.79% by 6.5 percentage points for MY 2020. The current MY 2021 prospective rate is 45.08% and exceeding the NCQA rate.
- **Abuse, Neglect, & Exploitation Education:** In response to Arizona Executive Order 2019-03 “Enhanced Protections for Individuals with Disabilities”, the executive order called for AHCCCS to convene the Abuse and Neglect Prevention Task Force. The Task Force identified needed reforms, practices, critical resources, policies, and commitments to improve and sustain safety and security for vulnerable individuals. A recommendation was to require State agencies, in partnership with community-based organizations, to provide evidence-based training for vulnerable individuals and their families on abuse, neglect, and exploitation prevention, reporting, and trauma recovery in collaboration with members of targeted populations. The DES/DDD developed and utilized an evidence-based training for vulnerable individuals and their family members to increase awareness, advocacy, and knowledge. The training includes targeted training modules to support member awareness and education for all Arizona families, providers, and community partners. In addition to the targeted training modules, the DES/DDD maintains a webpage with various education including in person and online training sessions, training materials, and training assistance for providers and is also made available to caregivers. Since the initiation of trainings in May 2021 through October 2021, 253 members have been trained and 66 different vendors have training 3,209 total staff, with majority being direct care workers. The DES/DDD anticipates training 60,000 direct care workers over the 12-month period.
- **Hourly Nursing Assessment Tool:** The DES/DDD developed the Hourly Nursing Assessment Tool (H-NAT) in response to the Nursing Assessment Corrective Action Plan (CAP). DES/DDD worked in partnership with Northern Arizona University (NAU) to develop the H-NAT that was consistent with the unique and special needs of DES/DDD members as well as the nursing staff responsible for assessment of their healthcare needs. DES/DDD and NAU developed the H-NAT to address the issue of properly assessing skilled nursing tasks and to provide inter-rater reliability (IRR). The H-NAT has eight components (general, neurological, respiratory, cardiovascular, nutrition, elimination, skin integrity, and medications) and five modifiers (behavior, communication, acute care, training, and PRN). The goal after development of the H-NAT was to support initial implementation of the skilled nursing tool, procedures, training, and inter-rater reliability system to determine the scope and quantity of cost-efficient and medically necessary, skilled nursing support authorized for DES/DDD members living in their homes. The use of the H-NAT demonstrated that members who received skilled nursing services are consistently and accurately assessed, allowing for IRR for the hours required across all districts. Subjectivity has been reduced by placing limits on the number of hours allowed to be submitted within the modifiers of the H-NAT. IRR testing was completed during September 2021. A total of 29 nurses participated in the IRR, which is 78% of the total number of nurses. A total of 64 individual H-NATS were completed. The overall combined IRR estimate across all districts is .85 or 85%, demonstrating positive consistency across nurses using the H-NAT.

7. Performance Measurement

Methodology

Title 42 of CFR §438.350(a) requires states that contract with MCOs, PIHPs, PAHPs, or PCCM entities to have a qualified EQRO perform an annual EQR that includes validation of contracted entity performance measures (42 CFR §438.358[b][1][ii]) for the preceding 12 months.

The purpose of the PMV is to assess the accuracy of performance measures reported by Contractors and to determine the extent to which performance measures reported by the Contractors follow state specifications and reporting requirements. According to the CMS publication, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019,⁷⁻¹ the mandatory PMV activity may be performed by the State Medicaid agency, an agent that is not an MCO, or an EQRO.

AHCCCS administers a wide variety of covered services through its Medicaid program. These services include acute care services, behavioral health services covering general mental health/substance use as well as crisis services, services for members determined to have a serious mental illness (SMI), children in the State's foster care program, and long-term care and support services for the State's aging and/or physically disabled population, including individuals with developmental disabilities. The ALTCS-EPD Contractors provide LTSS and acute physical and behavioral health services to eligible members who are elderly and/or have a physical disability. Each ALTCS-EPD Contractor is assigned to serve one of three geographic service areas (GSAs). The DES/DDD Contractor provides LTSS and acute physical and behavioral health services to eligible members with intellectual and/or development disabilities as outlined under Arizona state law.

To improve the timeliness of data collection, calculation, and reporting, AHCCCS transitioned from using EQRO-calculated performance measure rates to measure and report Contractor-level data. Starting with its CY 2020/MY 2020 performance measures, AHCCCS used Contractor-calculated performance measure rates that have undergone EQRO validation. HSAG, the EQRO for AHCCCS, conducted the program/LOB-specific PMV for each Contractor.

Additionally, the measurement period was transitioned from CYE (reflective of October 1 through September 30) to calendar year (CY) (reflective of January 1 through December 31). Beginning with its CYE 2021 contract amendments, AHCCCS also transitioned from its use of internally established minimum performance standards (MPSs) to the use of national benchmark data (i.e., NCQA Quality Compass national Medicaid HMO mean) to evaluate statewide and Contractor performance. To promote quality improvement, performance measure results will be compared to nationally recognized standards that account for national performance trends and changes in measure technical specifications. Therefore,

⁷⁻¹ The Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf>. Accessed on: Dec 9, 2021.

MY 2020 performance measure results are not comparable to previous CYE performance measure results calculated by AHCCCS, and trending of performance measure rates could not be performed. In future years, trending will be incorporated into this report.

The following section presents the results for the mandatory CYE 2021 performance measure validation activities conducted for the MY 2020 (i.e., January 1, 2020–December 31, 2020) reporting period. To evaluate performance levels and to provide an objective, comparative review of the Contractors' performance, HSAG validated a variety of performance measures to address different quality initiatives using the following technical specifications: NCQA's HEDIS and CMS Core Set of Children's Health Care Quality Measures for Medicaid (Child Core Set) and CHIP.

For a detailed explanation of the CYE 2021 PMV methodology, please see Appendix A.

Performance Measurement—ALTCS-EPD Contractors

CYE 2021 Performance Measure Validation

There are several aspects crucial to the calculation of performance measure data. These include data integration, data control, and documentation of performance measure calculations. Accurate data integration is essential for calculating valid performance measure data. The steps used to combine various data sources (including claims/encounter data, eligibility data, and other administrative data) must be carefully controlled and validated. A Contractor's organizational infrastructure must support all necessary information systems, and its quality assurance practices and backup procedures must be sound to ensure timely and accurate processing of data, and to provide data protection in the event of a disaster. Sufficient, complete documentation is necessary to support validation activities. While interviews and system demonstrations provided supplementary information, the majority of the validation review findings were based on documentation provided by the Contractor. During the CYE 2021 PMV, HSAG reviewed all related documentation, which included the completed Record of Administration, Data Management, and Processes (Roadmap), if applicable, Information Systems Capabilities Assessment Tool (ISCAT), job logs, computer programming code, output files, workflow diagrams, narrative descriptions of performance measure calculations, and other related documentation. HSAG determined if the data integration processes, data control processes, and documentation of performance measure generation by the Contractors were acceptable or not acceptable.

Performance Measure Validation Contractor Comparison

During CYE 2021, HSAG evaluated each ALTCS-EPD Contractor's data systems for processing of each data type used for reporting the Contractor's MY 2020 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. A summary of these findings by ALTCS-EPD Contractor is provided in Table 7-1, displaying if each ALTCS-EPD Contractor met the assessed Information System (IS) standards, which demonstrates the Contractor has effective IS practices and

control procedures for data reporting. Additional information about each ALTCS-EPD Contractor’s validation results for each data type reviewed in alignment with the CMS EQR Protocol 2 audit requirements, including more information about “Not Met” findings, can be found in Appendix A.

Table 7-1—Performance Measures Validation Contractor Comparison: CMS EQR Protocol 2 Validation Results for ALTCS-EPD Contractors

Data Type	BUFC LTC	Mercy Care LTC	UHCCP LTC
Medical Services Data	Met	Met	Met
Enrollment Data	Met	Met	Met
Provider Data	Met	Met	Met
Medical Record Review Processes	Not Applicable	Met	Met
Supplemental Data	Met	Met	Met
Data Preproduction Processing	Met	Met	Met
Data Integration and Reporting	Met	Met	Met

Performance Measure Results

Table 7-2 presents the MY 2020 performance measure rates for each ALTCS-EPD Contractor and the ALTCS-EPD program aggregate for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020. Performance measure rate cells shaded green indicate that the Contractor met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020. 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. Impacts of the COVID-19 PHE vary by performance measure and Contractor. NCQA has not released global guidance on how MY 2020 rates may be impacted by the PHE.

Table 7-2—MY 2020 Performance Measure Results for ALTCS-EPD Contractors

Performance Measure	BUFC LTC	Mercy Care LTC	UHCCP LTC	Aggregate
Behavioral Health Care				
<i>Antidepressant Medication Management</i>				
<i>Effective Acute Phase Treatment</i>	45.0%	65.1%	83.0%	72.6%
<i>Effective Continuation Phase Treatment</i>	42.5%	55.4%	72.7%	63.0%
<i>Follow-Up After Hospitalization for Mental Illness</i>				
<i>7-Day Follow-Up—Total</i>	24.3%	43.3%	36.6%	36.6%
<i>30-Day Follow-Up—Total</i>	27.0%	55.2%	61.0%	49.7%

Performance Measure	BUFC LTC	Mercy Care LTC	UHCCP LTC	Aggregate
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment				
<i>Total Initiation of AOD—Total</i>	44.0%	47.4%	57.8%	50.8%
<i>Total Engagement of AOD—Total</i>	5.6%	5.1%	2.9%	4.3%
Care of Acute and Chronic Conditions				
Comprehensive Diabetes Care				
<i>Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*</i>	75.1%	25.8%	30.4%	39.4%
Preventive Screening				
Breast Cancer Screening				
<i>Total</i>	38.5%	34.2%	37.2%	36.3%

* For this indicator, a lower rate indicates better performance.


 Cells shaded green indicate that the rate met or exceeded the national Medicaid mean for HEDIS MY 2020.

Table 7-3 highlights the ALTCS-EPD Contractors’ performance for the current year by domain of care. The table illustrates the Contractors’ MY 2020 measure rates and their performance relative to the NCQA national Medicaid Quality Compass HEDIS MY 2020 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

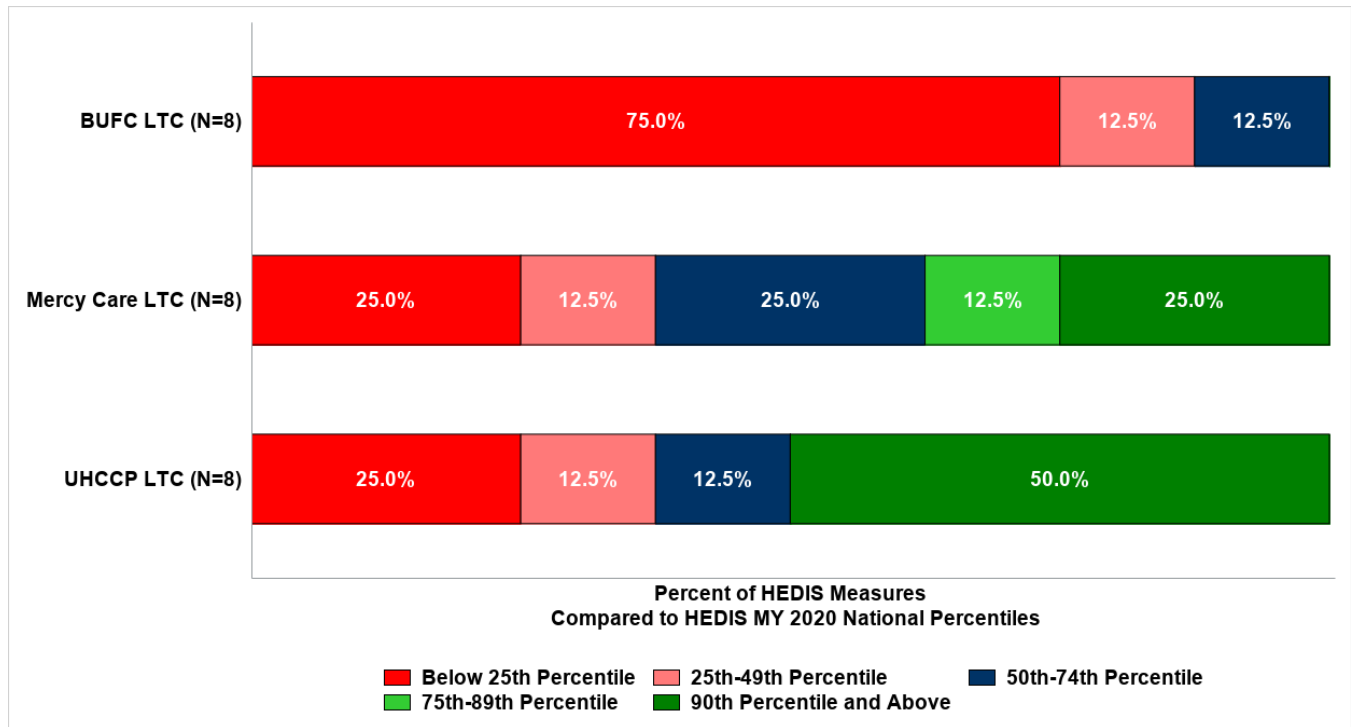
Table 7-3—MY 2020 National Percentiles Comparison for ALTCS-EPD Contractors

Performance Measure	BUFC LTC	Mercy Care LTC	UHCCP LTC	Aggregate
Behavioral Health Care				
Antidepressant Medication Management				
<i>Effective Acute Phase Treatment</i>	★	★★★★★	★★★★★	★★★★★
<i>Effective Continuation Phase Treatment</i>	★★★	★★★★★	★★★★★	★★★★★
Follow-Up After Hospitalization for Mental Illness				
<i>7-Day Follow-Up—Total</i>	★	★★★	★★	★★
<i>30-Day Follow-Up—Total</i>	★	★★	★★★	★
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment				
<i>Total Initiation of AOD—Total</i>	★★	★★★	★★★★★	★★★★
<i>Total Engagement of AOD—Total</i>	★	★	★	★

Performance Measure	BUFC LTC	Mercy Care LTC	UHCCP LTC	Aggregate
Care of Acute and Chronic Conditions				
<i>Comprehensive Diabetes Care</i>				
<i>Hemoglobin A1c (HbA1c) Poor Control (>9.0%)</i>	★	★★★★★	★★★★★	★★★
Preventive Screening				
<i>Breast Cancer Screening</i>				
<i>Total</i>	★	★	★	★

Figure 7-1 displays the ALTCS-EPD Contractors’ HEDIS MY 2020 performance compared to benchmarks. HSAG analyzed results from five performance measures for HEDIS MY 2020 for a total of eight indicator rates.

Figure 7-1— Comparison of Measure Indicators to HEDIS Medicaid National Percentiles for ALTCS-EPD Contractors



Performance Measurement—DES/DDD

CYE 2021 Performance Measure Validation

There are several aspects crucial to the calculation of performance measure data. These include data integration, data control, and documentation of performance measure calculations. Accurate data integration is essential for calculating valid performance measure data. The steps used to combine various data sources (including claims/encounter data, eligibility data, and other administrative data) must be carefully controlled and validated. A Contractor’s organizational infrastructure must support all necessary information systems, and its quality assurance practices and backup procedures must be sound to ensure timely and accurate processing of data, and to provide data protection in the event of a disaster. Sufficient, complete documentation is necessary to support validation activities. While interviews and system demonstrations provided supplementary information, the majority of the validation review findings were based on documentation provided by the Contractor. During the CYE 2021 PMV, HSAG reviewed all related documentation, which included the completed Record of Administration, Data Management, and Processes (Roadmap), if applicable, Information Systems Capabilities Assessment Tool (ISCAT), job logs, computer programming code, output files, workflow diagrams, narrative descriptions of performance measure calculations, and other related documentation. HSAG determined if the data integration processes, data control processes, and documentation of performance measure generation by the Contractors were acceptable or not acceptable.

Performance Measure Validation Contractor Comparison

During CYE 2021, HSAG evaluated DES/DDD’s data systems for processing of each data type used for reporting the MY 2020 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. A summary of these findings is provided in Table 7-4. Additional information about the DES/DDD validation results for each data type reviewed in alignment with the CMS EQR Protocol 2 audit requirements, including more information about “Not Met” findings, can be found in Appendix A.

**Table 7-4— Performance Measures Validation Contractor Comparison:
CMS EQR Protocol 2 Validation Results for DES/DDD**

Data Type	DES/DDD
Medical Services Data	<i>Met</i>
Enrollment Data	<i>Met</i>
Provider Data	<i>Met</i>
Medical Record Review Processes	<i>Met</i>
Supplemental Data	<i>Met</i>
Data Preproduction Processing	<i>Met</i>
Data Integration and Reporting	<i>Met</i>

Performance Measure Results

Table 7-5 presents the MY 2020 performance measure rates for DES/DDD for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020. Performance measure rate cells shaded green indicate that the Contractor met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020. 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. Impacts of the COVID-19 PHE vary by performance measure and Contractor. NCQA has not released global guidance on how MY 2020 rates may be impacted by the PHE.

Table 7-5—MY 2020 Performance Measure Results for DES/DDD

Performance Measure	MY 2020 Performance [^]
Behavioral Health Care	
<i>Antidepressant Medication Management</i>	
<i>Effective Acute Phase Treatment</i>	72.9%
<i>Effective Continuation Phase Treatment</i>	69.7%
<i>Follow-Up After Hospitalization for Mental Illness</i>	
<i>7-Day Follow-Up—Total</i>	68.9%
<i>30-Day Follow-Up—Total</i>	87.3%
<i>Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment</i>	
<i>Total Initiation of AOD—Total</i>	38.8%
<i>Total Engagement of AOD—Total</i>	S
Care of Acute and Chronic Conditions	
<i>Comprehensive Diabetes Care</i>	
<i>Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*</i>	24.2%
Pediatric Health	
<i>Child and Adolescent Well-Care Visits</i>	
<i>Total</i>	47.9%
<i>Well-Child Visits in the First 30 Months of Life</i>	
<i>Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	26.2%
Preventive Screening	
<i>Breast Cancer Screening</i>	
<i>Total</i>	47.4%

[^] Caution should be exercised when comparing MY 2020 performance to national Medicaid means, given the differences in the DES/DDD population compared to the overall Medicaid population.

* For this indicator, a lower rate indicates better performance.

S indicates that fewer than 11 cases exist in the numerator of this measure; therefore, the rate was suppressed to satisfy the HIPAA Privacy Rule’s de-identification standard.


 Cells shaded green indicate that the rate met or exceeded the national Medicaid mean for HEDIS MY 2020.

