ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Contract Year Ending 2024 External Quality Review Annual Technical Report

April 2025

HSAG HEALTH SERVICES ADVISORY GROUP

Contents

1. Executive Summary

Background

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, required states that contract with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) for administering Medicaid and Children's Health Insurance Program (CHIP) programs to contract with a qualified external quality review organization (EQRO) to provide an independent external quality review (EQR) of the domains of Quality, Timeliness, and Access to services provided by the contracted MCOs (also referred to as Contractors in this report). Revisions to the regulations originally articulated in the BBA were released in the May 2016 Medicaid and CHIP Managed Care Regulations,[1] with further revisions released in November 2020 [2] and May 2024.[3] The final rule is provided in Title 42 of the Code of Federal Regulations (CFR) Part 438 and cross-referenced in the CHIP regulations at 42 CFR Part 457. To comply with 42 CFR 438.358, the Arizona Health Care Cost Containment System (AHCCCS) has contracted with Health Services Advisory Group, Inc. (HSAG), a qualified EQRO. This technical report is intended to help AHCCCS:

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

[1] Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Jan 13, 2025.

[2] Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care. Available at: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care. Accessed on: Jan 13, 2025.

[3] Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality. Available at: https://www.federalregister.gov/documents/2024/05/10/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance. Accessed on: Jan 13, 2025.

Contractors Reviewed

AHCCCS maintains managed care agreements with several Contractors to administer its Medicaid Managed Care program. A general description of each AHCCCS program and the associated Contractors reviewed are included below. No Contractors were exempt from EQR in contract year ending (CYE) 2024.

AHCCCS Complete Care (ACC) Program

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

Table 1-1—ACC Program Contracted MCOs

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

* Contractor serves both the ACC and the ACC-RBHA SMI-Designated populations. Throughout this report, ACC Program discussions are limited to the ACC-RBHA Contractors' Non-SMI-Designated population.
[1] Care1st ACC-RBHA merged with AzCH-CCP ACC-RBHA effective October 1, 2024.

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

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

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

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

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

*The ACC-RBHA Contractors serve both the SMI-Designated population (under the ACC-RBHA program) and the Non-SMI-Designated population (under the ACC program).
[1] Care1st ACC-RBHA merged with AzCH-CCP ACC-RBHA effective October 1, 2024.

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

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

Table 1-3—DCS CHP Program Contracted MCO

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

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

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

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

Table 1-4—ALTCS-EPD Program Contracted MCOs

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

ALTCS Developmental Disabilities (ALTCS-DD) Program

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

Table 1-5—ALTCS-DD Program Contracted MCO

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

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

Program-Level Summary of Findings and Assessment

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

Table 1-6—Timeline for EQR Activities

Activity	EQR Activity Start Date	EQR Activity End Date
Performance Measure Validation (PMV)	03/04/2024	03/30/2025
Performance Improvement Projects (PIPs)	09/09/2024	03/28/2025
Compliance Review	12/11/2023	12/31/2024
Network Adequacy Validation (NAV)	04/09/2024	01/27/2025
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[4]	01/26/2024	12/23/2024

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

ACC Program

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

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

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths related to performance measure validation (PMV): • The rates for all seven ACC Program Contractors and the ACC Program Aggregate rate met or exceeded the National Committee for Quality Assurance (NCQA) Quality Compass®,[5] national Medicaid health maintenance organization (HMO) mean for Healthcare Effectiveness Data and Information Set (HEDIS®)[6] measurement year (MY) 2023 for these measures: – *Follow-Up After Emergency Department (ED) Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)* and *30-Day Follow-Up—Total (13+ Years)* measure rates **[Quality, Timeliness, Access]** – *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* **[Quality, Timeliness, Access]** – *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)* measure rate **[Quality]** • The rates for six of seven ACC Program Contractors and the ACC Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 for these measures: – *Immunization for Adolescents—Combination 1* **[Quality]** – *Follow-Up After Emergency Department (ED) Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* measure rates **[Quality, Timeliness, Access]** – *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* **[Quality, Timeliness, Access]** – *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total (13+ Years)* measure rate **[Quality, Timeliness, Access]** – *Well-Child Visits in the First 30 Months of Life—First 15 Months— Six or More Well-Child Visits* **[Quality]**

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

Strengths, Opportunities for Improvement, and Recommendations

HSAG identified the following strengths related to PIPs:

- For the *Back to Basics* PIP, three ACC Program Contractors were able to achieve statistically significant improvement for both performance indicators when comparing baseline rates to Remeasurement 2 rates. Additionally, another ACC Program contractor had statistically significant improvement for one of the two performance indicators. At Remeasurement 2, one ACC Program Contractor sustained the statistically significant improvement that it achieved at Remeasurement 1 for both performance indicators. **[Quality, Access]**

HSAG identified the following strengths related to compliance reviews:

- The ACC Program Contractors' average compliance score was at or above 95 percent in the following compliance focus areas:
  - Corporate Compliance (CC) **[Quality, Access]**
  - Claims and Information Standards (CIS) **[Access]**
  - Delivery Systems (DS) **[Timeliness, Access]**
  - General Administration (GA) **[Timeliness, Access]**
  - Grants Management (GM) **[Quality, Access]**
  - Grievance Systems (GS) **[Timeliness, Access]**
  - Adult, EPSDT and Maternal Child Health (MCH) **[Quality, Timeliness, Access]**
  - Medical Management (MM) **[Timeliness, Access]**
  - Quality Improvement (QI) **[Quality, Access]**
  - Reinsurance (RI) **[Quality]**
  - Third-Party Liability (TPL) **[Quality, Timeliness, Access]**
  - Integrated Systems of Care (ISOC) **[Quality, Access]**
- In CYE 2024, six of the seven ACC Program Contractors successfully completed all outstanding corrective action plans (CAPs).

HSAG identified the following strengths related to NAV:

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

Strengths, Opportunities for Improvement, and Recommendations

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

- The ACC Program's member experience ratings did not meet or exceed the 75th percentile for any measure; therefore, no substantial strengths were identified for national comparison results for the adult Medicaid population. **[Quality]**
- The adult ACC Program's 2024 scores were not statistically significantly higher than the 2023 scores; therefore, no substantial strengths were identified for trend results for the adult Medicaid population. **[Quality]**

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

- The ACC Program's member experience ratings were above the 90th percentile for *Getting Care Quickly* and *Customer Service* for the general child population. **[Quality, Timeliness]**
- The ACC Program's member experience ratings were at or between the 75th and 89th percentile for *Rating of Health Plan* and *Rating of All Health Care* for the general child population. **[Quality]**
- The ACC Program's member experience rating was above the 90th percentile for *Rating of All Health Care, Coordination of Care for Children with Chronic Conditions, Access to Prescription Medicines,* and *FCC: Getting Needed Information* for the Children with Chronic Conditions (CCC) population. **[Quality, Access]**
- The ACC Program's member experience ratings were at or between the 75th and 89th percentile for *Rating of Health Plan*, *Rating of Personal Doctor, Rating of Specialist Seen Most Often,* and *Getting Care Quickly* for the CCC population. **[Quality]**The ACC Program's 2024 scores were statistically significantly higher than the 2023 scores for *Rating of Health Plan*, *Rating of All Health Care, Rating of Personal Doctor*, *Rating of Specialist Seen Most Often,* and *Access to Prescription Medicines* for the CCC population. **[Quality, Access]**

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

- KidsCare's member experience ratings for *How Well Doctors Communicat*e and *Customer Service* were above the 90th percentile for the general child population. **[Quality]**
- KidsCare's member experience rating for *Rating of Health Plan*, *Rating of All Health Care*, and *Getting Care Quickly* were at or between the 75th and 89th percentile for the general child population. **[Quality, Timeliness]**
- KidsCare's member experience ratings for *How Well Doctors Communicat*e and *Coordination of Care for Children with Chronic Conditions* were above the 90th percentile for the CCC population. **[Quality]**
- KidsCare's member experience ratings for *Rating of Health Plan, Rating of Personal Doctor, Rating of Specialist Seen Most Often, (FCC): Personal Doctor Who Knows Child,* and *FCC:*