Table 7-6 highlights DES/DDD’s performance for the current year by domain of care. The table illustrates the MY 2020 measure rates and performance relative to the NCQA national Medicaid Quality Compass HEDIS MY 2020 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

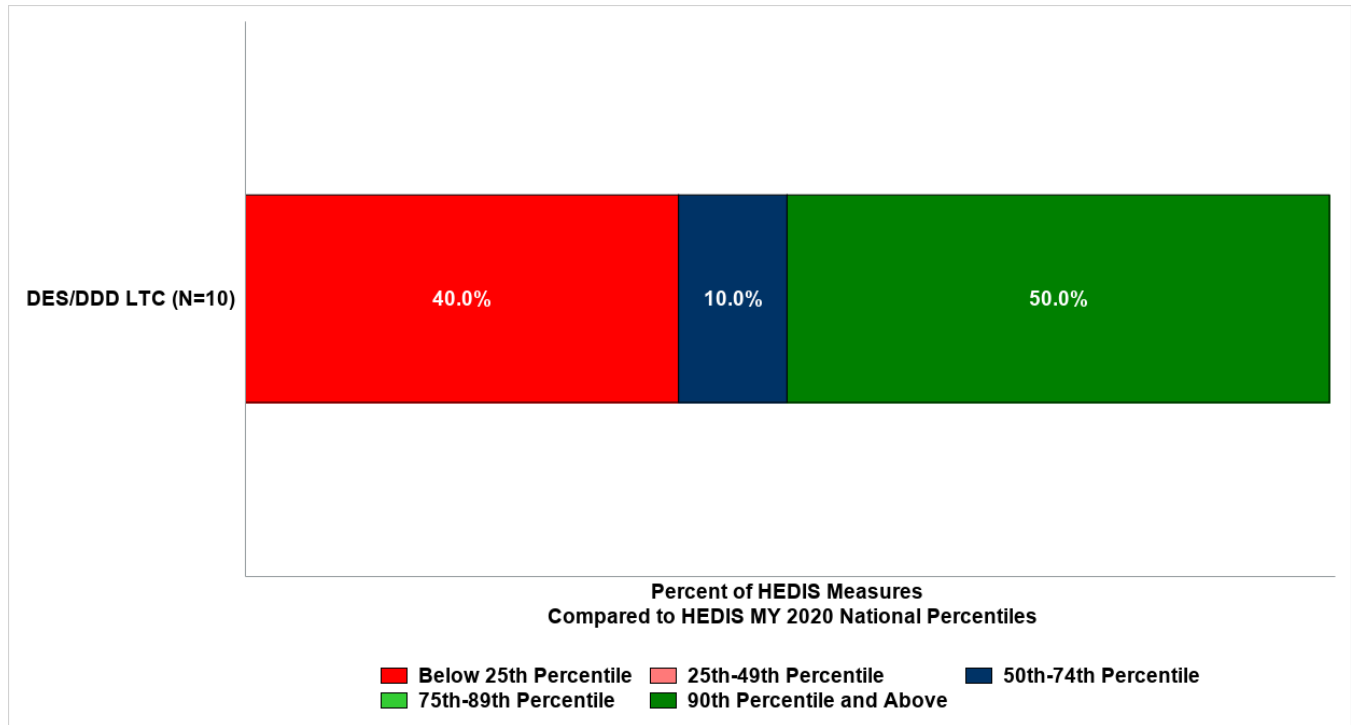
Table 7-6—MY 2020 National Percentiles Comparison for DES/DDD

Performance Measure	MY 2020 Performance [^]
Behavioral Health Care	
<i>Antidepressant Medication Management</i>	
<i>Effective Acute Phase Treatment</i>	★★★★★
<i>Effective Continuation Phase Treatment</i>	★★★★★
<i>Follow-Up After Hospitalization for Mental Illness</i>	
<i>7-Day Follow-Up—Total</i>	★★★★★
<i>30-Day Follow-Up—Total</i>	★★★★★
<i>Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment</i>	
<i>Total Initiation of AOD—Total</i>	★
<i>Total Engagement of AOD—Total</i>	★
Care of Acute and Chronic Conditions	
<i>Comprehensive Diabetes Care</i>	
<i>Hemoglobin A1c (HbA1c) Poor Control (>9.0%)</i>	★★★★★
Pediatric Health	
<i>Child and Adolescent Well-Care Visits</i>	
<i>Total</i>	★★★
<i>Well-Child Visits in the First 30 Months of Life</i>	
<i>Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	★
Preventive Screening	
<i>Breast Cancer Screening</i>	
<i>Total</i>	★

[^] Caution should be exercised when comparing MY 2020 performance to national Medicaid percentiles, given the differences in the DES/DDD population compared to the overall Medicaid population.

Figure 7-2 displays DES/DDD’s HEDIS MY 2020 performance compared to benchmarks. HSAG analyzed results from seven performance measures for HEDIS MY 2020 for a total of 10 indicator rates.

Figure 7-2—Comparison of Measure Indicators to HEDIS Medicaid National Percentiles for DES/DDD



Quality, Access, and Timeliness—Strengths, Opportunities for Improvement, and Recommendations

BUFLTC

Table 7-7—Strengths, Opportunities for Improvement, and Recommendations for BUFLTC

Strengths
1. BUFLTC’s measure rate for <i>Antidepressant Medication Management—Effective Continuation Phase Treatment</i> met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and met or exceeded the 50th percentile, indicating that most members with a diagnosis of major depression were receiving continuous medication treatment. Effective medication treatment of major depression can improve a person’s daily functioning and well-

Strengths
<p>being, and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated as well.⁷⁻²</p>
Opportunities for Improvement and Recommendations
<p>1. HSAG identified during the CYE 2021 PMV that BUFC LTC did not integrate data from its nonstandard supplemental data source, which it used to collect medical record abstracted data throughout the year.</p> <p style="padding-left: 40px;">Recommendation: HSAG recommends that BUFC LTC clarify its understanding of any future State-specific guidance. To ensure all possible performance measure numerator compliant records are appropriately identified, HSAG further recommends that BUFC LTC document and submit its nonstandard supplemental data source for audit review and approval for future years’ data integration and continue to explore other potential data streams for future supplemental data submission. This may include electronic health record data feeds, lab result files, exclusion history files, etc.</p>
<p>2. BUFC LTC did not use the hybrid methodology for any performance measures eligible for hybrid reporting, which did not align with the State-specific guidance.</p> <p style="padding-left: 40px;">Recommendation: HSAG recommends that BUFC LTC review and clarify expectations related to hybrid/medical record review requirements for future years’ reporting. This should include the planning and development of abstraction tools and data capture and integration for non-HEDIS measures, in accordance with State-specific guidance for measures required to be reported following hybrid methodology.</p>
<p>3. In the Behavioral Health Care domain, BUFC LTC’s performance measure rates for <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up–Total</i> and <i>30-Day Follow-Up–Total</i> fell below the 25th percentile, indicating that members were not always accessing follow-up care with a mental health provider within seven days and 30 days following inpatient discharge. Individuals hospitalized for mental health disorders often do not receive adequate follow-up care. Providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes and decrease the likelihood of rehospitalization and the overall cost of outpatient care.⁷⁻³</p> <p style="padding-left: 40px;">Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended.</p>

⁷⁻² National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: <https://www.ncqa.org/hedis/measures/antidepressant-medication-management/>. Accessed on: Jan 25, 2022.

⁷⁻³ National Committee for Quality Assurance. Follow-Up After Hospitalization for Mental Illness (FUH). Available at: <https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/>. Accessed on: Jan 25, 2022.

Opportunities for Improvement and Recommendations

Recommendation: HSAG recommends that BUFC LTC conduct a root cause analysis to determine why members were not receiving timely follow-up care with a mental health provider. BUFC LTC should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of mental health service providers, or the need for community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, BUFC LTC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, BUFC LTC should implement appropriate interventions to improve the performance related to follow-up care following a hospitalization.

4. In the Behavioral Health Care domain, BUFC LTC’s performance measure rate for *Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment—Engagement of AOD—Total—Total* fell below the 25th percentile, indicating that members with a new episode of AOD dependence were not always accessing AOD services or MAT within 34 days of the initiation visit. Treatment, including MAT, in conjunction with counseling or other behavioral therapies, has been shown to reduce AOD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.⁷⁻⁴

Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended.

Recommendation: HSAG recommends that BUFC LTC conduct a root cause analysis to determine why members were not receiving timely AOD services or MAT. BUFC LTC should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, BUFC LTC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, BUFC LTC should implement appropriate interventions to improve the performance related to initiating and engaging in timely treatment following a new episode of AOD dependence.

5. In the Care of Acute and Chronic Conditions domain, BUFC LTC’s performance measure rate for *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* fell below the 25th percentile, indicating that although members with chronic conditions may have had access to care, they were not able to manage their conditions according to evidence-based guidelines through the appropriate use of medications, diet and nutrition, or physical activity. Proper diabetes

⁷⁻⁴ National Committee for Quality Assurance. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET). Available at: <https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/>. Accessed on: Jan 25, 2022.

Opportunities for Improvement and Recommendations

management is essential to control blood glucose, reduce risks for complications, and prolong life.⁷⁻⁵

A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE.

Recommendation: HSAG recommends that BUFC LTC conduct a root cause analysis or focused study to determine why members were not maintaining their chronic health conditions at optimal levels or why some adult members were experiencing issues with access to care. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, BUFC LTC should implement appropriate interventions to improve the performance related to this chronic condition.

6. In the Preventive Screening domain, BUFC LTC’s performance measure rate for *Breast Cancer Screening* fell below the 25th percentile, indicating that women were not 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.⁷⁻⁶

A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE.

Recommendation: HSAG recommends that BUFC LTC conduct a root cause analysis or focused study to determine why its female members were not receiving timely screenings for breast cancer. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, BUFC LTC should implement appropriate interventions to improve the performance related to preventive screenings.

⁷⁻⁵ National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: <https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/>. Accessed on: Jan 25, 2022.

⁷⁻⁶ National Committee for Quality Assurance. Breast Cancer Screening (BCS). Available at: <https://www.ncqa.org/hedis/measures/breast-cancer-screening/>. Accessed on: Jan 25, 2022.

Mercy Care LTC

Table 7-8—Strengths, Opportunities for Improvement, and Recommendations for Mercy Care LTC

Strengths
<p>1. Mercy Care LTC performed well within the Behavioral Health Care domain, with four of six (66.7 percent) measure rates meeting or exceeding the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020.</p>
<p>2. Mercy Care LTC performed well within the Care of Acute and Chronic Conditions domain, as the measure rate for <i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)</i> met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020.</p>
<p>3. Overall, Mercy Care LTC had five of nine (55.6 percent) measure rates meet or exceed the 50th percentile, with two of these measure rates (<i>Antidepressant Medication Management—Effective Continuation Phase Treatment</i> and <i>Comprehensive Diabetes Care—HbA1c Poor Control [>9.0%]</i>) meeting or exceeding the 90th percentile. The measure rates that met or exceeded the 50th percentile were in the Behavioral Health Care and Care of Acute and Chronic Conditions domains.</p>
Opportunities for Improvement and Recommendations
<p>1. Mercy Care LTC did not collect or assign the provider specialty within its source systems. Mercy Care LTC reviewed the provider specialty listed in AHCCCS’ PMMIS for accuracy and monitored it quarterly with the PAT report.</p> <p style="padding-left: 40px;">Recommendation: HSAG recommends that Mercy Care LTC ensure that the mapping of provider specialties to HEDIS provider types is compliant with AHCCCS guidance for reporting performance measures where provider specialty type is required.</p>
<p>2. While Mercy Care LTC was not required to complete any source code updates for measures in the scope of PMV, a formalized test plan was not demonstrated, which may present future risks to ensuring alignment with technical specification for new or revised measures.</p> <p style="padding-left: 40px;">Recommendation: HSAG recommends that Mercy Care LTC conduct a formal review of its source code followed by a complete test plan, including live system validation of data, prior to reporting any performance measure data.</p>
<p>3. In the Behavioral Health Care domain, Mercy Care LTC’s performance measure rate for <i>Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment—Engagement of AOD—Total—Total</i> fell below the 25th percentile, indicating that members with a new episode of AOD dependence were not always accessing AOD services or MAT within 34 days of the initiation visit. Treatment, including MAT, in conjunction with counseling or other behavioral therapies, has been shown to reduce AOD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.</p>

Opportunities for Improvement and Recommendations

Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended.

Recommendation: HSAG recommends that Mercy Care LTC conduct a root cause analysis to determine why members were not receiving timely AOD services or MAT. Mercy Care LTC should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, Mercy Care LTC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, Mercy Care LTC should implement appropriate interventions to improve the performance related to initiating and engaging in timely treatment following a new episode of AOD dependence.

4. In the Preventive Screening domain, Mercy Care LTC's performance measure rate for *Breast Cancer Screening* fell below the 25th percentile, indicating that women were not receiving timely screening for breast cancer. Early detection reduces the risk of dying from this type of cancer and can lead to a greater range of treatment options and lower healthcare costs.

A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE.

Recommendation: HSAG recommends that Mercy Care LTC conduct a root cause analysis or focused study to determine why its female members were not receiving timely screening for breast cancer. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, Mercy Care LTC should implement appropriate interventions to improve the performance related to preventive screenings.

UHCCP LTC

Table 7-9—Strengths, Opportunities for Improvement, and Recommendations for UHCCP LTC

Strengths
<p>1. UHCCP LTC performed well within the Behavioral Health Care domain, with four of six (66.7 percent) measure rates meeting or exceeding the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020.</p>
<p>2. UHCCP LTC performed well within the Care of Acute and Chronic Conditions domain, as the measure rate for <i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)</i> met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020.</p>
<p>3. Overall, UHCCP LTC had five of nine (55.6 percent) measure rates meet or exceed the 50th percentile, with four of these measure rates (<i>Antidepressant Medication Management—Effective Acute Phase Treatment</i> and <i>Effective Continuation Phase Treatment, Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment—Initiation of AOD—Total—Total</i>, and <i>Comprehensive Diabetes Care—HbA1c Poor Control [>9.0%]</i>) meeting or exceeding the 90th percentile. The measure rates that met or exceeded the 50th percentile were in the Behavioral Health Care and Care of Acute and Chronic Conditions domains.</p>
Opportunities for Improvement and Recommendations
<p>1. While UHCCP LTC was not required to complete any source code updates for measures in the scope of PMV, a formalized test plan was not demonstrated, which may present future risks to ensuring alignment with technical specification for new or revised measures.</p> <p style="padding-left: 40px;">Recommendation: HSAG recommends that UHCCP LTC conduct a formal review of its source code followed by a complete test plan, including live system validation of data, prior to reporting any performance measure data.</p>
<p>2. In the Behavioral Health Care domain, UHCCP LTC’s performance measure rate for <i>Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD—Total</i> fell below the 25th percentile, indicating that members with a new episode of AOD dependence were not always accessing AOD services or MAT within 34 days of the initiation visit. Treatment, including MAT, in conjunction with counseling or other behavioral therapies, has been shown to reduce AOD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.⁷⁻⁷</p> <p style="padding-left: 40px;">Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended.</p>

⁷⁻⁷ National Committee for Quality Assurance. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET). Available at: <https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/>. Accessed on: Jan 25, 2022.

Opportunities for Improvement and Recommendations
<p>Recommendation: HSAG recommends that UHCCP LTC conduct a root cause analysis to determine why members were not receiving timely AOD services or MAT. UHCCP LTC should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, UHCCP LTC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, UHCCP LTC should implement appropriate interventions to improve the performance related to initiating and engaging in timely treatment following a new episode of AOD dependence.</p>
<p>3. In the Preventive Screening domain, UHCCP LTC’s performance measure rate for <i>Breast Cancer Screening</i> fell below the 25th percentile, indicating that women were not 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.</p> <p>A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE.</p> <p>Recommendation: HSAG recommends that UHCCP LTC conduct a root cause analysis or focused study to determine why its female members were not receiving timely screening for breast cancer. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, UHCCP LTC should implement appropriate interventions to improve the performance related to preventive screenings.</p>

DES/DDD

Table 7-10—Strengths, Opportunities for Improvement, and Recommendations for DES/DDD

Strengths
<p>1. DES/DDD performed well within the Behavioral Health Care domain, with four of six (66.7 percent) measure rates meeting or exceeding the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020.</p>
<p>2. DES/DDD performed well within the Care of Acute and Chronic Conditions domain, as the measure rate for <i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)</i> met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020.</p>
<p>3. Overall, DES/DDD had six of 11 (54.5 percent) measure rates meet or exceed the 50th percentile, with five of these measure rates (<i>Antidepressant Medication Management—Effective Acute Phase Treatment</i> and <i>Effective Continuation Phase Treatment, Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total</i> and <i>30-Day Follow-Up—Total</i>, and <i>Comprehensive</i></p>

Strengths
<p><i>Diabetes Care—HbA1c Poor Control [$>9.0\%$]</i>) meeting or exceeding the 90th percentile. The measure rates that met or exceeded the 50th percentile were in the Behavioral Health Care and Care of Acute and Chronic Conditions domains.</p>
Opportunities for Improvement and Recommendations
<p>1. DES/DDD has responsibility for both of its subcontractors’ data completeness, accuracy, integration, and reporting. Although both subcontracted health plans have multiple years of extensive experience in ongoing performance measure production and reporting, DES/DDD did not demonstrate well-defined routine oversight of the volume and trends in each subcontracted health plan’s data streams.</p> <p style="padding-left: 40px;">Recommendation: HSAG recommends that DES/DDD increase its routine oversight of the volume and trends in each subcontracted health plan’s data streams, creating tracking and monitoring reports that are reviewed and analyzed periodically to ensure that services and data are stable with no anomalies throughout the reporting year. DES/DDD should consider reviewing and comparing quarterly performance rates across its subcontracted health plans over time to identify any potential differences in services/results, areas for improvement, and best practices to integrate for all DES/DDD members.</p> <p>2. In the Behavioral Health Care domain, DES/DDD’s performance measure rates for <i>Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment—Initiation of AOD—Total—Total</i> and <i>Engagement of AOD—Total—Total</i> fell below the 25th percentile, indicating that members with a new episode of AOD dependence were not always initiating treatment within 14 days of diagnosis or accessing AOD services or MAT within 34 days of the initiation visit. Treatment, including MAT, in conjunction with counseling or other behavioral therapies, has been shown to reduce AOD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.</p> <p>Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended.</p> <p style="padding-left: 40px;">Recommendation: HSAG recommends that DES/DDD conduct a root cause analysis to determine why members were not initiating treatment or receiving timely AOD services or MAT. DES/DDD should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, DES/DDD should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, DES/DDD should implement appropriate interventions to improve the performance related to initiating and engaging in timely treatment following a new episode of AOD dependence.</p>

Opportunities for Improvement and Recommendations

3. In the Pediatric Health domain, DES/DDD’s performance measure rate for *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* fell below the 25th percentile, indicating that children were not always accessing well-child visits with a PCP or OB/GYN practitioner. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.⁷⁻⁸

A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE.

Recommendation: HSAG recommends that DES/DDD conduct a root cause analysis to determine why children were not always accessing well-child visits. DES/DDD should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of PCP or OB/GYN service providers, or the need for community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, DES/DDD should implement appropriate interventions to improve the performance related to well-care visits.

4. In the Preventive Screening domain, DES/DDD’s performance measure rate for *Breast Cancer Screening* fell below the 25th percentile, indicating that women were not receiving timely screening for breast cancer. Early detection reduces the risk of dying from this type of cancer and can lead to a greater range of treatment options and lower healthcare costs.

A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE.

Recommendation: HSAG recommends that DES/DDD conduct a root cause analysis or focused study to determine why its female members were not receiving timely screenings for breast cancer. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, DES/DDD should implement appropriate interventions to improve the performance related to preventive screenings.

⁷⁻⁸ National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: <https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/#:~:text=Well%2DChild%20Visits%20in%20the,first%201%205%20months%20of%20life>. Accessed on: Jan 25, 2022.

8. Performance Improvement Project Results

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

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

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

Conducting the Review

In the AHCCCS Medical Policy Manual, Policy 980—Performance Improvement Projects, AHCCCS mandates that the Contractor participate in selected AHCCCS-mandated and Contractor self-selected PIPs. AHCCCS-mandated PIP topics are selected through analysis of internal and external data/trends and may include Contractor input. Topics take into account comprehensive aspects of member needs, care, and services for a broad spectrum of members or a focused subset of the population, including those members with special health care needs such as members receiving LTSS [42 CFR 438.330]. AHCCCS may also mandate that a PIP be conducted by a Contractor or group of Contractors, according to standardized methodology developed by AHCCCS.

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

Note that AHCCCS initiated and later suspended the *LTSS Assessment and Care Planning* PIP due to the continued efforts around the implementation of Home and Community Based Services (HCBS) rules and the impact of the COVID-19 PHE. This PIP was replaced with the *Breast Cancer Screening* PIP, initiated in CYE 2019 and detailed later in this section.

Breast Cancer Screening PIP Background and Objective

In CYE 2019, AHCCCS implemented a new PIP, *Breast Cancer Screening*, for ALTCS-EPD. For this PIP, indicator baseline rates were based on the Contractors’ breast cancer screening performance measure rates. Typically, PIPs include one intervention year; however, to account for the impact of the COVID-19 PHE, this PIP includes two intervention years within its design in which each Contractor will implement strategies and interventions to improve performance. CYE 2019 (October 1, 2018, through September 30, 2019) serves as the baseline year for all Contractors (Mercy Care LTC and UHCCP LTC) except BUFC LTC. In CYE 2019, the BUFC LTC performance measure rate had a small denominator, which did not allow for reporting of the measure. As such, BUFC LTC’s CY 2020 breast cancer screening performance measure rate will be used as the baseline rate, and BUFC LTC will only have one intervention year (CY 2021) before remeasurement.

Following the two intervention years, AHCCCS will conduct annual measurements to evaluate Contractor performance, with remeasurement years in alignment with calendar years: the first remeasurement year reflective of CY 2022 (January 1, 2022, through December 31, 2022) and the second remeasurement year reflective of CY 2023 (January 1, 2023, through December 31, 2023). Table 8-1 presents the timeline for the *Breast Cancer Screening* PIP.

Table 8-1—Timeline for *Breast Cancer Screening* PIP

PIP— <i>Breast Cancer Screening</i>					
Health Plan	CYE 2019	CY 2020	CY 2021	CY 2022	CY 2023
BUFC LTC	NR ¹	Baseline	Intervention Y1	Remeasurement 1*	Remeasurement 2*
Mercy Care LTC	Baseline	Intervention Y1	Intervention Y2	Remeasurement 1*	Remeasurement 2*
UHCCP LTC	Baseline	Intervention Y1	Intervention Y2	Remeasurement 1*	Remeasurement 2*

¹NR indicates a small denominator. CY 2020 will serve as baseline for BUFC LTC. Due to this, BUFC LTC will have only one intervention year (CY 2021). Each of the other plans will have two intervention years as noted above (CY 2020 and CY 2021).

*Data for Remeasurement 1 and Remeasurement 2 will be reported and included in the CYE 2023 and CYE 2024 EQR Technical Reports, respectively, as the PIP indicator rates are based on validated performance measure rates.

AHCCCS implemented the *Breast Cancer Screening* PIP because of the prevalence of breast cancer among women. 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,⁸⁻¹ and accounts for 15 percent of all new cancer diagnoses in the U.S.⁸⁻² 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

⁸⁻¹ Jemal A, Siegel R, Ward E, Hao Y, Xu J, Thun MJ. Cancer statistics, 2009. *CA Cancer J Clin*. 2009 Jul-Aug;59(4):225-49. doi: 10.3322/caac.20006. Epub 2009 May 27. PMID: 19474385.

⁸⁻² Howlander N, Noone AM, Krapcho M, Miller D, Brest A, Yu M, Ruhl J, Tatalovich Z, Mariotto A, Lewis DR, Chen HS, Feuer EJ, Cronin KA (eds). *SEER Cancer Statistics Review, 1975-2016*, National Cancer Institute. Bethesda, MD; 2016.

or symptoms are present, when the chances of survival are the highest. Even if breast cancer incidences cannot be substantially reduced for some women who are at high risk for developing the disease, the risk of death from breast cancer can be reduced by regular screenings.

The objective of the *Breast Cancer Screening* PIP is to increase the number and percentage of breast cancer screenings. The goal is to demonstrate a statistically significant increase in the number and percentage of breast cancer screenings followed by sustained improvement for one consecutive year. The eligible population for this PIP includes women, 50 to 74 years of age, who were continuously enrolled with no more than one gap in enrollment of up to 45 days during the measurement period.

Table 8-2 shows the indicator, numerator, and denominator that were used to measure the baseline of this PIP.

Table 8-2—Breast Cancer Screening PIP Indicator for ALTCS-EPD

PIP Measure Indicator: <i>Breast Cancer Screening (BCS)</i>	
Indicator 1: The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	Numerator: Number of women who had one or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.
	Denominator: The eligible population.

Breast Cancer Screening PIP Summary for CY 2021

To account for the impact of the COVID-19 PHE, this PIP includes two intervention years within its design, with CYE 2019 serving as the baseline year. CY 2020 served as an intervention year for this PIP; as the PIP is in the early stages of implementation, repeated measurements are not yet available. Improvement for subsequent remeasurement years in comparison to the baseline year will be evaluated using Contractor-calculated performance measure rates that have undergone EQRO validation. AHCCCS required the Contractors to develop and implement interventions to improve performance of the identified indicators based on an evaluation of barriers to care/use of services and evidence-based approaches to improving performance. In addition, interventions implemented may consider any unique factors, such as a Contractor’s membership, provider network, or geographic area(s) served.

ALTCS-EPD Contractor Results

Table 8-3 presents BUFC LTC’s baseline rate for the *Breast Cancer Screening* PIP.

Table 8-3—Breast Cancer Screening PIP Baseline Rate for BUFC LTC

Health Plan	Baseline Year	PIP Measure Indicator: BCS
BUFC LTC	CY 2020	38.5%*

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

Table 8-4 presents Mercy Care LTC’s baseline rate for the *Breast Cancer Screening* PIP.

Table 8-4—Breast Cancer Screening PIP Baseline Rate for Mercy Care LTC

Health Plan	Baseline Year	PIP Measure Indicator: BCS
Mercy Care LTC	CYE 2019	37.8%

Table 8-5 presents UHCCP LTC’s baseline rate for the *Breast Cancer Screening* PIP.

Table 8-5—Breast Cancer Screening PIP Baseline Rate for BUFC LTC

Health Plan	Baseline Year	PIP Measure Indicator: BCS
UHCCP LTC	CYE 2019	34.1%

PIP Validation Contractor Comparison

Table 8-6 presents each Contractor’s comparative baseline rate for the *Breast Cancer Screening* PIP.

Table 8-6—Breast Cancer Screening PIP Comparative Baseline Rates

Health Plan	Baseline Year	PIP Measure Indicator: BCS
BUFC LTC	CY 2020	38.5%
Mercy Care LTC	CYE 2019	37.8%
UHCCP LTC	CYE 2019	34.1%

Breast Cancer Screening PIP Findings

For the *Breast Cancer Screening* PIP, all Contractors provided lists of interventions that were in place for CY 2021, which detailed the identified population, the intervention in place, and whether or not the intervention was continued for CY 2022. Notable Contractor interventions are included in the Quality, Access, and Timeliness—Strengths, Opportunities for Improvement, and Recommendations section. Common interventions across the ALTCS-EPD Contractors targeted 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; emails; and letters and other physical mailers. These interventions may impact indicator performance, which will be evaluated after the first remeasurement year (CY 2022). Improvement for subsequent remeasurement years in comparison to the baseline year will be evaluated using Contractor-calculated performance measure rates that have undergone EQRO validation.

Back to Basics PIP Background and Objective

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Back to Basics* PIP for ACC/KidsCare, DCS CHP, and DDD populations. Typically, PIPs include one intervention year; however, to account for the impact of the COVID-19 PHE, this PIP includes two intervention years within its design in which each Contractor will implement strategies and interventions to improve performance, with CYE 2019 serving as the baseline year. AHCCCS will then conduct annual measurements to evaluate Contractor performance, with remeasurement years in alignment with calendar years: the first remeasurement reflective of calendar year (CY) 2022 (January 1, 2022, through December 30, 2022) and the second remeasurement year reflective of CY 2023 (January 1, 2023, through December 30, 2023). Table 8-7 presents the timeline for the *Back to Basics* PIP.

Table 8-7—Timeline for *Back to Basics* PIP

PIP— <i>Back to Basics</i>				
CYE 2019	CY 2020	CY 2021	CY 2022	CY 2023
Baseline	Intervention Y1	Intervention Y2	Remeasurement 1*	Remeasurement 2*

*Data for Remeasurement 1 and Remeasurement 2 will be reported and included in the CYE 2023 and CYE 2024 EQR Technical Reports, respectively, as the PIP indicator rates are based on validated performance measure rates.

Well-care and annual dental visits for children and adolescents aim to promote optimal health and development. Ensuring that children and adolescents receive regular well-care and dental visits is critical in disease prevention, early detection, and treatment. There are many benefits of well-child/well-care visits, including disease prevention, tracking growth and development, raising concerns, and establishing a team approach to assist with the development of optimal physical, mental, and social health of a child.⁸⁻³

⁸⁻³ American Academy of Pediatrics. AAP Schedule of Well-Child Care Visits. Available at: <https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx>. Accessed on: Mar 8, 2021.

Adolescence is a critical stage of development during which physical, intellectual, emotional, and psychological changes occur.⁸⁻⁴ Adolescent well-care visits assist with promoting healthy choices and behaviors, preventing risky behaviors, and detecting early the conditions that can inhibit an adolescent’s development.

Maintaining good oral health is an essential component in the overall health of infants, children, and adolescents. Oral health addresses several disease prevention and health promotion topics including dental caries, tooth decay, and periodontal health. Tooth decay (or cavities) is one of the most common chronic conditions of childhood in the United States.⁸⁻⁵ If untreated, tooth decay can lead to pain and infections that cause children and adolescents to experience problems with playing, learning, eating, and speaking.

The objective of the *Back to Basics* PIP is to increase the number of child and adolescent well-child/well-care visits, as well as increase the number of children and adolescents receiving annual dental visits. 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.

Table 8-8, Table 8-9, and Table 8-10 show the indicator, numerator, and denominator that will be used to measure the baseline of this PIP.

Table 8-8—Back to Basics PIP Indicator 1*

PIP Measure Indicator 1: <i>Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W15)</i>	
Indicator 1: Percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.	Numerator: The total number of members receiving six or more well-child visits, on different dates of service, with a PCP during their first 15 months of life.
	Denominator: The eligible population.

*Note that Indicator 1 is not reported in this section, as it is not applicable to DDD/DES.

Table 8-9—Back to Basics PIP Indicator 2

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

⁸⁻⁴ Centers for Disease Control and Prevention. Adolescence: Preparing for Lifelong Health and Wellness. Available at: <https://www.cdc.gov/grand-rounds/pp/2015/20150818-adolescent-wellness.html>. Accessed on: Mar 8, 2021.

⁸⁻⁵ Centers for Disease Control and Prevention. Children’s Oral Health, Division of Oral Health. Available at: https://www.cdc.gov/oralhealth/children_adults/child.htm. Accessed on: Mar 8, 2021.

Table 8-10—Back to Basics PIP Indicator 3

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

Back to Basics PIP Summary for CY 2021

To account for the impact of the COVID-19 PHE, this PIP includes two intervention years within its design, with CYE 2019 serving as the baseline year. CY 2020 served as an intervention year for this PIP; as the PIP is in the early stages of implementation, repeated measurements are not yet available. Improvement for subsequent remeasurement years in comparison to the baseline year will be evaluated using Contractor-calculated performance measure rates that have undergone EQRO validation. AHCCCS required Contractors to develop and implement interventions to improve performance of the identified indicators based on an evaluation of barriers to care/use of services and evidence-based approaches to improving performance. In addition, interventions implemented may consider any unique factors, such as a Contractor’s membership, provider network, or geographic area(s) served.

DES/DDD Results

Table 8-11 presents DES/DDD’s baseline rate for each PIP Measure Indicator for the Back to Basics PIP.

Table 8-11—Back to Basics PIP Baseline Rates

Health Plan	Baseline Year	PIP Measure Indicator 1: W15	PIP Measure Indicator 2: WCV	PIP Measure Indicator 3: ADV
DES/DDD	CYE 2019	N/A*	50.7%	52.7%

*Note that Indicator 1 is not reported in this section, as it is not applicable to DDD/DES.

Back to Basics PIP Findings

For the *Back to Basics* PIP, DES/DDD provided a list of interventions that were in place for CY 2021, which detailed the identified population, the intervention in place, and whether or not the intervention was continued for CY 2022. Notable Contractor interventions are included in the Quality, Access, and Timeliness—Strengths, Opportunities for Improvement, and Recommendations section. Interventions targeted members and providers for outreach and education related to well care and dental visits.

Outreach methods included IVR and person-to-person phone calls, text message campaigns, emails, and physical mailers. Additionally, DDD described physician and member incentives in place directly tied to closing gaps in care. These interventions may impact indicator performance, which will be evaluated after the first remeasurement year (CY 2022).

Quality, Access, and Timeliness—Strengths, Opportunities for Improvement, and Recommendations

BUFC LTC

BUFC LTC provided a list of interventions for the *Breast Cancer Screening* PIP that were in place for CY 2021. Interventions focused on the full eligible population. Table 8-12 presents strengths, opportunities for improvement, and recommendations for BUFC LTC.

Table 8-12—Strengths, Opportunities for Improvement, and Recommendations for BUFC LTC

Strengths
1. BUFC LTC developed and implemented interventions that may lead to improvement in indicator outcomes. Below is a summary of notable interventions BUFC LTC had in place for CY 2021: <ul style="list-style-type: none"> • Member outreach based on gaps-in-care reports [Timeliness] • Education for members provided through social media [Timeliness]
Opportunities for Improvement and Recommendations
Recommendation: While the PIP is in an intervention year and no opportunities for improvement have yet been identified, BUFC LTC should continue to implement identified interventions and assess the impact and effectiveness of the interventions after the first remeasurement year.

Mercy Care LTC

Mercy Care LTC provided a list of interventions for the *Breast Cancer Screening* PIP that were in place for CY 2021. Interventions either focused on the full eligible population or were targeted interventions focused on an identified associated subpopulation. Table 8-13 presents strengths, opportunities for improvement, and recommendations for Mercy Care LTC.

Table 8-13—Strengths, Opportunities for Improvement, and Recommendations for Mercy Care LTC

Strengths
1. Mercy Care LTC developed and implemented interventions that may lead to improvement in indicator outcomes. Below is a summary of notable interventions Mercy Care LTC had in place for CY 2021:

Strengths
<ul style="list-style-type: none"> Member outreach, including letters, phone calls, and physical mailers to educate and remind members of recommended services [Timeliness] Incentives for members to received needed services [Timeliness] Proactive telephonic outreach to members in advance of recommended visits with direct access to providers’ offices for scheduling of mammograms [Access and Timeliness] Provider outreach, including site visits, education, and providing gaps-in-care reports [Quality and Timeliness]
Opportunities for Improvement and Recommendations
<p>Recommendation: While the PIP is in an intervention year and no opportunities for improvement have yet been identified, Mercy Care LTC should continue to implement identified interventions and assess the impact and effectiveness of the interventions after the first remeasurement year.</p>

UHCCP LTC

UHCCP LTC provided a list of interventions for the *Breast Cancer Screening* PIP that were in place for CY 2021. Interventions either focused on the full eligible population or were targeted interventions focused on an identified associated subpopulation. Table 8-14 presents strengths, opportunities for improvement, and recommendations for UHCCP LTC.

Table 8-14—Strengths, Opportunities for Improvement, and Recommendations for UHCCP LTC

Strengths
<p>1. UHCCP LTC developed and implemented interventions that may lead to improvement in indicator outcomes. Below is a summary of notable interventions UHCCP LTC had in place for CY 2021:</p> <ul style="list-style-type: none"> Member outreach, including IVR phone calls, person-to-person phone calls, text messages, emails, and physical mailers to educate and remind members of recommended services [Timeliness] Provider outreach, including providing and discussing gaps in care and similar reports [Quality and Timeliness] Partnership with skilled nursing and assisted living facilities to provide gaps-in-care reports [Timeliness] UHCCP case manager education regarding breast cancer screening [Timelines]
Opportunities for Improvement and Recommendations
<p>Recommendation: While the PIP is in an intervention year and no opportunities for improvement have yet been identified, UHCCP LTC should continue to implement identified interventions and assess the impact and effectiveness of the interventions after the first remeasurement year.</p>

DES/DDD

DES/DDD provided a list of interventions for the *Back to Basics* PIP that were in place for CY 2021. Interventions either focused on the full eligible population or were targeted interventions focused on an identified associated subpopulation. Table 8-15 presents strengths, opportunities for improvement, and recommendations for DES/DDD.

Table 8-15—Strengths, Opportunities for Improvement, and Recommendations for DES/DDD

Strengths
<p>1. DES/DDD developed and implemented interventions that may lead to improvement in indicator outcomes. Below is a summary of notable interventions DES/DDD had in place for CY 2021:</p> <ul style="list-style-type: none"> • Member outreach, including IVR phone calls, person-to-person phone calls, text messages, emails, and physical mailers to educate and remind members of recommended services [Timeliness] • Incentives for members to receive needed services [Timeliness] • Provider outreach, including providing and discussing gaps in care and similar reports [Quality and Timeliness] • Provider education and training on well-child visits and oral health through a provider portal [Quality] • Agreements and/or incentives for providers that show improvement in performance [Quality and Timeliness]
Opportunities for Improvement and Recommendations
<p>Recommendation: While the PIP is in an intervention year and no opportunities for improvement have yet been identified, DES/DDD should continue to implement identified interventions and assess the impact and effectiveness of the interventions after the first remeasurement year.</p>

9. Organizational Assessment and Structure Performance

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

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

Conducting the Review

CYE 2019 commenced a new three-year review cycle of ORs. During the three-year review cycle, AHCCCS conducted a comprehensive OR for the ALTCS-EPD Contractors, including monitoring the progress of the Contractors' implementation of CAPs required as part of the CYE 2019 OR process. Due to complications arising from COVID-19, AHCCCS did not review CAPs for the EPD Contractors for CYE 2020 and CYE 2021.

Though postponed due to complications arising from COVID-19, AHCCCS conducted a comprehensive OR for the DES/DDD Contractor during CYE 2021. However, the final findings of this OR were not completed until after the end of CYE 2021.

The following sections describe the process that AHCCCS uses to determine whether or not its Contractors meet compliance with federal and AHCCCS' contract requirements. Included in this report are the updates on CAPs issued during the review.

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

Standards

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

- Case Management (CM), 21 standards
- Corporate Compliance (CC), five standards
- Claims and Information Systems (CIS), 10 standards
- Delivery Systems (DS), 14 standards
- General Administration (GA), three standards
- Grievance Systems (GS), 17 standards
- Adult, EPSDT, and Maternal Child Health (MCH), 16 standards
- Medical Management (MM), 27 standards
- Member Information (MI), 10 standards
- Quality Management (QM), 22 standards
- Reinsurance (RI), four standards
- Third-Party Liability (TPL), eight standards

The DES/DDD OR in CYE 2021 included an additional focus area for Quality Improvement (QI). This new focus area was composed of 10 total standards, including some previously reviewed under the Quality Management focus area.