Strengths, Opportunities for Improvement, and Recommendations
Getting Needed Information were at or between the 75th and 89th percentile for the CCC population. **[Quality]** • KidsCare's 2024 scores were statistically significantly higher than the 2023 scores for *Rating of Health Plan* for the general child population and *FCC: Personal Doctor Who Knows Child* for the CCC population. **[Quality]**
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement related to PMV: • The rates for all seven ACC Program Contractors and the ACC Program Aggregate rate fell below the NCQA Quality Compass national Medicaid HMO mean for MY 2023 and fell below the 25th percentile (i.e., HEDIS measures) for the following measure: – *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years* **[Quality]** • The rates for four of seven ACC Program Contractors and the ACC Program Aggregate rate fell below both the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and the 25th percentile for this measure: – *Prenatal and Postpartum Care—Postpartum Care* measure rate **[Quality, Timeliness, Access]** Recommendations: • Regarding *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years,* HSAG recommends that ACC Program Contractors consider implementing one or more of these interventions that have been associated with increased medication adherence for members with schizophrenia. In a systematic review of medication adherence studies, several interventions that worked in studies were motivational interviewing, daily texts to individuals with schizophrenia, and other medication reminders. Other effective studies utilized Meds Help, a pharmacy-based intervention, environmental support through home visits and reminders to adhere to medication, a psychoeducational program (FSPP), an intervention called STOP that focuses on the importance of the supervisor's role for patients during treatment, and an individualized occupational therapy (IOT) program.[7] In addition, HSAG recommends that ACC Program Contractors consider utilizing financial incentives offered to patients with severe mental illness improves treatment adherence. • Regarding the *Prenatal and Postpartum Care—Postpartum Care* measure, ACC Program Contractors are currently conducting the *Prenatal and Postpartum Care* PIP, which includes a root cause analysis and interventions to address this measure. HSAG

[7] Cahaya N, Kristina SA, Widayanti AW, et al. Interventions to Improve Medication Adherence in People with Schizophrenia: A Systematic Review. Patient preference and adherence vol. 16 2431-2449. 1 Sep. 2022, doi:10.2147/PPA.S378951. Available at: https://pubmed.ncbi.nlm.nih.gov/36072918/. Accessed on: Feb 13, 2025.

Strengths, Opportunities for Improvement, and Recommendations

recommends that ACC Program Contractors continue monitoring the success of the interventions, and the ACC Program Contractors should submit results as required by AHCCCS.

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

Recommendations: Although there were no opportunities for improvement identified, HSAG recommends that:

- The Contractors seek technical assistance from HSAG to understand the requirements for statistical testing, if needed.
- The Contractors ensure that all interventions are evaluated for effectiveness through a measure directly linked to the intervention.

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

- The ACC Program Contractors' average score was below 95 percent in the following compliance focus areas:
- Member Information (MI) **[Quality]**
- Quality Management (QM) **[Quality]**

Recommendation: HSAG recommends that the ACC Program Contractors continue to work on any outstanding CAPs during CYE 2025.

HSAG identified the following opportunities for improvement related to NAV:

- Isolated data issues may have contributed to specific instances affecting the ACC Program Contractors' compliance with time/distance standards **[Access]**
- Based on the NAV results, more than one ACC Program Contractor did not meet the standards for Behavioral Health Outpatient and Integrated Clinic, Pediatric; Dentist, Pediatric; and Pharmacy. **[Access]**

Recommendations:

- HSAG recommends that AHCCCS support the ACC Program Contractors in continuing to monitor their processes for creating the Provider Affiliation Transmission (PAT) file and review this file for accuracy prior to submitting to AHCCCS.
- HSAG recommends that AHCCCS support each ACC Program Contractor in continuing to monitor and maintain its existing provider network coverage as of CYE 2024 Semiannual Review 1 (S1), with specific attention to ensuring the availability of the following provider categories where more than one ACC Program Contractor did not meet the network requirement:

Strengths, Opportunities for Improvement, and Recommendations

- Behavioral Health Outpatient and Integrated Clinic, Pediatric in Apache, Gila, and Maricopa counties.
- Dentist, Pediatric in Apache, Coconino, Gila, Greenlee, and La Paz counties.
- Pharmacy in La Paz County.