AHCCCS conducts a review of Contractor information systems as part of its OR process. In addition to the OR process, AHCCCS evaluates the Contractors' information systems through ongoing monthly deliverables, encounter editing process, and data validation processes. Further, as of calendar year 2020, AHCCCS transitioned to using Contractor-calculated performance measure rates that are validated by the Arizona EQRO. The EQRO performance measure validation activities (detailed in Section 8) included a review of the Contractors' information systems.

Standards Crosswalk with Federal Requirements

Table 9-1 provides a crosswalk of AHCCCS' OR standards with the federal regulations.

Table 9-1—Crosswalk of AHCCCS Operational Review Standards/Focus Areas with Federal Medicaid Managed Care Regulations

OR Focus Areas	Medicaid Managed Care Requirement
Case Management (CM)	438.208, 438.240, 438.608, 440.70, 440.169, 440.180, 440.189, 441.18, 441.400, 441.468, 441.725, 441.730
Corporate Compliance (CC)	438.242, 438.608, 438.610, 455.1, 455.17, 455.100-106, 455.436
Claims and Information Standards (CIS)	433.135, 434.6, 438.242, 438.600
Delivery Systems (DS)	438.12, 438.102, 438.206, 438.207, 438.214, 438.242
General Administration (GA)	164.530, 438.3
Grievance Systems (GS)	438.10, 438.228(a)*, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.420, 438.424
Adult, EPSDT and Maternal Child Health (MCH)	441.56, 441.58
Medical Management (MM)	438.62, 438.114, 438.136, 438.208, 438.210, 438.228(b)*, 438.230, 438.236, 438.240, 438.330, 438.404, 456.125-133
Member Information (MI)	438.10, 438.100, 438.206, 438.207, 438.208, 438.406
Quality Management (QM)	438.3, 438.66, 438.206, 438.214, 438.230, 438.402, 438.406, 438.408, 438.416, 438.330, 479.98, 476.160
Quality Improvement (QI)	438.330, 438.240, 438.242

**42 CFR §438.228: While not specifically cited within past operational review tools, the State conducts random reviews of each MCO, its providers and subcontractors through its OR process to ensure that they are notifying members of adverse decisions and benefit implications when required in a timely manner. For additional clarity, this citation will be added to future review tools.*

Findings

Due to complications arising from COVID-19, AHCCCS did not review CAPs for the ALTCS-EPD Contractors for CYE 2020 and CYE 2021.⁹⁻¹

Though postponed due to complications arising from COVID-19, AHCCCS conducted a comprehensive OR for the DES/DDD Contractor during CYE 2021. However, the final findings of this OR were not completed until after the end of CYE 2021. Therefore, there are no findings to include as part of this report (findings will be included in the CYE 2022 EQR Annual Technical Report for ALTCS).

⁹⁻¹ OR and CAPs findings for the ALTCS-EPD Contractors can be found within the CYE 2019 and CYE 2020 EQR annual technical reports for ALTCS.

Quality, Access, and Timeliness—Strengths, Opportunities for Improvement, and Recommendations

BUFC LTC

Table 9-2 presents the strengths, opportunities for improvement, and recommendations for BUFC LTC.

Table 9-2—Strengths, Opportunities for Improvement, and Recommendations for BUFC LTC

Strengths
No OR CAP findings were provided; therefore, HSAG did not provide any strengths.
Opportunities for Improvement and Recommendations
No OR CAP findings were provided for CYE 2021.
<p>Recommendation: Although no OR CAP findings were provided for CYE 2021, HSAG recommends that the Contractor continue to remedy any findings identified in its CAP to ensure that it remains compliant with the requirements in each of the AHCCCS focus areas.</p>

Mercy Care LTC

Table 9-3 presents the strengths, opportunities for improvement, and recommendations for Mercy Care LTC.

Table 9-3—Strengths, Opportunities for Improvement, and Recommendations for Mercy Care LTC

Strengths
No OR CAP findings were provided; therefore, HSAG did not provide any strengths.
Opportunities for Improvement and Recommendations
No OR CAP findings were provided for CYE 2021.
<p>Recommendation: Although no OR CAP findings were provided for CYE 2021, HSAG recommends that the Contractor continue to remedy any findings identified in its CAP to ensure that it remains compliant with the requirements in each of the AHCCCS focus areas.</p>

UHCCP LTC

Table 9-4 presents the strengths, opportunities for improvement, and recommendations for UHCCP LTC.

Table 9-4—Strengths, Opportunities for Improvement, and Recommendations for UHCCP LTC

Strengths
No OR CAP findings were provided; therefore, HSAG did not provide strengths.
Opportunities for Improvement and Recommendations
No OR CAP findings were provided for CYE 2021. <p>Recommendation: Although no OR CAP findings were provided for CYE 2021, HSAG recommends that the Contractor continue to remedy any findings identified in its CAP to ensure that it remains compliant with the requirements in each of the AHCCCS focus areas.</p>

DES/DDD

Table 9-5 presents the strengths, opportunities for improvement, and recommendations for DES/DDD.

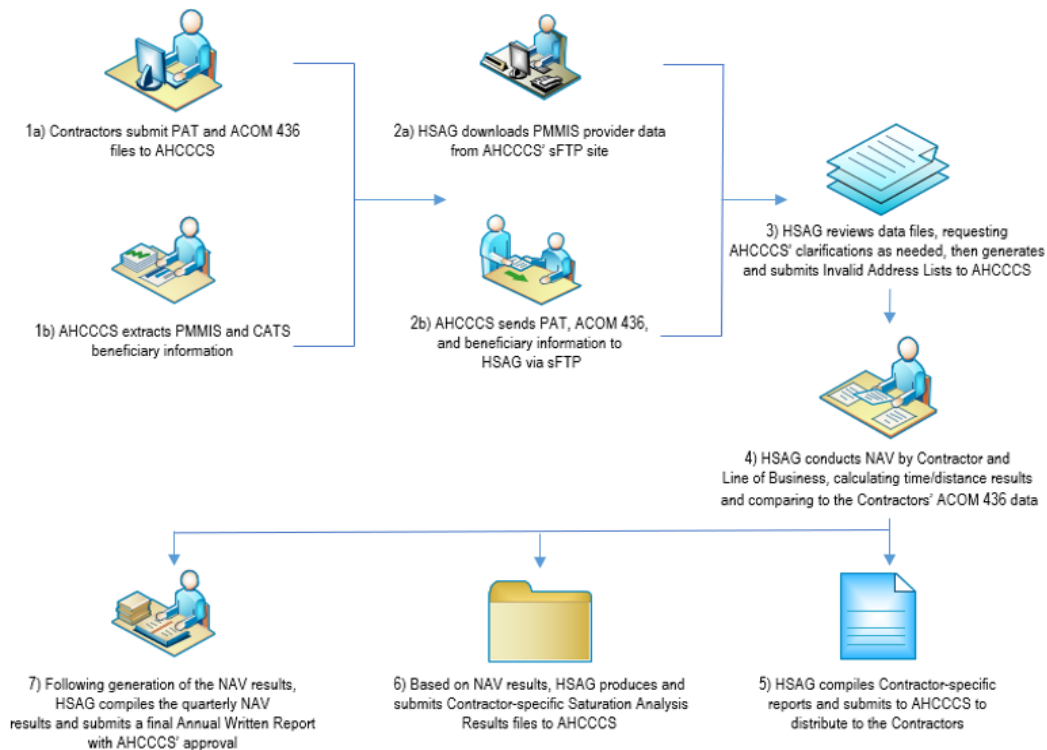
Table 9-5—Strengths, Opportunities for Improvement, and Recommendations for DES/DDD

Strengths
No OR CAP findings were provided; therefore, HSAG did not provide strengths.
Opportunities for Improvement and Recommendations
Although DES/DDD underwent a compliance review, the results were not available at publication of this annual technical report. <p>Recommendation: Although DES/DDD underwent a compliance review, the results were not available; however, HSAG recommends that the Contractor work to remedy the report findings to ensure that it remains compliant with the requirements in each of the AHCCCS focus areas.</p>

10. Network Adequacy Validation

CYE 2021 is the third year in which AHCCCS contracted HSAG to support biannual analysis and validation of healthcare provider networks subcontracted to AHCCCS' ALTCS-EPD Contractors and DES/DDD subcontracted health plans.¹⁰⁻¹ HSAG's biannual NAV considered each ALTCS-EPD Contractor's compliance with 12 AHCCCS-established time/distance standards and each ALTCS-DD subcontracted health plan's compliance with 11 AHCCCS-established time/distance standards during the CYE 2021 measurement period.¹⁰⁻² Figure 10-1 summarizes the biannual network adequacy data process and reporting products.

Figure 10-1—CYE 2021 Biannual Network Adequacy Validation Process



Note: PAT=Provider Affiliation Transmission; PMMIS=Prepaid Medical Management Information System; CATS=Client Assessment and Tracking System; sFTP=secure file transfer protocol

¹⁰⁻¹ Validation of network adequacy is a mandatory EQR activity, and states must begin conducting this activity, described in CMS rule 438.358(b)(1)(iv), no later than one year from the issuance of the associated EQR protocol. While the protocol was not released during this study, HSAG's analysis of the Contractor's time/distance results aligns with current federal regulations.

¹⁰⁻² The AHCCCS Contractors Operations Manual (ACOM), Section 436—Network Standards defines time/distance standards, as well as provider identification and members' county assignment criteria. The ACOM is available at: https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/436_Network_Standards.pdf.

In addition to HSAG’s NAV activities, AHCCCS measures network adequacy using other mechanisms outlined in Appendix E.

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

ALTCS-EPD

HSAG’s biannual validation of the ALTCS Contractors’ results reflect minor discrepancies between the Contractors’ self-reported ACOM 436 results and HSAG’s time/distance calculations for all Contractors 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 each Contractor’s time/distance calculation results were common, these findings are most likely attributable to the timing of the input data, software versions used by each Contractor (refer to Table D-3), or due to a small number of members eligible for inclusion in time/distance calculations for the standard and county.

Table 10-1 summarizes HSAG’s assessment of each ALTCS-EPD Contractor’s compliance with AHCCCS’ minimum time/distance network standards. A check mark indicates that the ALTCS-EPD Contractor met the minimum network standard for all assigned counties during the biannual assessments, and an “X” indicates that the ALTCS-EPD Contractor failed to meet one or more minimum network standards in any assigned county or quarter. Appendix D contains NAV results specific to each county and biannual validation period.

Table 10-1—Summary of CYE 2021 Compliance with Minimum Time/Distance Network Requirements for ALTCS-EPD 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	✓	✓	✓
Behavioral Health Residential Facility (<i>only Maricopa and Pima counties</i>)	✓	✓	✓
Cardiologist, Adult	✓	✓	✓
Cardiologist, Pediatric	✓	✓	✓
Dentist, Pediatric	✓	✓	✓
Hospital	✓	✓	✓
Nursing Facility	✓	✓	✗

Minimum Network Requirement	BUFC LTC	Mercy Care LTC	UHCCP LTC
Obstetrics/Gynecology (OB/GYN)	✓	✓	✓
Pharmacy	✗	✓	✓
PCP, Adult	✓	✓	✓
PCP, Pediatric	✓	✓	✓

While Mercy Care LTC met all minimum time/distance network requirements in all applicable counties and quarters, Mercy Care LTC only serves ALTCS-EPD members in the Central Region (i.e., Gila, Maricopa, and Pinal counties) and Pima County, where provider networks are typically robust due to the Phoenix and Tucson metropolitan areas and key cities serving surrounding rural areas (e.g., Casa Grande, Florence, Globe, Maricopa, Marana, and Payson).

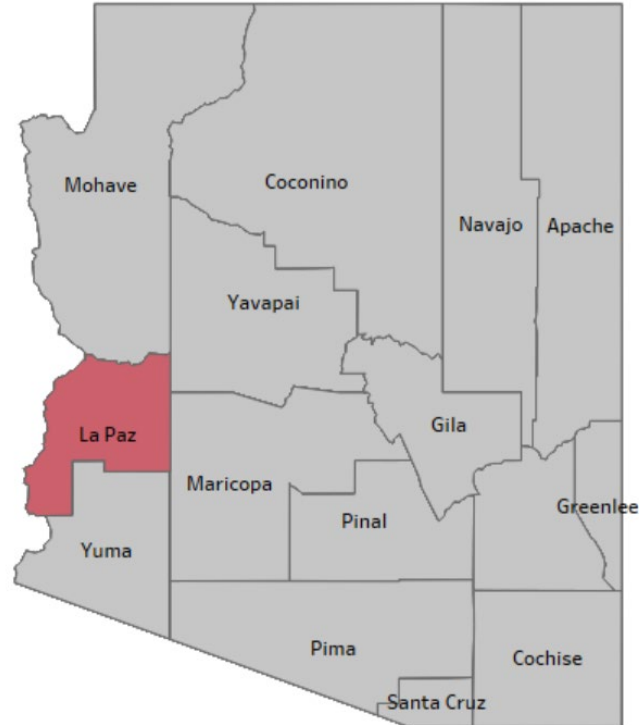
Isolated data issues may have contributed to specific instances affecting ALTCS-EPD Contractors’ compliance with time/distance standards. Specific examples include the following:

- In Quarter 4, 2021, BUFC LTC’s data for dentists did not include the specialty codes used to identify dentists meeting the criteria for the Dentist, Pediatric category. At AHCCCS’ request, HSAG used PMMIS specialty provider data for BUFC LTC’s reported dentists to identify pediatric dentists and calculate the time and distance results. Due to the use of data not submitted by the Contractor, HSAG was unable to accurately validate and assess compliance for BUFC LTC’s reported Dentist, Pediatric provider category. Results are shown for informational purposes only.

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

As of CYE 2021, Quarter 4, Figure 10-2 summarizes how ALTCS-EPD Contractors performed on meeting the time/distance standards by county. Red shading indicates one or more of the ALTCS-EPD Contractors failed to meet one or more of the time/distance standards. Gray shading indicates all ALTCS-EPD Contractors met all of the time/distance standards in the given county.

Figure 10-2—Summary of CYE 2021 Quarter 4 Compliance with Minimum Time/Distance Network Requirements by County for ALTCS-EPD Contractors



Overall, for CYE 2021, Quarter 4, the most recent biannual assessment, all ALTCS-EPD Contractors met all minimum time/distance network requirements except for La Paz County.

Each ALTCS-EPD Contractor should continue to monitor and maintain its existing provider network coverage, based on the following validation conclusions:

- BUFC LTC submitted data that did not include the specialty codes used to identify dentists meeting the criteria for the Dentist, Pediatric category. As such, BUFC LTC should continue to monitor its process for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.
- Mercy Care LTC met all standards and did not receive saturation analysis results.
- UHCCP LTC met all standards for CYE 2021, Quarter 4 and did not receive saturation analysis results.

ALTCS-DD

Table 10-2 summarizes HSAG’s assessment of each ALTCS-DD subcontracted health plans’ compliance with AHCCCS’ minimum time/distance network standards. A check mark indicates that the ALTCS-DD subcontracted health plan met the minimum network standard for each Arizona county during the biannual assessments, and an “X” indicates that the ALTCS-DD subcontracted health plan failed to meet one or more minimum network standards in any county or quarter. Appendix D contains NAV results specific to each county and quarterly validation period.

Table 10-2—Summary of CYE 2021 Compliance with Minimum Time/Distance Network Requirements for ALTCS-DD Subcontracted Health Plans

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

*Mercy Care LTC and UHCCP LTC were subcontracted health plans for some NAV activities for DES/DDD.

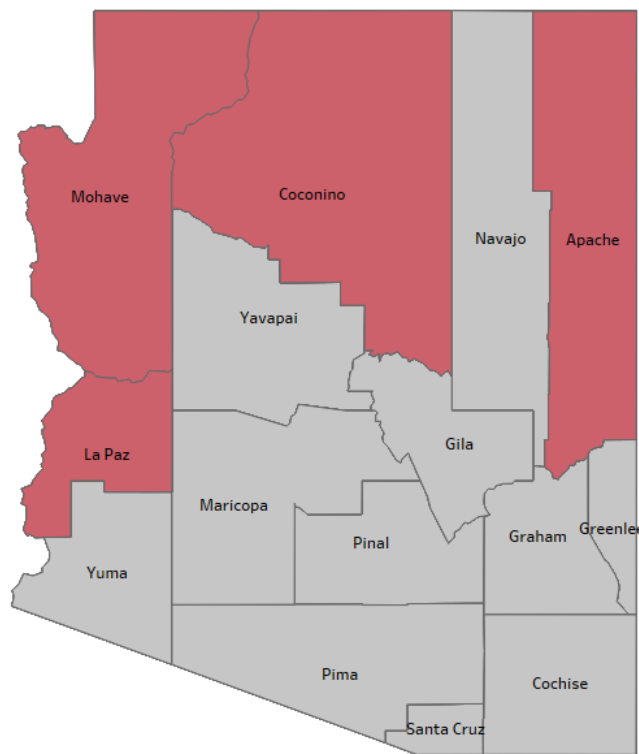
The DES/DDD subcontracted health plans met minimum network standards for all quarters for the majority of counties; however, it did not meet the Behavioral Health Outpatient and Integrated Clinic, Adult; PCP, Adult; Cardiologist, Adult; and Dentist, Pediatric standards in the North region, with persistent deficiencies in Apache and Coconino counties.

As part of the NAV, AHCCCS maintained its feedback process for ALTCS-DD subcontracted health plans to review and improve the accuracy of their data submissions. Specifically, AHCCCS supplied each ALTCS-DD subcontracted health plan with a copy of HSAG’s quarterly network adequacy analysis, a copy of the PAT file that HSAG used to conduct the analysis, and a copy of HSAG’s saturation analysis results. When issues were identified, ALTCS-DD subcontracted health plans were

expected to research the instances and make corrections for future PAT data and/or ACOM 436 submissions.

Figure 10-3 summarizes how the ALTCS-DD subcontracted health plans performed on meeting the time/distance standards by county as of CYE 2021, Quarter 4. Red shading indicates one or more of the ALTCS-DD subcontracted health plans failed to meet one or more of the time/distance standards. Gray shading indicates all ALTCS-DD subcontracted health plans met all of the time/distance standards in the given county.

Figure 10-3—Summary of CYE 2021 Quarter 4 Compliance with Minimum Time/Distance Network Requirements by County for ALTCS-DD Subcontracted Health Plans



Overall, for CYE 2021, Quarter 4 (the most recent biannual assessment), all ALTCS-DD subcontracted health plans met all minimum time/distance network requirements except for Apache, Coconino, La Paz, and Mohave counties.

Mercy Care DD met all minimum time/distance network standards during both quarters in Gila, Maricopa, Pinal, Yavapai, Cochise, Graham, Pima, Santa Cruz, and Yuma counties. Mercy Care DD should continue to monitor and maintain its existing provider network coverage while working to assure the availability of:

- Behavioral health outpatient and integrated clinics for adults in Apache and Coconino counties.
- Cardiologists for adults in Apache County.

- Pediatric dentists in Mohave and La Paz counties.¹⁰⁻³
- PCPs for adults in Apache and Coconino counties.
- Pharmacies in La Paz County.

UHCCP DD met all minimum time/distance network standards during both quarters in all assigned counties except Apache and Coconino. UHCCP DD should continue to monitor and maintain its existing provider network coverage while working to assure the availability of:

- Behavioral health outpatient and integrated clinics for adults or children in Apache County.
- Cardiologists for adults or children in Apache County.
- Pediatric dentists in Apache County.
- Pharmacies in Apache County.

Quality, Access, and Timeliness—Strengths, Opportunities for Improvement, and Recommendations for ALTCS-EPD Contractors

For the ALTCS-EPD Contractors, Table 10-3 through Table 10-5 outline strengths, opportunities for improvement, and recommendations for each Contractor and subcontracted health plan.

BUFLTC

Table 10-3—Strengths, Opportunities for Improvement, and Recommendations for BUFLTC

Strengths
<p>1. After accounting for data-related findings, BUFLTC met all time/distance network standards in all assigned counties for both quarters in CYE 2021, except for La Paz County.</p> <p>Note: BUFLTC provides coverage in the following counties: Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Santa Cruz, and Yuma.</p>
Opportunities for Improvement and Recommendations
<p>1. Isolated data issues may have contributed to specific instances affecting the ALTCS-EPD Contractors’ compliance with time/distance standards.</p> <p>Recommendation: The ALTCS-EPD Contractors should continue to monitor their processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.</p>

¹⁰⁻³ These results may be influenced by the limited number of members in the time/distance calculations for selected counties and quarters.

Opportunities for Improvement and Recommendations
<p>2. BUFC LTC failed to meet the time/distance standard for pharmacies in La Paz County.</p> <p>Recommendation: BUFC LTC should continue to monitor and maintain its existing provider network coverage with specific attention to ensuring the availability of pharmacies in La Paz County.</p>
<p>3. In CYE 2021, Quarter 4, BUFC LTC submitted provider data for dentists but did not include the specialty codes used to identify dentists meeting the criteria for the pediatric dentist provider category.</p> <p>Recommendation: BUFC LTC should continue to monitor its process for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.</p>

Mercy Care LTC

Table 10-4—Strengths, Opportunities for Improvement, and Recommendations for Mercy Care LTC

Strengths
<p>1. Mercy Care LTC met all time/distance network standards for both quarters in CYE 2021 for all assigned counties.</p> <p>Note: Mercy Care LTC provides coverage in the following counties: Gila, Maricopa, Pima, and Pinal.</p>
Opportunities for Improvement and Recommendations
<p>1. Isolated data issues may have contributed to specific instances affecting the ALTCS-EPD Contractors’ compliance with time/distance standards.</p> <p>Recommendation: The ALTCS-EPD Contractors should continue to monitor their processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.</p> <p>Recommendation: Mercy Care LTC should continue to monitor and maintain its existing provider network coverage.</p>

UHCCP LTC

Table 10-5—Strengths, Opportunities for Improvement, and Recommendations for UHCCP LTC

Strengths
<p>1. UHCCP LTC met all time/distance network standards in all assigned counties for both quarters in CYE 2021, except for Coconino County.</p>

Strengths
<p>Note: UHCCP LTC provides coverage in the following counties: Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal, and Yavapai.</p>
Opportunities for Improvement and Recommendations
<p>1. Isolated data issues may have contributed to specific instances affecting the ALTCS-EPD Contractors’ compliance with time/distance standards.</p> <p style="padding-left: 40px;">Recommendation: The ALTCS-EPD Contractors should continue to monitor their processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.</p>
<p>2. UHCCP LTC failed to meet the Nursing Facility standard in Coconino County for CYE 2021, Quarter 2.</p> <p style="padding-left: 40px;">Recommendation: UHCCP LTC should continue to monitor and maintain its existing provider network coverage with specific attention to ensuring the availability of nursing facilities in Coconino County.</p>

Quality, Access, and Timeliness—Strengths, Opportunities for Improvement, and Recommendations for ALTCS-DD Subcontracted health Plans

For the DES/DDD subcontracted health plans, Table 10-6 and Table 10-7 outline strengths, opportunities for improvement, and recommendations for each subcontracted health plan.

Mercy Care DD

Table 10-6—Strengths, Opportunities for Improvement, and Recommendations for Mercy Care DD

Strengths
<p>1. Mercy Care DD met all time/distance network standards for both quarters in CYE 2021 for Gila, Maricopa, Pinal, Yavapai, Cochise, Graham, Pima, Santa Cruz, and Yuma counties.</p> <p>Note: Mercy Care DD 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.</p>

Opportunities for Improvement and Recommendations
<p>1. Isolated data issues may have contributed to specific instances affecting the ALTCS-DD subcontracted health plans’ compliance with time/distance standards.</p> <p>Recommendation: The ALTCS-DD subcontracted health plans should continue to monitor their processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.</p>
<p>Recommendation: Mercy Care DD should continue to monitor and maintain its existing provider network coverage as of CYE 2021, Quarter 4, with specific attention to ensuring the availability of the following provider types among the applicable ALTCS-DD subcontracted health plans:</p> <ul style="list-style-type: none"> • Behavioral health outpatient and integrated clinics for adults in Apache and Coconino counties • Cardiologists for adults in Apache County • PCPs for adults in Apache and Coconino counties • Pediatric dentists in Mohave and La Paz counties • Pharmacies in La Paz County

UHCCP DD

Table 10-7—Strengths, Opportunities for Improvement, and Recommendations for UHCCP DD

Strengths
<p>1. UHCCP DD met all minimum time/distance network standards during both quarters in all assigned counties except Apache and Coconino.</p> <p>Note: UHCCP DD 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.</p>
Opportunities for Improvement and Recommendations
<p>1. Isolated data issues may have contributed to specific instances affecting the ALTCS-DD subcontracted health plans’ compliance with time/distance standards.</p> <p>Recommendation: The ALTCS-DD subcontracted health plans should continue to monitor their processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.</p>
<p>Recommendation: UHCCP DD should continue to monitor and maintain its existing provider network coverage as of CYE 2021, Quarter 4, with specific attention to ensuring the availability of the following provider types among the applicable ALTCS-DD subcontracted health plans:</p> <ul style="list-style-type: none"> • Behavioral health outpatient and integrated clinics for adults or children in Apache county

Opportunities for Improvement and Recommendations

- Cardiologists for adults or children in Apache County
- Pediatric dentists in Apache County
- Pharmacies in Apache County

Appendix A. Validation of Performance Measure Methodology and Additional Results

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

The purpose of the PMV is to assess the accuracy of performance measures reported by MCOs and to determine the extent to which performance measures reported by the MCOs follow state specifications and reporting requirements. According to the CMS publication, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019,^{A-1} the mandatory PMV activity may be performed by the State Medicaid agency, an agent that is not an MCO, or an EQRO.

Description of Validation Activities

Pre-Audit Strategy

HSAG conducted the validation activities as outlined in the CMS PMV protocol. To complete the validation activities, HSAG obtained a list of the performance measures that AHCCCS selected for validation.

HSAG then prepared a document request letter that was submitted to the Contractors outlining the steps in the PMV process. The document request letter included a request for the source code for each performance measure, as applicable; a completed HEDIS MY 2020 Roadmap, if applicable; a completed ISCAT; any additional supporting documentation necessary to complete the audit; a timetable for completion; and instructions for submission. HSAG also forwarded a letter that included requested documentation needed to complete the medical record review validation (MRRV) process. HSAG responded to any audit-related questions received directly from the Contractors during the pre-on-site phase.

Approximately two weeks prior to the on-site visit, HSAG provided each Contractor with an agenda describing all on-site visit activities and indicating the type of staff needed for each session. HSAG also

^{A-1} The Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf>. Accessed on: Dec 9, 2021.

conducted a pre-on-site conference call with each Contractor to discuss on-site logistics and expectations, important deadlines, outstanding documentation, and any outstanding questions from the Contractor.

Technical Methods of Data Collection and Analysis

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

- **NCQA’s HEDIS MY 2020 Roadmap:** Contractors completed and submitted the required and relevant portions of its Roadmap for HSAG’s review of the required HEDIS measures, if applicable. HSAG used responses from the Roadmap to complete the pre-on-site assessment of information systems.
- **Information Systems Capabilities Assessment Tool (ISCAT):** Contractors completed and submitted an ISCAT to supplement the information included in the Roadmap and address data collection and reporting specifics of non-HEDIS 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 that calculated the performance measures using source code were required to submit the source code used to generate each performance measure being validated. HSAG completed a line-by-line review of the supplied source code to ensure compliance with the measure specifications required by AHCCCS. HSAG identified any areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any). Contractors that did not use source code to generate the performance measures were required to submit documentation describing the steps taken for calculation of each of the required performance measures. If the Contractors outsourced programming for HEDIS measure production to an outside vendor, the Contractors were required to submit the vendor’s NCQA measure certification reports.
- **Medical record documentation:** Contractors completed the medical record review (MRR) section within the Roadmap. In addition, Contractors submitted the following documentation for review: medical record hybrid tools and instructions, training materials for MRR staff members, and policies and procedures outlining the processes for monitoring the accuracy of the reviews performed by the review staff members. HSAG did not request a convenience sample but conducted an over-read of approximately 30 records from the hybrid sample to ensure the accuracy of the hybrid data being abstracted by the Contractor. HSAG followed NCQA’s guidelines to validate the integrity of the MRRV processes used by the Contractor and then used the MRRV results to determine if the findings impacted the audit results for each performance measure rate.
- **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.

Virtual On-Site Activities

HSAG conducted an on-site visit with each Contractor. HSAG collected information using several methods, including interviews, system demonstration, review of data output files, primary source verification (PSV), observation of data processing, and review of data reports. The on-site visit activities are described as follows:

- **Opening meeting:** The opening meeting included an introduction of the validation team and key staff members involved in the PMV activities. The review purpose, the required documentation, basic meeting logistics, and queries to be performed were discussed.
- **Review of ISCAT and Roadmap documentation:** This session was designed to be interactive with key staff so that the validation team could obtain a complete picture of all steps taken to generate responses to the ISCAT and Roadmap, if applicable, and evaluate the degree of compliance with written documentation. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and ascertained written policies and procedures were used and followed in daily practice.
- **Evaluation of enrollment, eligibility, and claims systems and processes:** This evaluation included a review of the information systems, focusing on claims processing, enrollment and disenrollment data processing, and tracking changes. The evaluation also encompassed a review of the Contractor's claims processing steps through its encounter data submissions to AHCCCS, reviewing for a general reconciliation, however acknowledging that the encounter data submissions would not include all denied claims, based on AHCCCS' guidance to Contractors. Throughout the evaluation HSAG conducted interviews with key staff familiar with the processing, monitoring, reporting, and calculating of the performance measures. Key staff included executive leadership, enrollment specialists, claims processors, business analysts, customer operations staff, data analytics staff, and other front-line staff familiar with the processing, monitoring, and generating of the enrollment, eligibility, and claims performance measure data.
- **Overview of data integration and control procedures:** The overview included discussion and observation of source code logic, a review of how all data sources were combined, and a review of how the analytic file was produced for the reporting of selected performance measure data. HSAG performed PSV to further validate the output files and reviewed backup documentation on data integration. HSAG also addressed data control and security procedures during this session.
- **Primary source verification:** HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Each Contractor provided a listing of the data that it had reported to AHCCCS to HSAG from which HSAG selected a sample. These data included numerator positive records for HEDIS and Core Set measures. HSAG selected a random sample from the submitted data and requested that the Contractor provide proof of service documents or system screenshots that allowed for validation against the source data in the system. These data were also reviewed live in the Contractor's systems during the on-site review for verification, which provided the Contractor an opportunity to explain its processes as needed for any exception processing or unique, case-specific nuances that may not impact final measure reporting.

There may be instances in which a sample case is acceptable based on on-site clarification and follow-up documentation provided by the Contractor.

Using this technique, HSAG assessed the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across measures to verify that the Contractors have system documentation which supports that the Contractor appropriately includes records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected may result in the selection of additional cases to better examine the extent of the issue and its impact on reporting.

- Closing conference:** The closing conference included a summation of preliminary findings based on the review of the ISCAT, Roadmap, and on-site visit, and revisited the documentation requirements for any post-on-site activities.

Performance Measure-Specific Findings

Based on all validation activities, HSAG determined results for each performance measure. The CMS PMV protocol identifies three possible validation finding designations for performance measures, which are defined in Table A-1.

Table A-1—Designation Categories for Performance Measures

Report (R)	Measure data were compliant with the specifications required by the State and the rate reported was valid.
Do Not Report (DNR)	Measure data were materially biased.
Not Applicable (NA)	Not applicable; the Contractor was not required to report the measure (i.e., small denominator).

According to the CMS protocol, the validation designation for each performance measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be noncompliant based on the review findings. Consequently, an error for a single audit element may result in a designation of “DNR” because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, leading to a designation of “R.”

Any suggested corrective action that is closely related to accurate rate reporting that could not be implemented in time to produce validated results will render a particular measure as “DNR.”

Required Performance Measures

The selected MY 2020 performance measures for the ALTCS-EPD Contractors and DES/DDD were grouped into the following domains of care: Behavioral Health Care, Care of Acute and Chronic Conditions, Pediatric Health, and Preventive Screening. While performance is reported primarily at the measure indicator level, grouping these measures into domains encourages the Contractors and AHCCCS to consider the measures as a whole rather than in isolation and to develop strategic changes required to improve overall performance. Table A-2 and Table A-3 display the technical specifications used during PMV: NCQA’s HEDIS Measurement Year (MY) 2020 and CMS Core Set of Children’s Health Care Quality Measures for Medicaid (Child Core Set) and CHIP for Federal Fiscal Year (FFY) 2021.

Table A-2—MY 2020 Performance Measures for ALTCS-EPD Contractors

Performance Measure	Measure Steward
Behavioral Health Care	
<i>Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment</i>	NCQA
<i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total</i>	NCQA
<i>Total Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total and Total Engagement of AOD Treatment—Total</i>	NCQA
Care of Acute and Chronic Conditions	
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)</i>	NCQA
Preventive Screening	
<i>Breast Cancer Screening—Total</i>	NCQA

Table A-3—MY 2020 Performance Measures for DES/DDD

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

Performance Measure	Measure Steward
Pediatric Health	
<i>Child and Adolescent Well-Care Visits—Total</i>	NCQA
<i>Developmental Screening in the First Three Years of Life—Total</i>	CMS
<i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	NCQA
Preventive Screening	
<i>Breast Cancer Screening—Total</i>	NCQA

HSAG organized, aggregated, and analyzed the data to draw conclusions about Contractor performance related to providing quality, timely, and accessible care and services to AHCCCS members. (See Table A-4 for the assignment of performance measures to the Quality, Timeliness, and Access areas.) When applicable, HSAG formulated and presented recommendations to improve Contractor performance rates.

Table A-4—Assignment of Performance Measures to the Quality, Timeliness, and Access Areas

Performance Measure	Quality	Timeliness	Access
Behavioral Health Care			
<i>Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment</i>	✓		
<i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total</i>		✓	✓
<i>Total Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total and Total Engagement of AOD Treatment—Total</i>		✓	✓
Care of Acute and Chronic Conditions			
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)</i>	✓		
Pediatric Health			
<i>Child and Adolescent Well-Care Visits—Total</i>	✓		✓
<i>Developmental Screening in the First Three Years of Life</i>	✓	✓	✓
<i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	✓		✓
Preventive Screening			
<i>Breast Cancer Screening—Total</i>	✓		

Performance Measurement—ALTCS-EPD Contractors

For each ALTCS-EPD Contractor, the following information is provided: findings from the CMS EQR Protocol 2 audit and a table that includes MY 2020 performance for all measures.

BUFC LTC

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. Additionally, HSAG found the following based on its PMV:


- *Medical Service Data (Claims/Encounters):* HSAG identified no concerns with BUFC LTC claims system or processes.
- *Enrollment Data:* HSAG identified no concerns with BUFC LTC eligibility system or processes.
- *Provider Data:* HSAG identified no concerns with BUFC LTC provider data systems or processes.
- *Medical Record Review Process:* BUFC LTC did not perform hybrid review for MY 2020; therefore, the medical record review process is not applicable.
- *Supplemental Data:* HSAG identified no concerns with BUFC LTC supplemental data systems and processes.
- *Data Integration:* While BUFC LTC produced final validated rates for all measures, HSAG identified a concern with BUFC LTC’s procedures for data integration and measure production. HSAG found that BUFC LTC was only loading paid medical claims, which was identified as a missed opportunity since many of the performance measure specifications allow the use of denied claims to count toward numerator compliance.

Table A-5—MY 2020 Performance Measure Results for BUFC LTC

Performance Measure	Data Collection Methodology	MY 2020 Performance
Behavioral Health Care		
<i>Antidepressant Medication Management</i>		
<i>Effective Acute Phase Treatment</i>	Administrative	45.0%
<i>Effective Continuation Phase Treatment</i>	Administrative	42.5%
<i>Follow-Up After Hospitalization for Mental Illness</i>		
<i>7-Day Follow-Up—Total</i>	Administrative	24.3%
<i>30-Day Follow-Up—Total</i>	Administrative	27.0%
<i>Initiation and Engagement of AOD Abuse or Dependence Treatment</i>		
<i>Total Initiation of AOD Treatment—Total</i>	Administrative	44.0%
<i>Total Engagement of AOD Treatment—Total</i>	Administrative	5.6%

Performance Measure	Data Collection Methodology	MY 2020 Performance
Care of Acute and Chronic Conditions		
<i>Comprehensive Diabetes Care</i>		
<i>HbA1c Poor Control (>9.0%)*</i>	Administrative	75.1%
Preventive Screening		
<i>Breast Cancer Screening</i>		
<i>Total</i>	Administrative	38.5%

* A lower rate indicates better performance for this measure.

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

Mercy Care LTC


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. Additionally, HSAG found the following based on its PMV:

- *Medical Service Data (Claims/Encounters)*: HSAG identified no concerns with Mercy Care LTC’s claims system or processes.
- *Enrollment Data*: HSAG identified no concerns with Mercy Care LTC’s eligibility system or processes.
- *Provider Data*: HSAG identified no concerns with Mercy Care LTC’s provider data systems or processes.
- *Medical Record Review Process*: HSAG identified no concerns with Mercy Care LTC’s medical record review processes.
- *Supplemental Data*: HSAG identified no concerns with Mercy Care LTC’s supplemental data systems and processes.
- *Data Integration*: HSAG identified no concerns with Mercy Care LTC’s procedures for data integration and measure production.

Table A-6—MY 2020 Performance Measure Results for Mercy Care LTC

Performance Measure	Data Collection Methodology	MY 2020 Performance
Behavioral Health Care		
<i>Antidepressant Medication Management</i>		
<i>Effective Acute Phase Treatment</i>	Administrative	65.1%
<i>Effective Continuation Phase Treatment</i>	Administrative	55.4%
<i>Follow-Up After Hospitalization for Mental Illness</i>		
<i>7-Day Follow-Up—Total</i>	Administrative	43.3%
<i>30-Day Follow-Up—Total</i>	Administrative	55.2%
<i>Initiation and Engagement of AOD Abuse or Dependence Treatment</i>		
<i>Total Initiation of AOD Treatment—Total</i>	Administrative	47.4%
<i>Total Engagement of AOD Treatment—Total</i>	Administrative	5.1%
Care of Acute and Chronic Conditions		
<i>Comprehensive Diabetes Care</i>		
<i>HbA1c Poor Control (>9.0%)*</i>	Hybrid	25.8%
Preventive Screening		
<i>Breast Cancer Screening</i>		
<i>Total</i>	Administrative	34.2%

* A lower rate indicates better performance for this measure.

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

UHCCP LTC


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. Additionally, HSAG found the following based on its PMV:

- *Medical Service Data (Claims/Encounters)*: HSAG identified no concerns with UHCCP LTC’s claims system or processes.
- *Enrollment Data*: HSAG identified no concerns with UHCCP LTC’s eligibility system or processes.
- *Provider Data*: HSAG identified no concerns with UHCCP LTC’s provider data systems or processes.
- *Medical Record Review Process*: HSAG identified no concerns with UHCCP LTC’s medical record review processes.
- *Supplemental Data*: HSAG identified no concerns with UHCCP LTC’s supplemental data systems and processes.
- *Data Integration*: HSAG identified no concerns with UHCCP LTC’s procedures for data integration and measure production.

Table A-7—MY 2020 Performance Measure Results for UHCCP LTC

Performance Measure	Data Collection Methodology	MY 2020 Performance
Behavioral Health Care		
<i>Antidepressant Medication Management</i>		
<i>Effective Acute Phase Treatment</i>	Administrative	83.0%
<i>Effective Continuation Phase Treatment</i>	Administrative	72.7%
<i>Follow-Up After Hospitalization for Mental Illness</i>		
<i>7-Day Follow-Up—Total</i>	Administrative	36.6%
<i>30-Day Follow-Up—Total</i>	Administrative	61.0%
<i>Initiation and Engagement of AOD Abuse or Dependence Treatment</i>		
<i>Total Initiation of AOD Treatment—Total</i>	Administrative	57.8%
<i>Total Engagement of AOD Treatment—Total</i>	Administrative	2.9%
Care of Acute and Chronic Conditions		
<i>Comprehensive Diabetes Care</i>		
<i>HbA1c Poor Control (>9.0%)*</i>	Hybrid	30.4%
Preventive Screening		
<i>Breast Cancer Screening</i>		
<i>Total</i>	Administrative	37.2%

* A lower rate indicates better performance for this measure.

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


ALTCS-EPD Aggregate

Table A-8—MY 2020 Aggregate Performance Measure Results for ALTCS-EPD Contractors

Performance Measure	Data Collection Methodology	MY 2020 Performance
Behavioral Health Care		
<i>Antidepressant Medication Management</i>		
<i>Effective Acute Phase Treatment</i>	Administrative	72.6%
<i>Effective Continuation Phase Treatment</i>	Administrative	63.0%
<i>Follow-Up After Hospitalization for Mental Illness</i>		
<i>7-Day Follow-Up—Total</i>	Administrative	36.6%
<i>30-Day Follow-Up—Total</i>	Administrative	49.7%
<i>Initiation and Engagement of AOD Abuse or Dependence Treatment</i>		
<i>Total Initiation of AOD Treatment—Total</i>	Administrative	50.8%
<i>Total Engagement of AOD Treatment—Total</i>	Administrative	4.3%
Care of Acute and Chronic Conditions		
<i>Comprehensive Diabetes Care</i>		
<i>HbA1c Poor Control (>9.0%)*</i>	Mixed**	39.4%
Preventive Screening		
<i>Breast Cancer Screening</i>		
<i>Total</i>	Administrative	36.3%

* A lower rate indicates better performance for this measure.

** Mixed methodology indicates some Contractors used an administrative method and some used a hybrid method.

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

Performance Measurement—DES/DDD

HSAG determined that DES/DDD followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures. Additionally, HSAG found the following based on its PMV:

- *Medical Service Data (Claims/Encounters)*: HSAG identified no concerns with DES/DDD’s claims system or processes.
- *Enrollment Data*: HSAG identified no concerns with DES/DDD’s eligibility system or processes.
- *Provider Data*: HSAG identified no concerns with DES/DDD’s provider data systems or processes.
- *Medical Record Review Process*: HSAG identified no concerns with DES/DDD’s medical record review processes.
- *Supplemental Data*: HSAG identified no concerns with DES/DDD’s supplemental data systems and processes.
- *Data Integration*: HSAG identified no concerns with DES/DDD’s procedures for data integration and measure production.

Table A-9—MY 2020 Performance Measure Results for DES/DDD

Performance Measure	Data Collection Methodology	MY 2020 Performance [^]
Behavioral Health Care		
<i>Antidepressant Medication Management</i>		
<i>Effective Acute Phase Treatment</i>	Administrative	72.9%
<i>Effective Continuation Phase Treatment</i>	Administrative	69.7%
<i>Follow-Up After Hospitalization for Mental Illness</i>		
<i>7-Day Follow-Up—Total</i>	Administrative	68.9%
<i>30-Day Follow-Up—Total</i>	Administrative	87.3%
<i>Initiation and Engagement of AOD Abuse or Dependence Treatment</i>		
<i>Total Initiation of AOD Treatment—Total</i>	Administrative	38.8%
<i>Total Engagement of AOD Treatment—Total</i>	Administrative	S
Care of Acute and Chronic Conditions		
<i>Comprehensive Diabetes Care</i>		
<i>HbA1c Poor Control (>9.0%)*</i>	Hybrid	24.2%
Pediatric Health		
<i>Child and Adolescent Well-Care Visits</i>		
<i>Total</i>	Administrative	47.9%
<i>Developmental Screening in the First Three Years of Life[†]</i>		
<i>Total</i>	Hybrid	42.6%


Performance Measure	Data Collection Methodology	MY 2020 Performance [^]
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>	Administrative	26.2%
Preventive Screening		
Breast Cancer Screening		
<i>Total</i>	Administrative	47.4%

[^] Caution should be exercised when comparing MY 2020 performance to national Medicaid means, given the differences in the DES/DDD population compared to the overall Medicaid population

* A lower rate indicates better performance for this measure.

[†] Indicates the measure was not compared to the MY 2020 national Medicaid mean.

S indicates that fewer than 11 cases exist in the numerator of this measure; therefore, the rate was suppressed to satisfy the HIPAA Privacy Rule's de-identification standard.

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

Appendix B. Validation of Performance Improvement Project Methodology

Performance Improvement Project Design

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

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

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

Data Collection Methodology

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

Measurement of Significant Improvement: How Data Were Aggregated and Analyzed

AHCCCS expects the Contractor to implement interventions to achieve and sustain statistically significant improvement, followed by sustained improvement for one consecutive year, for each PIP indicator. The Contractor shall initiate interventions that result in significant improvement, sustained over time, in its performance for the PIP indicators being measured. Improvement shall be evidenced in

repeated measurements of the PIP indicators specified for each active PIP. AHCCCS determines a Contractor has demonstrated significant improvement when the improvement in the PIP indicator rate(s) from one measurement year to the next measurement year is statistically significant. .

AHCCCS determines a Contractor has demonstrated sustained improvement when the Contractor achieves both of the following conditions:

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

Performance Improvement Project Reporting

Beginning CY 2020, AHCCCS-mandated PIPs begin on a date that corresponds with a calendar year. Baseline data for the PIP are collected and analyzed at the beginning of the PIP. During the first year of the PIP, AHCCCS requires the Contractors to implement interventions to improve performance based on an evaluation of barriers to care/use of services and evidence-based approaches to improving performance. An intervention may consider any unique factors, such as a Contractor's membership, provider network, or geographic area(s) served.

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

Annual measurements are utilized to evaluate Contractor performance. AHCCCS may conduct interim measurements, depending on the resources required, to collect and analyze data. Annual measurements (rates and results) are used as the basis for quantitative and qualitative analysis, and the selection/modification of interventions.

Contractors are required to submit a formal PIP report to AHCCCS in accordance with the contract. AHCCCS reviews and validates each Contractor PIP Report submission to ensure alignment with AHCCCS PIP policy and checklist requirements are met. Following this review, each AHCCCS Contractor is provided formal feedback and may be required to resubmit its PIP Report if such requirements are not met. AHCCCS requires Contractors' participation in the PIP to continue until demonstration of significant and sustained improvement is shown, as outlined above.

Appendix C. Validation of Organizational Assessment and Structure Performance Methodology

Objectives for Conducting the Review

AHCCCS' objectives for conducting ORs are to:

- Determine if the Contractor satisfactorily met AHCCCS' requirements as specified in its contract, AHCCCS policies, Arizona Revised Statutes, the Arizona Administrative Code (AAC), and Medicaid managed care regulations (42 CFR §438).
- Increase AHCCCS' knowledge of the Contractor's operational encounter processing procedures.
- Provide technical assistance and identify areas in which the Contractor can improve as well as areas of noteworthy performance and accomplishments.
- Review the Contractor's progress in implementing recommendations that AHCCCS made during prior ORs.
- Determine if the Contractor complied with its own policies and evaluate the effectiveness of those policies and procedures.
- Perform oversight of the Contractor as required by CMS in accordance with AHCCCS' 1115 waiver.
- Provide information to HSAG as AHCCCS' EQRO to use in preparing this report as described in 42 CFR §438.364.

Methodology for Conducting the Review

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

AHCCCS' methodology for conducting the OR includes the following:

- Reviewing supporting documentation and evidence of implementation that the Contractor was required to submit to AHCCCS
- Conducting interviews with key Contractor administrative and program staff

^{C-1} Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf>. Accessed on: Mar 11, 2021.

AHCCCS conducts activities following the review that include documenting and compiling the results of the review, preparing the draft report of findings, and issuing the draft report to the Contractor for review and comment. In the report, each focus area and standard is individually listed with the applicable performance designation based on AHCCCS' review findings and assessment of the degree to which the Contractor complied with the standards.

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

As needed throughout the preparation of this report, AHCCCS clarifies any remaining questions regarding the accuracy and completeness of the data and information that HSAG would use to prepare this section of the EQR report. Using the verified results that AHCCCS obtains from conducting the OR, HSAG organizes and aggregates the performance data for each Contractor. HSAG then analyzes the data by focus area.

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

As part of the AHCCCS methodology, each Contractor receives a report containing review findings. The Contractor has the opportunity to respond to AHCCCS concerning any disagreements related to the findings. AHCCCS reviews and responds to any Contractor disagreements based on review of the Contractor information, then revises the report if necessary. AHCCCS issues the final report to the Contractor, describing the findings, scores, and required CAPs.

Scoring Methodology: How Data Were Aggregated and Analyzed

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

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

Corrective Action Plans

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

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

Appendix D. Validation of Network Adequacy Methodology and Detailed Results

HSAG used data supplied by AHCCCS to calculate the number and percentage of ALTCS-EPD and ALTCS-DD members within a defined time or distance from up to 12 types of AHCCCS-defined providers. As Table D-1 describes, these time/distance standards vary by provider type and county, and some standards may not apply to every Contractor or subcontracted health plan.

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

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

1. Applies only to Maricopa and Pima counties.
2. Applies only to ALTCS-EPD Contractors.

Data Sources

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

- Prepaid Medical Management Information System (PMMIS) provider data—Data files maintained by AHCCCS that list all AHCCCS-contracted providers and their corresponding addresses.
- AHCCCS member data—A data file compiled by AHCCCS from the PMMIS and Client Assessment and Tracking System (CATS) data. PMMIS data elements include the addresses and other necessary demographic information on AHCCCS members. Specific data elements from CATS identify all AHCCCS members who live in their own homes, for calculation of the Nursing Facility time/distance standard.
- Contractor-specific Provider Affiliation Transmission (PAT) files—An aggregated data file listing each Contractor’s network providers, as identified to AHCCCS by each Contractor. In CYE 2021, Quarter 4, a separate file identified the DDD providers.
- Contractor-specific ACOM 436 submissions—One Microsoft (MS) Excel workbook for each Contractor and LOB with tabs listing the Contractor’s results for compliance with county-level time/distance standards.

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

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

Data Source	CYE 2021 Quarter Two	CYE 2021 Quarter Four
Measurement Period	April 2021	October 2021
PMMIS Providers	April 2021	October 2021
AHCCCS Members	April 2021	October 2021
Contractor-Specific PAT Providers	April 2021	October 2021
Contractor-Specific ACOM 436 Submissions	April 2021	October 2021

Study Indicators

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

1. **Time/Distance Calculation:** HSAG’s calculation of results for all applicable AHCCCS-established time/distance standards by Contractor, LOB, and county, using member and PAT data.
 - Study indicators show the percentage of members assigned by AHCCCS to the specified county, with access to any provider location serving the LOB within the time/distance standard.
2. **Time/Distance Validation:** Validation of each Contractor’s compliance with the time/distance standards, based on HSAG’s time/distance calculation results from #1 above.

- Study indicators validate each Contractor’s reported compliance with each time/distance standard applicable to the LOB and county.
 - A score of “*met*” indicates that HSAG’s time/distance results show a percentage of members at or above the time/distance standard.
 - A score of “*not met*” indicates that HSAG’s time/distance results show a percentage of members below the time/distance standard.
 - The value “*NA*” identifies standards not applicable to the LOB and/or geography.
 - The value “*NR*” identifies standards for which no members met the network requirement denominator for the LOB and geography; therefore, HSAG calculated no corresponding time/distance result.
 - Study indicators also consider the degree to which HSAG’s time/distance results align with the time/distance values reported in each Contractor’s ACOM 436 submission.
 - Shaded cells in the Findings tables identify notable differences between each Contractor’s ACOM 436 time/distance calculation results and HSAG’s results.
3. **Provider Saturation Analysis:** HSAG’s assessment of the degree to which each Contractor’s provider network reflects available AHCCCS-contracted providers.
- Study indicators include the number of AHCCCS-contracted provider locations not reflected in each Contractor’s quarterly PAT file for each applicable time/distance standard scored as “*not met.*”

Analytical Process

HSAG used the Quest Analytics Suite software, version 2021.3 (Quest) to geocode the PAT and PMMIS addresses for members and providers, assigning each address to an exact geographic location (i.e., latitude and longitude). To facilitate geocoding, HSAG standardized member and provider address data to align with the United States Postal Service Coding Accuracy Support System (USPS CASS) to ensure consistent address formatting across data files.

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

To assess the validity of each ALTCS Contractor’s biannual ACOM 436 submission, HSAG compared the time/distance results calculated from the PMMIS and PAT data against the biannual ACOM 436 time/distance results submitted to AHCCCS by each ALTCS-EPD and ALTCS-DD Contractor.

Biannual analyses reflect the following measurement periods, which is a change from the previous quarterly measurement periods:

- CYE 2021, Quarter Two (Q2): January 1–March 31, 2021
- CYE 2021, Quarter Four (Q4): July 1–September 30, 2021

Additionally, detailed time/distance results were presented to AHCCCS and the Contractors each quarter as interactive Tableau dashboards containing the following information:

- Network Adequacy Assessment Comparison—Time and Distance: A dashboard assessing the differences between Contractors’ network adequacy results and HSAG’s results calculated for the time/distance standards.
- Network Adequacy Assessment Trending—Time and Distance: A dashboard comparing Contractor and HSAG Network Adequacy Assessment results across reporting periods by county, urbanicity, and provider category.
- Time and Distance Standards Assessment: A dashboard assessing Contractors’ compliance with time and distance standards by county, urbanicity, and provider category.

Analytical Considerations

AHCCCS does not define the software or process by which each ALTCS Contractor calculates the biannual ACOM 436 time/distance results. HSAG uses Quest to calculate time/distance results based on driving distances, and additional discrepancies may result if Contractors use different versions of Quest during each of the different data network validations.^{D-1} Table D-3 describes each ALTCS Contractor’s self-reported methods for calculating the ACOM 436 results, as of April 2021.

Table D-3—AHCCCS Contractors’ ACOM 436 Calculation Methods, as of April 2021

Contractor	ACOM 436 Calculation Method
BUFC LTC	Calculates time/distance results based on driving distances using Quest version 2020.1
Mercy Care LTC	Calculates time/distance results based on driving distances using Quest version 2020.4
UHCCP LTC	Calculates time/distance results based on driving distances using Quest version 2020.4
Mercy Care DD	Calculates time/distance results based on driving distances using Quest version 2020.4
UHCCP DD	Calculates time/distance results based on driving distances using Quest version 2020.4

^{D-1} 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.

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 an LOB when calculating time/distance results. This appendix presents, by LOB, the biannual validation results for Contractors' county-specific time/distance network standards. However, HSAG's time/distance calculations included all available provider locations noted in Contractors' PAT data files, without considering potential barriers to new patient acceptance or appointment availability at individual provider locations.

Additionally, HSAG's time/distance calculations did not include some facilities available to American Indian members enrolled with an ALTCS Contractor. American Indian members, Title XIX and Title XXI, on- or off-reservation, and eligible to receive services, may choose to receive services at any time from an American Indian Health Facility, 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 under-reported, particularly in areas with high concentrations of these facilities.

Similarly, HSAG's validation included time/distance standards that do not reflect all potential healthcare needs or service delivery options for AHCCCS' ALTCS members. Selected time/distance standards may be addressed through telehealth, mobile service providers, mail delivery for prescriptions, or other emerging service delivery approaches that may be evaluated using metrics other than time/distance calculation results.

Detailed Validation of Network Adequacy Results

ALTCS-EPD

Table D-4 presents the counts of ALTCS-EPD Contractors' provider locations^{D-2} identified for each time/distance network standard for CYE 2021, Quarter 4 (i.e., the July 1–September 30, 2021 measurement period).

^{D-2} The number of provider locations contributing to time/distance calculation results is a function of Contractor's PAT data quality and integrity; the presence of multiple physical locations for an individual provider may cause the appearance of a greater number of provider locations than physically exist. Since HSAG is unable to identify which PAT provider locations would be appropriate to exclude from analyses, all active provider locations are reflected in the network adequacy results. These data limitations may impact the validity of HSAG's time/distance results, and the magnitude of the impact may vary by provider type and county.

Table D-4—Summary of CYE 2021, Quarter 4 Provider Locations by Time/Distance Network Standard and Contractor for ALTCS-EPD

Minimum Network Requirement	Count of BUFC LTC Provider Locations	Count of Mercy Care LTC Provider Locations	Count of UHCCP LTC Provider Locations
Behavioral Health Outpatient and Integrated Clinic, Adult	509	560	580
Behavioral Health Outpatient and Integrated Clinic, Pediatric	509	560	580
Behavioral Health Residential Facility (<i>only Maricopa and Pima counties</i>)	249	373	234
Cardiologist, Adult	965	1,842	2,904
Cardiologist, Pediatric	1,062	2,040	3,100
Dentist, Pediatric	2,719	3,061	2,127
Hospital	169	130	74
Nursing Facility (<i>only ALTCS-EPD Contractors</i>)	108	107	73
Obstetrics/ Gynecology (OB/GYN)	1,265	2,531	3,743
Pharmacy	924	961	822
PCP, Adult	24,803	24,725	55,241
PCP, Pediatric	22,221	20,074	45,996

ALTCS-DD

Table D-5 presents the counts of ALTCS-DD subcontracted health plans’ provider locations^{D-3} identified for each time/distance network standard for CYE 2021, Quarter 4 (i.e., the July 1–September 30, 2021 measurement period).

Table D-5—Summary of CYE 2021, Quarter 4 Provider Locations by Time/Distance Network Standard and Subcontracted Health Plan for ALTCS-DD

Minimum Network Requirement	Count of Mercy Care DD Provider Locations	Count of UHCCP DD Provider Locations
Behavioral Health Outpatient and Integrated Clinic, Adult	569	633
Behavioral Health Outpatient and Integrated Clinic, Pediatric	569	633
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	344	272
Cardiologist, Adult	1,844	3,047
Cardiologist, Pediatric	2,042	3,241
Dentist, Pediatric	3,070	2,502
Hospital	125	98
Obstetrics/ Gynecology (OB/GYN)	2,546	3,818
Pharmacy	1,004	824
PCP, Adult	24,819	59,206
PCP, Pediatric	20,161	49,432

^{D-3} The number of provider locations contributing to time/distance calculation results is a function of Contractor’s PAT data quality and integrity; the presence of multiple physical locations for an individual provider may cause the appearance of a greater number of provider locations than physically exist. Since HSAG is unable to identify which PAT provider locations would be appropriate to exclude from analyses, all active provider locations are reflected in the network adequacy results. These data limitations may impact the validity of HSAG’s time/distance results, and the magnitude of the impact may vary by provider type and county.

This section presents biannual validation findings specific to the ALTCS-EPD LOB, with one results table for each of the following counties by region:

- Central Region: Gila, Maricopa,^{D-4} Pinal
- North Region: Apache, Coconino, Mohave, Navajo, Yavapai
- South Region: Cochise, Graham,^{D-5} Greenlee, La Paz, Pima, Santa Cruz,^{D-6} Yuma

Each county-specific table summarizes biannual validation results containing the percent of members meeting each time/distance standard by quarter and Contractor, with color-coding to identify whether the time/distance standard was “met” or “not met.”

The value, “NA,” is shown for time/distance standards that do not apply to the county or ALTCS-EPD LOB.

The value, “NR,” is shown for time/distance standards in which no members met the network requirement denominator for the ALTCS-EPD LOB and county; therefore, HSAG calculated no corresponding time/distance result.

Yellow color-coding identifies instances in which HSAG’s time/distance results met the minimum network requirement, but differed from the Contractor’s ACOM 436 results.

Red color-coding identifies instances in which HSAG’s time/distance results that did not meet the compliance standard, regardless of the Contractor’s ACOM 436 results.

An asterisk (*) identifies instances in which fewer than five members were included in the denominator of HSAG’s time/distance results.

^{D-4} Maricopa County includes the 85342, 85358, and 85390 ZIP codes; these ZIP codes are physically located in both Maricopa and Yavapai counties.

^{D-5} Graham County includes the 85542, 85192, and 85550 ZIP codes representing the San Carlos Tribal area; these ZIP codes are physically located in Gila or Pinal County.

^{D-6} Santa Cruz County includes the 85645 ZIP code; this ZIP code is physically located in both Pima and Santa Cruz counties.

Central Region: Gila, Maricopa, and Pinal Counties

Table D-6—ALTCS-EPD Time/Distance Validation Results for Gila County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	BUFC LTC		Mercy Care LTC		UHCCP LTC	
	Q2	Q4	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR*	100.0*	100.0*	100.0*	NR*	NR*
Behavioral Health Residential Facility (<i>only Maricopa and Pima counties</i>)	NA	NA	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0*	100.0*	100.0*	100.0*	NR*	NR*
Dentist, Pediatric	100.0*	100.0*^	100.0*	100.0*	NR*	NR*
Hospital	100.0	100.0	100.0	100.0	100.0	100.0
Nursing Facility (<i>only ALTCS-EPD contractors</i>)	100.0	100.0	100.0	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	100.0*	100.0*	100.0*	100.0*	100.0*	100.0
Pharmacy	100.0	100.0	100.0	100.0	100.0	100.0
PCP, Adult	100.0	100.0	100.0	100.0	100.0	100.0
PCP, Pediatric	100.0*	100.0*	100.0*	100.0*	NR*	NR*

NR

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

represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.

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

^In CYE 2021, Quarter 4, BUFC LTC’s data for dentists did not include the specialty codes used to identify dentists meeting the criteria for the Dentist, Pediatric category. At AHCCCS’ request, HSAG used PMMIS specialty provider data for BUFC LTC’s reported dentists to identify pediatric dentists and calculate the time and distance results. Due to the use of data not submitted by the health plan, HSAG was unable to accurately validate and assess compliance for BUFC LTC’s reported Dentist, Pediatric provider category. Results are shown for informational purposes only.

NA indicates results are not applicable to the county.

Table D-7—ALTCS-EPD Time/Distance Validation Results for Maricopa County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	BUFC LTC		Mercy Care LTC		UHCCP LTC	
	Q2	Q4	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	99.2	99.2	99.0	99.0	99.4	99.3
Behavioral Health Outpatient and Integrated Clinic, Pediatric	96.8	97.1	97.7	98.2	100.0	100.0
Behavioral Health Residential Facility (<i>only Maricopa and Pima counties</i>)	99.3	99.0	99.7	99.7	98.9	98.7
Cardiologist, Adult	100.0	99.6	100.0	100.0	99.9	99.9
Cardiologist, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0 [^]	99.6	100.0	100.0	100.0
Hospital	99.8	99.7	100.0	100.0	99.6	99.6
Nursing Facility (<i>only ALTCS-EPD Contractors</i>)	99.9	99.6	99.9	99.9	99.6	99.5
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	99.7	99.5	99.7	99.7	99.4	99.4
PCP, Adult	99.9	99.8	99.8	99.8	99.9	99.8
PCP, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0

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

[^]In CYE 2021, Quarter 4, BUFC LTC’s data for dentists did not include the specialty codes used to identify dentists meeting the criteria for the Dentist, Pediatric category. At AHCCCS’ request, HSAG used PMMIS specialty provider data for BUFC LTC’s reported dentists to identify pediatric dentists and calculate the time and distance results. Due to the use of data not submitted by the health plan, HSAG was unable to accurately validate and assess compliance for BUFC LTC’s reported Dentist, Pediatric provider category. Results are shown for informational purposes only.

Table D-8—ALTCS-EPD Time/Distance Validation Results for Pinal County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	BUFC LTC		Mercy Care LTC		UHCCP LTC	
	Q2	Q4	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0*	100.0*	100.0	100.0	100.0	100.0
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0*	100.0*	100.0	100.0	100.0	100.0
Dentist, Pediatric	100.0*	100.0*^	100.0	100.0	100.0	100.0
Hospital	100.0	100.0	100.0	100.0	100.0	100.0
Nursing Facility (<i>Only ALTCS-EPD Contractors</i>)	100.0	100.0	100.0	100.0	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	100.0	100.0	100.0	100.0	100.0	100.0
PCP, Adult	100.0	100.0	100.0	100.0	100.0	100.0
PCP, Pediatric	100.0*	100.0*	100.0	100.0	100.0	100.0

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

^In CYE 2021, Quarter 4, BUFC LTC's data for dentists did not include the specialty codes used to identify dentists meeting the criteria for the Dentist, Pediatric category. At AHCCCS' request, HSAG used PMMIS specialty provider data for BUFC LTC's reported dentists to identify pediatric dentists and calculate the time and distance results. Due to the use of data not submitted by the health plan, HSAG was unable to accurately validate and assess compliance for BUFC LTC's reported Dentist, Pediatric provider category. Results are shown for informational purposes only.

NA indicates results are not applicable to the county.

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

Table D-9—ALTCS-EPD Time/Distance Validation Results for Apache County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	UHCCP LTC	
	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	98.8	97.7
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0*	100.0*
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA
Cardiologist, Adult	98.8	97.7
Cardiologist, Pediatric	100.0*	100.0*
Dentist, Pediatric	100.0*	100.0*
Hospital	100.0	100.0
Nursing Facility (<i>Only ALTCS-EPD Contractors</i>)	100.0	98.3
Obstetrics/ Gynecology (OB/GYN)	100.0*	100.0*
Pharmacy	98.8	97.7
PCP, Adult	100.0	98.8
PCP, Pediatric	100.0*	100.0*

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

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

NA indicates results are not applicable to the county.

Table D-10—ALTCS-EPD Time/Distance Validation Results for Coconino County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	UHCCP LTC	
	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA
Cardiologist, Adult	100.0	100.0
Cardiologist, Pediatric	100.0	100.0
Dentist, Pediatric	100.0	100.0
Hospital	93.9	99.6
Nursing Facility (<i>Only ALTCS-EPD Contractors</i>)	89.1	90.7
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0
Pharmacy	98.7	98.3
PCP, Adult	100.0	100.0
PCP, Pediatric	100.0	100.0


 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.
 NA indicates results are not applicable to the county.

Table D-11—ALTCS-EPD Time/Distance Validation Results for Mohave County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	UHCCP LTC	
	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0*	100.0*
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA
Cardiologist, Adult	99.9	100.0
Cardiologist, Pediatric	100.0	100.0
Dentist, Pediatric	100.0	100.0
Hospital	98.1	98.8
Nursing Facility (<i>Only ALTCS-EPD Contractors</i>)	99.3	99.5
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0
Pharmacy	99.8	99.4
PCP, Adult	99.8	99.8
PCP, Pediatric	100.0	100.0

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

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

NA indicates results are not applicable to the county.

Table D-12—ALTCS-EPD Time/Distance Validation Results for Navajo County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	UHCCP LTC	
	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0*	100.0*
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA
Cardiologist, Adult	100.0	100.0
Cardiologist, Pediatric	100.0*	100.0*
Dentist, Pediatric	100.0*	100.0*
Hospital	100.0	100.0
Nursing Facility (<i>Only ALTCS-EPD Contractors</i>)	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0
Pharmacy	100.0	100.0
PCP, Adult	100.0	100.0
PCP, Pediatric	100.0*	100.0*

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

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

NA indicates results are not applicable to the county.

Table D-13—ALTCS-EPD Time/Distance Validation Results for Yavapai County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	UHCCP LTC	
	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA
Cardiologist, Adult	100.0	100.0
Cardiologist, Pediatric	100.0	100.0
Dentist, Pediatric	100.0	100.0
Hospital	100.0	100.0
Nursing Facility (<i>Only ALTCS-EPD Contractors</i>)	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0
Pharmacy	99.7	99.8
PCP, Adult	100.0	100.0
PCP, Pediatric	100.0	100.0

represents Contractor-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.
 NA indicates results are not applicable to the county.

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

Table D-14—ALTCS-EPD Time/Distance Validation Results for Cochise County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	BUFC LTC	
	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0*	100.0*
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA
Cardiologist, Adult	100.0	100.0
Cardiologist, Pediatric	100.0	100.0
Dentist, Pediatric	100.0	100.0^
Hospital	100.0	100.0
Nursing Facility (<i>Only ALTCS-EPD Contractors</i>)	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0
Pharmacy	100.0	100.0
PCP, Adult	100.0	100.0
PCP, Pediatric	100.0	100.0

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

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

^In CYE 2021, Quarter 4, BUFC LTC’s data for dentists did not include the specialty codes used to identify dentists meeting the criteria for the Dentist, Pediatric category. At AHCCCS’ request, HSAG used PMMIS specialty provider data for BUFC LTC’s reported dentists to identify pediatric dentists and calculate the time and distance results. Due to the use of data not submitted by the health plan, HSAG was unable to accurately validate and assess compliance for BUFC LTC’s reported Dentist, Pediatric provider category. Results are shown for informational purposes only.

NA indicates results are not applicable to the county.

Table D-15—ALTCS-EPD Time/Distance Validation Results for Graham County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	BUFC LTC	
	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0*	100.0*
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA
Cardiologist, Adult	100.0	100.0
Cardiologist, Pediatric	100.0*	100.0*
Dentist, Pediatric	100.0*	100.0*^
Hospital	100.0	100.0
Nursing Facility (<i>Only ALTCS-EPD Contractors</i>)	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0*	100.0*
Pharmacy	100.0	100.0
PCP, Adult	100.0	100.0
PCP, Pediatric	100.0*	100.0*

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

^In CYE 2021, Quarter 4, BUFC LTC's data for Dentists did not include the specialty codes used to identify dentists meeting the criteria for the Dentist, Pediatric category. At AHCCCS' request, HSAG used PMMIS specialty provider data for BUFC LTC's reported dentists to identify pediatric dentists and calculate the time and distance results. Due to the use of data not submitted by the health plan, HSAG was unable to accurately validate and assess compliance for BUFC LTC's reported Dentist, Pediatric provider category. Results are shown for informational purposes only.

NA indicates results are not applicable to the county.

Table D-16—ALTCs-EPD Time/Distance Validation Results for Greenlee County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	BUFC LTC	
	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR*	NR*
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA
Cardiologist, Adult	100.0	100.0
Cardiologist, Pediatric	NR*	NR*
Dentist, Pediatric	NR*	NR*^
Hospital	100.0	100.0
Nursing Facility (<i>Only ALTCs-EPD Contractors</i>)	100.0*	100.0*
Obstetrics/ Gynecology (OB/GYN)	NR*	NR*
Pharmacy	100.0	100.0
PCP, Adult	100.0	100.0
PCP, Pediatric	NR*	NR*

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

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

^In CYE 2021, Quarter 4, BUFC LTC's data for dentists did not include the specialty codes used to identify dentists meeting the criteria for the Dentist, Pediatric category. At AHCCCS' request, HSAG used PMMIS specialty provider data for BUFC LTC's reported dentists to identify pediatric dentists and calculate the time and distance results. Due to the use of data not submitted by the health plan, HSAG was unable to accurately validate and assess compliance for BUFC LTC's reported Dentist, Pediatric provider category. Results are shown for informational purposes only.

NA indicates results are not applicable to the county.

Table D-17—ALTCES-EPD Time/Distance Validation Results for La Paz County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	BUFC LTC	
	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR*	NR*
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA
Cardiologist, Adult	100.0	100.0
Cardiologist, Pediatric	100.0*	100.0*
Dentist, Pediatric	100.0*	100.0* [^]
Hospital	100.0	100.0
Nursing Facility (<i>Only ALTCES-EPD Contractors</i>)	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0*	100.0*
Pharmacy	87.8	87.8
PCP, Adult	100.0	100.0
PCP, Pediatric	100.0*	100.0*

NR

represents time/distance standard results that do not meet the compliance standard based on HSAG's results.

represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.

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

[^]In CYE 2021, Quarter 4, BUFC LTC's data for dentists did not include the specialty codes used to identify dentists meeting the criteria for the Dentist, Pediatric category. At AHCCCS' request, HSAG used PMMIS specialty provider data for BUFC LTC's reported dentists to identify pediatric dentists and calculate the time and distance results. Due to the use of data not submitted by the health plan, HSAG was unable to accurately validate and assess compliance for BUFC LTC's reported Dentist, Pediatric provider category. Results are shown for informational purposes only.

NA indicates results are not applicable to the county.

Table D-18—ALTCS-EPD Time/Distance Validation Results for Pima County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	BUFC LTC		Mercy Care LTC	
	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	98.7	99.0	98.5	98.5
Behavioral Health Outpatient and Integrated Clinic, Pediatric	93.9	94.1	96.0	96.3
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	93.3	92.4	98.4	98.7
Cardiologist, Adult	99.9	99.2	99.9	99.8
Cardiologist, Pediatric	100.0	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0 [^]	100.0	100.0
Hospital	99.9	99.8	99.9	99.9
Nursing Facility (<i>Only ALTCS-EPD Contractors</i>)	99.7	99.7	99.7	99.7
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0	98.4	98.5
Pharmacy	99.3	99.2	99.5	99.5
PCP, Adult	99.9	99.9	100.0	99.9
PCP, Pediatric	100.0	100.0	100.0	100.0

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

[^]In CYE 2021, Quarter 4, BUFC LTC’s data for dentists did not include the specialty codes used to identify dentists meeting the criteria for the Dentist, Pediatric category. At AHCCCS’ request, HSAG used PMMIS specialty provider data for BUFC LTC’s reported dentists to identify pediatric dentists and calculate the time and distance results. Due to the use of data not submitted by the health plan, HSAG was unable to accurately validate and assess compliance for BUFC LTC’s reported Dentist, Pediatric provider category. Results are shown for informational purposes only.

Table D-19—ALTCs-EPD Time/Distance Validation Results for Santa Cruz County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	BUFC LTC	
	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0*	100.0*
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA
Cardiologist, Adult	100.0	100.0
Cardiologist, Pediatric	100.0*	100.0*
Dentist, Pediatric	100.0*	100.0*^
Hospital	100.0	100.0
Nursing Facility (<i>Only ALTCs-EPD Contractors</i>)	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0
Pharmacy	100.0	100.0
PCP, Adult	100.0	100.0
PCP, Pediatric	100.0*	100.0*

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

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

^In CYE 2021, Quarter 4, BUFC LTC’s data for dentists did not include the specialty codes used to identify dentists meeting the criteria for the Dentist, Pediatric category. At AHCCCS’ request, HSAG used PMMIS specialty provider data for BUFC LTC’s reported dentists to identify pediatric dentists and calculate the time and distance results. Due to the use of data not submitted by the health plan, HSAG was unable to accurately validate and assess compliance for BUFC LTC’s reported Dentist, Pediatric provider category. Results are shown for informational purposes only.

NA indicates results are not applicable to the county.

Table D-20—ALTCS-EPD Time/Distance Validation Results for Yuma County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	BUFC LTC	
	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	99.9
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA
Cardiologist, Adult	100.0	99.9
Cardiologist, Pediatric	100.0	100.0
Dentist, Pediatric	100.0	100.0 [^]
Hospital	100.0	100.0
Nursing Facility (<i>Only ALTCS-EPD Contractors</i>)	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0
Pharmacy	100.0	99.9
PCP, Adult	100.0	99.9
PCP, Pediatric	100.0	100.0

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

[^]In CYE 2021, Quarter 4, BUFC LTC’s data for dentists did not include the specialty codes used to identify dentists meeting the criteria for the Dentist, Pediatric category. At AHCCCS’ request, HSAG used PMMIS specialty provider data for BUFC LTC’s reported dentists to identify pediatric dentists and calculate the time and distance results. Due to the use of data not submitted by the health plan, HSAG was unable to accurately validate and assess compliance for BUFC LTC’s reported Dentist, Pediatric provider category. Results are shown for informational purposes only.

NA indicates results are not applicable to the county.

This section presents biannual validation findings specific to the ALTCS-DD LOB, with one results table for each of the following counties by region:

- Central Region: Gila, Maricopa,^{D-7} Pinal
- North Region: Apache, Coconino, Mohave, Navajo, Yavapai
- South Region: Cochise, Graham,^{D-8} Greenlee, La Paz, Pima, Santa Cruz,^{D-9} Yuma

Each county-specific table summarizes biannual validation results containing the percent of members meeting each time/distance standard by quarter and subcontracted health plan, with color-coding to identify whether the time/distance standard was “met” or “not met.”

The value, “NA,” is shown for time/distance standards that do not apply to the county or ALTCS-DD LOB.

The value, “NR,” is shown for time/distance standards in which no members met the network requirement denominator for the ALTCS-DD LOB and county; therefore, HSAG calculated no corresponding time/distance result.

Yellow color-coding identifies instances in which HSAG’s time/distance results met the minimum network requirement, but differed from the subcontracted health plan’s ACOM 436 results.

Red color-coding identifies instances in which HSAG’s time/distance results that did not meet the compliance standard, regardless of the subcontracted health plan’s ACOM 436 results.

An asterisk (*) identifies instances in which fewer than five members were included in the denominator of HSAG’s time/distance results.

^{D-7} Maricopa County includes the 85342, 85358, and 85390 ZIP codes; these ZIP codes are physically located in both Maricopa and Yavapai counties.

^{D-8} Graham County includes the 85542, 85192, and 85550 ZIP codes representing the San Carlos Tribal area; these ZIP codes are physically located in Gila or Pinal County.

^{D-9} Santa Cruz County includes the 85645 ZIP code; this ZIP code is physically located in both Pima and Santa Cruz counties.

Central Region: Gila, Maricopa, and Pinal County

Table D-21—ALTCS-DD Time/Distance Validation Results for Gila County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	Mercy Care DD		UHCCP DD	
	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	100.0
Behavioral Health Residential Facility (<i>only Maricopa and Pima counties</i>)	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	100.0	100.0
Hospital	100.0	100.0	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0	100.0	100.0
Pharmacy	100.0	100.0	100.0	100.0
PCP, Adult	100.0	100.0	100.0	100.0
PCP, Pediatric	100.0	100.0	100.0	100.0

 represents subcontracted health plan-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.
 NA indicates results are not applicable to the county.

Table D-22—ALTCS-DD Time/Distance Validation Results for Maricopa County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	Mercy Care DD		UHCCP DD	
	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	97.4	97.5	98.7	98.6
Behavioral Health Outpatient and Integrated Clinic, Pediatric	97.7	97.6	98.9	98.9
Behavioral Health Residential Facility (<i>only Maricopa and Pima counties</i>)	99.3	99.3	98.6	98.6
Cardiologist, Adult	100.0	100.0	100.0	99.9
Cardiologist, Pediatric	100.0	100.0	100.0	100.0
Dentist, Pediatric	99.6	99.7	99.7	99.7
Hospital	100.0	99.9	99.9	99.9
Obstetrics/ Gynecology (OB/GYN)	99.9	100.0	99.9	99.9
Pharmacy	99.4	99.3	99.3	99.3
PCP, Adult	99.7	99.7	99.8	99.7
PCP, Pediatric	99.6	99.6	99.8	99.9

represents subcontracted health plan-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.

Table D-23—ALTCs-DD Time/Distance Validation Results for Pinal County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	Mercy Care DD		UHCCP DD	
	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	100.0
Behavioral Health Residential Facility (<i>only Maricopa and Pima counties</i>)	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	100.0	100.0
Hospital	100.0	100.0	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0	100.0	100.0
Pharmacy	100.0	100.0	100.0	100.0
PCP, Adult	100.0	100.0	100.0	100.0
PCP, Pediatric	100.0	100.0	100.0	100.0


 represents subcontracted health plan-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.
 NA indicates results are not applicable to the county.

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

Table D-24—ALTCs-DD Time/Distance Validation Results for Apache County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	Mercy Care DD		UHCCP DD	
	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	57.1	57.1	64.6	67.1
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0*	100.0*	73.3	68.2
Behavioral Health Residential Facility (<i>only Maricopa and Pima counties</i>)	NA	NA	NA	NA
Cardiologist, Adult	42.9	42.9	64.3	62.9
Cardiologist, Pediatric	100.0*	100.0*	72.2	81.1
Dentist, Pediatric	100.0*	100.0*	63.0	64.2
Hospital	100.0	100.0	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0*	100.0*	100.0	100.0
Pharmacy	100.0	100.0	66.1	64.2
PCP, Adult	85.7	71.4	87.1	91.4
PCP, Pediatric	100.0*	100.0*	90.7	90.6

 represents subcontracted health plan-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 fewer than five members were included in the denominator of HSAG's results.

NA indicates results are not applicable to the county.

Table D-25—ALTCS-DD Time/Distance Validation Results for Coconino County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	Mercy Care DD		UHCCP DD	
	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	88.9	90.0	98.4	98.4
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	95.5	94.4
Behavioral Health Residential Facility (<i>only Maricopa and Pima counties</i>)	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	99.7	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	98.7	98.0
Hospital	100.0	100.0	88.7	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0*	100.0*	100.0	100.0
Pharmacy	100.0	100.0	93.4	91.1
PCP, Adult	85.7	88.9	96.6	96.0
PCP, Pediatric	100.0	100.0	92.9	91.3

 represents subcontracted health plan-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 fewer than five members were included in the denominator of HSAG's results.

NA indicates results are not applicable to the county.

Table D-26—ALTCS-DD Time/Distance Validation Results for Mohave County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	Mercy Care DD		UHCCP DD	
	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	99.8
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	100.0
Behavioral Health Residential Facility (<i>only Maricopa and Pima counties</i>)	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0
Dentist, Pediatric	85.7	88.2	99.7	99.7
Hospital	100.0	100.0	100.0	99.9
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0	100.0	100.0
Pharmacy	95.2	91.7	98.6	98.6
PCP, Adult	100.0	100.0	99.4	99.2
PCP, Pediatric	92.9	94.1	99.5	99.7

 represents subcontracted health plan-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.

NA indicates results are not applicable to the county.

Table D-27—ALTCS-DD Time/Distance Validation Results for Navajo County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	Mercy Care DD		UHCCP DD	
	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	97.5	96.4
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	94.7	96.4
Behavioral Health Residential Facility (<i>only Maricopa and Pima counties</i>)	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	95.9	98.8
Cardiologist, Pediatric	100.0	100.0	99.3	100.0
Dentist, Pediatric	88.9	100.0	98.6	98.5
Hospital	100.0	100.0	99.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0*	100.0	100.0
Pharmacy	94.1	92.9	96.8	97.0
PCP, Adult	100.0	100.0	100.0	100.0
PCP, Pediatric	100.0	100.0	100.0	100.0

 represents subcontracted health plan-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 fewer than five members were included in the denominator of HSAG's results.

NA indicates results are not applicable to the county.

Table D-28—ALTCs-DD Time/Distance Validation Results for Yavapai County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	Mercy Care DD		UHCCP DD	
	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	100.0
Behavioral Health Residential Facility (<i>only Maricopa and Pima counties</i>)	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	99.1	98.6
Hospital	100.0	100.0	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0*	100.0	100.0	100.0
Pharmacy	100.0	100.0	99.2	99.0
PCP, Adult	100.0	100.0	100.0	100.0
PCP, Pediatric	100.0	100.0	100.0	100.0

represents subcontracted health plan-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.

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

NA indicates results are not applicable to the county.

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

Table D-29—ALTCS-DD Time/Distance Validation Results for Cochise County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	Mercy Care DD		UHCCP DD	
	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	100.0
Behavioral Health Residential Facility (<i>only Maricopa and Pima counties</i>)	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	97.3	97.3
Hospital	100.0	100.0	99.7	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0	100.0	100.0
Pharmacy	99.3	99.3	99.5	99.7
PCP, Adult	98.3	98.3	100.0	100.0
PCP, Pediatric	100.0	100.0	100.0	100.0

represents subcontracted health plan-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.
 NA indicates results are not applicable to the county.

Table D-30—ALTCs-DD Time/Distance Validation Results for Graham County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	Mercy Care DD		UHCCP DD	
	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	100.0
Behavioral Health Residential Facility (<i>only Maricopa and Pima counties</i>)	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0
Dentist, Pediatric	92.5	98.1	95.7	95.5
Hospital	100.0	100.0	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0	100.0	100.0
Pharmacy	98.1	100.0	96.1	98.7
PCP, Adult	100.0	100.0	96.7	100.0
PCP, Pediatric	96.2	100.0	100.0	97.7

represents subcontracted health plan-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.
 NA indicates results are not applicable to the county.

Table D-31—ALTCS-DD Time/Distance Validation Results for Greenlee County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	Mercy Care DD		UHCCP DD	
	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	100.0
Behavioral Health Residential Facility (<i>only Maricopa and Pima counties</i>)	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0*
Cardiologist, Pediatric	100.0	100.0	100.0	100.0
Dentist, Pediatric	71.4	100.0	100.0	100.0
Hospital	100.0	100.0	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0	100.0*	100.0*
Pharmacy	100.0	100.0	100.0	100.0
PCP, Adult	100.0	100.0	100.0	100.0*
PCP, Pediatric	100.0	100.0	100.0	100.0

 represents subcontracted health plan-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 fewer than five members were included in the denominator of HSAG's results.

NA indicates results are not applicable to the county.

Table D-32—ALTCS-DD Time/Distance Validation Results for La Paz County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	Mercy Care DD		UHCCP DD	
	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0*	100.0*	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0*	100.0*	100.0	100.0
Behavioral Health Residential Facility (<i>only Maricopa and Pima counties</i>)	NA	NA	NA	NA
Cardiologist, Adult	100.0*	100.0*	100.0	100.0
Cardiologist, Pediatric	100.0*	100.0*	100.0	100.0
Dentist, Pediatric	50.0*	50.0*	94.4	100.0
Hospital	100.0	100.0	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0*	100.0*	100.0	100.0
Pharmacy	80.0	80.0	100.0	100.0
PCP, Adult	100.0*	100.0*	100.0	100.0
PCP, Pediatric	100.0*	100.0*	100.0	100.0

 represents subcontracted health plan-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 fewer than five members were included in the denominator of HSAG's results.
 NA indicates results are not applicable to the county.

Table D-33—ALTCs-DD Time/Distance Validation Results for Pima County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	Mercy Care DD		UHCCP DD	
	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	95.8	95.8	98.3	98.1
Behavioral Health Outpatient and Integrated Clinic, Pediatric	94.4	94.2	96.8	97.3
Behavioral Health Residential Facility (<i>only Maricopa and Pima counties</i>)	94.5	96.6	92.3	92.5
Cardiologist, Adult	99.7	99.7	99.8	99.8
Cardiologist, Pediatric	99.8	100.0	99.9	99.8
Dentist, Pediatric	98.8	98.6	99.1	99.0
Hospital	99.6	99.6	99.8	99.8
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0	99.9	100.0
Pharmacy	98.4	98.2	98.1	98.2
PCP, Adult	99.7	99.7	99.9	99.9
PCP, Pediatric	99.7	99.7	99.6	99.7

represents subcontracted health plan-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.

Table D-34—ALTCS-DD Time/Distance Validation Results for Santa Cruz County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	Mercy Care DD		UHCCP DD	
	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	99.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	100.0
Behavioral Health Residential Facility (<i>only Maricopa and Pima counties</i>)	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	100.0	100.0
Hospital	100.0	100.0	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0	100.0	100.0
Pharmacy	100.0	100.0	100.0	99.5
PCP, Adult	100.0	100.0	100.0	100.0
PCP, Pediatric	100.0	100.0	100.0	100.0

represents subcontracted health plan-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.
 NA indicates results are not applicable to the county.

Table D-35—ALTCS-DD Time/Distance Validation Results for Yuma County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	Mercy Care DD		UHCCP DD	
	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	99.7	99.7
Behavioral Health Residential Facility (<i>only Maricopa and Pima counties</i>)	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	99.8	99.8
Hospital	100.0	100.0	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0	100.0	100.0
Pharmacy	100.0	100.0	99.9	99.9
PCP, Adult	100.0	100.0	100.0	100.0
PCP, Pediatric	100.0	100.0	99.8	99.8

represents subcontracted health plan-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.
 NA indicates results are not applicable to the county.

Appendix E. Network Adequacy Report

The following pages contain the 2021 AHCCCS Network Adequacy Report.



2021 AHCCCS NETWORK ADEQUACY REPORT

PREPARED BY:
DIVISION OF HEALTH CARE MANAGEMENT, OPERATIONS

January 25, 2022



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2021 Network Adequacy Report

Purpose

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

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

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

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

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Program Description

Arizona currently operates under an 1115 Waiver, extended by CMS on September 30, 2016. The waiver was approved for a five-year period from October 1, 2016 through September 30, 2021, with an additional approved extension through September 20, 2022. A pending request to renew the waiver for an additional five years is under review by CMS.

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

For most members¹, services are administered through contracts with health plans, including contracts with two Arizona state agencies.

- **AHCCCS Complete Care (ACC) Contractors** provide integrated care addressing the physical and behavioral health needs for the majority of Title XIX/XXI eligible children and adults. AHCCCS contracts with seven ACC Contractors: Arizona Complete Health-Complete Care Plan, Banner University Family Care, Care1st Health Plan, Molina Complete Care², Mercy Care, Health Choice of Arizona, and UnitedHealthcare Community Plan. Each ACC Contractor is assigned to serve one or more of three county-based Geographic Service Areas (GSAs).
- **Regional Behavioral Health Authority (RBHA) Contractors** provide integrated physical and behavioral health services to eligible members determined to have a Serious Mental Illness and for a period to time, comprehensive behavioral health services to individuals enrolled in DCS/CHP as outlined below. RBHA Contractors are also responsible for the provision of crisis services to all individuals, including but not limited to, crisis telephone services, mobile crisis teams and crisis stabilization services. AHCCCS contracts with three RBHA Contractors: Arizona Complete Health-Complete Care Plan, Mercy Care and Health Choice of Arizona. Each RBHA Contractor is assigned to serve one of three county-based GSAs.
- **Arizona Long Term Care System Elderly and Physically Disabled (ALTCS/EPD) Contractors** provide long term services and supports and acute physical and behavioral health services to eligible members who are Elderly and/or have a Physical Disability. AHCCCS Contracts with three ALTCS/EPD Contractors: Banner University Family Care, Mercy Care and UnitedHealthcare Community Plan. Each ALTCS/EPD Contractor is assigned to serve one or more of three county-based GSAs.

¹ Arizona American Indian members meeting specific criteria may receive services through a health plan, or may choose to receive services through the state-administered fee for service program

² Formerly Magellan Complete Care, which was purchased by Molina Healthcare, Inc and began doing business as Molina Complete Care July 1, 2021

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- **Arizona Long Term Care System Arizona Department of Economic Security/Division of Developmental Disabilities (ALTCS/DDD)** is a contracted Arizona state agency responsible for providing long term services and supports and acute physical and behavioral health services to eligible members with Intellectual and/or Developmental Disabilities as outlined under Arizona state law. The ALTCS/DDD Contractor directly contracts with providers for long term care services and supports statewide, and subcontracts with two health plans who administer acute physical and behavioral health services to ALTCS/DDD members statewide.
- **Department of Child Safety/Comprehensive Health Program (DCS/CHP)** is a contracted Arizona state agency responsible for providing health care services for children in the custody of DCS as outlined under Arizona state law. Prior to April 1, 2021, DCS managed acute physical health care services directly with providers, while behavioral health services were managed through RBHAs. After April 1, DCS/CHP consolidated these services to provide integrated physical and behavioral health services through a subcontracted health plan to DCS/CHP members statewide.

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

AHCCCS [Contracts](#) are available on the AHCCCS website.

The AHCCCS Contractor Operations Manual (ACOM) provides information to health plans on their operational responsibilities and requirements under the AHCCCS program. The AHCCCS Medical Policy Manual (AMPM) provides information to health plans and providers regarding the services covered within the AHCCCS program. Both [Policy Manuals](#) are available on the AHCCCS website.

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

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

If, as a result of AHCCCS’ review of the deliverable, or if for any other reason a health plan fails to demonstrate compliance with contractual requirements, AHCCCS may elect to impose an Administrative Action. Administrative Actions may include the issuance of any or all of the following: Notice of Concern, Notice to Cure, a mandated Corrective Action Plan, or financial sanction. AHCCCS publishes issued [Administrative Actions](#) on its website

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Deliverables Demonstrating Network Adequacy

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

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

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

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

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

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

Minimum Network Requirements Verification – Every six months, health plans³ submit a completed Minimum Network Requirement Verification Report (Verification Report). The requirements for this report are outlined in ACOM Policy 436. In the Verification Report health plans describe their compliance with minimum network requirements, including time and

³ Prior to April 1, 2021, DCS/CHP was exempted from this requirement as state law allowed members enrolled in DCS/CHP to see any AHCCCS registered provider. The lack of a defined provider network prohibited this kind of network analysis for DCS/CHP. The law was revised to allow DCS/CHP to manage a contracted provider network as of April 1, 2021, and as a result the exemption from network reporting was removed.

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distance requirements (See Attachment C ACOM 436 Verification Report). These requirements identify thirteen provider types for which AHCCCS has developed minimum time and distance standards to ensure geographic access to services. The Verification Report includes standards for all health plans, as well as some standards specific to RBHA and ALTCS/EPD health plans. Moreover, some standards are measured against specific member populations and the standards vary by county. These standards are identified in Table 1, below:

Table 1 - AHCCCS Minimum Time and Distance Standards

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

AHCCCS validates the Verification Report submissions by conducting an independent time and distance analysis of the health plan’s compliance. This analysis is completed through a contract with Health Services Advisory Group (HSAG). AHCCCS provides HSAG with each health plan’s Verification Report submission, the health plan’s PAT file, the health plan’s enrolled

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membership, and a file of all AHCCCS registered providers. HSAG then posts its findings to a dashboard accessible by AHCCCS and its contracted health plans.

To ensure health plans have the resources to address discrepancies found in the validation process, AHCCCS provides the following information to the health plans:

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

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

After completion of the individual quarterly reports, HSAG also generates an annual validation report which is attached with this Network Adequacy Report (*See Attachment A HSAG Validation Report*). This report covers Contract Year Ending (CYE) 2021 with data for Quarter 2 and Quarter 4.

AHCCCS identified a number of areas where health plans appear to struggle to meet the minimum network requirements. For example, the validation of ACC contractors serving Apache County shows difficulty in meeting the time and distance requirements for several provider types, primarily Pediatric Dentists and Pharmacies. Compliance with these standards is complicated by the extremely rural nature of significant parts of these counties, as well as the presence of tribal providers that have been excluded from these time and distance calculations. In addition to Apache County, health plans also struggle with dentists in several rural counties such as La Paz and Greenlee counties.

The process of reviewing and validating the health plans' progress towards compliance with minimum network requirements is underscoring the relative lack of providers in some of Arizona's more rural counties. ACOM Policy 436 does include an exception process for health plans to request an exception from any minimum network standard that cannot be met after all efforts are exhausted. When an exception is requested, AHCCCS will review certain criteria to determine if the exception will be allowed, these criteria include but are not limited to; the number of providers available in the area, provider willingness to contract with a health plan, the availability of IHS/638 facilities⁴ to serve the American Indian population, and the availability of alternate service delivery mechanisms. Plans are then required to monitor member access to the services covered by the exception while the exception is in place. In CYE 2021 there were no exceptions in place.

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

- ALTCS/EPD and ALTCS/DDD health plans report compliance with minimum requirements for long term care facilities in specific areas of any county served.

⁴ American Indian members are able to receive services from any IHS/638 facility regardless of contracted status with a health plan.

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- All health plans report compliance with network requirements related to Multi-Specialty Interdisciplinary Clinics (MSICs).
- RBHA health plans report compliance with Mobile Crisis Team response time requirements.

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

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

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

Material Changes to the Provider Network – AHCCCS has established reporting requirements for when a significant change is made to a health plan’s provider network in order to evaluate the impact of the change. As outlined in ACOM Policy 439, AHCCCS requires health plans to evaluate changes made to their provider network for materiality. A material change to provider network is defined as any change in the composition of or payments to the health plan’s provider network that would cause or is likely to cause more than five percent of its members in a GSA to change where they receive services, or any change impacting fewer than five percent of members but involving a provider or provider group who is the sole source of a service, or operates in an area with limited alternate sources.

When the health plan identifies a material change to provider network, it submits an assessment of the impact of the change, how the health plan will transition members, a communication plan regarding the change, and how the health plan will monitor the impact of the change after transition (*See Attachment E ACOM 439 Material Change Checklist*). After approval of a material change in provider network, AHCCCS commonly requires periodic reports on the status

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of transitioning members. In CYE 2021, AHCCCS approved and monitored one material change from contracted health plans.

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

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

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