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

- The ACC Program's member experience ratings for *Getting Needed Care*, *Customer Service*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* were below the 25th percentile for the adult Medicaid population. **[Quality, Access]**
- The ACC Program's member experience ratings for *Rating of All Health Care*, *Rating of Specialist Seen Most Often,* and *Getting Care Quickly* were at or between the 25th and 49th percentile for the adult Medicaid population. **[Quality, Timeliness]**
- The ACC Program's 2024 scores were not statistically significantly lower than the 2023 scores; therefore, no substantial weaknesses were identified for trend results for the adult Medicaid population. **[Quality]**

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

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

- The ACC Program's member experience rating for *Rating of Specialist Seen Most Often* was at or between the 25th and 49th percentile for the general child population. **[Quality]**
- The ACC Program's member experience rating for *Coordination of Care* was at or between the 25th and 49th percentile for the general child population. **[Quality]**
- The ACC Program's member experience rating for *Coordination of Care* was at or between the 25th and 49th percentile for the CCC population. **[Quality]**
- The ACC Program's member experience ratings for *Customer Service, Access to Specialized Services*, and *FCC: Personal Doctor Who Knows Child* were below the 25th percentile for the CCC population. **[Quality, Access]**
- The ACC Program's 2024 scores were not statistically significantly lower than the 2023 scores; therefore, no substantial weaknesses were identified for trend results for the general child population. **[Quality]**

Strengths, Opportunities for Improvement, and Recommendations
• The ACC Program's 2024 scores were not statistically significantly lower than the 2023 scores; therefore, no substantial weaknesses were identified for trend results for the CCC population. **[Quality]** Recommendation: HSAG recommends that the ACC Program Contractors explore what may be driving lower experience scores and develop initiatives designed to improve the quality of and access to care, including a focus on improving parents'/caretakers' overall experiences with their child's specialist, personal doctor who knows child, coordination of care, customer service, and access to specialized services for child members. HSAG identified the following opportunities for improvement related to CAHPS results for KidsCare: • KidsCare member experience ratings were at or above the 49th percentile; therefore, no substantial weaknesses were identified for national comparison results for the general child population. **[Quality]** • KidsCare's member experience ratings for *Customer Service*, *Coordination of Care*, and *Access to Prescription Medicines* were at or between the 25th and 49th percentile for the CCC population. **[Quality, Access]** • KidsCare's member experience rating for *Access to Specialized Services* was below the 25th percentile for the CCC population. **[Quality, Access]** • KidsCare's 2024 scores were not statistically significantly lower than the 2023 scores; therefore, no substantial weaknesses were identified for trend results for the general child or CCC population. **[Quality]** Recommendations: HSAG recommends that the KidsCare Contractors explore what may be driving lower experience scores and develop initiatives designed to improve the quality of and access to care, including a focus on improving parents'/caretakers' overall experiences with coordination of care, customer service, access to prescription medicines, and access to specialized services for child members.

ACC-RBHA SMI-Designated Population Program

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

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

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths related to PMV: • Rates for all of the ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Population Program Aggregate rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 for these measures: – *Follow-Up After Emergency Department (ED) Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)* and *30-Day Follow-Up—Total (13+ Years)* **[Quality, Timeliness, Access]** – *Follow-Up After Emergency Department (ED) Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* measure rates **[Quality, Timeliness, Access]** – *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* measure rates **[Quality, Timeliness, Access]** HSAG identified the following strengths related to PIPs: • For the *Preventive Screening* PIP, both ACC-RBHA Contractors adhered to acceptable methodology through all phases of the PIP and were able to measure the effectiveness of interventions and perform accurate statistical testing between the baseline rate and the Remeasurement 2 rate. Both ACC-RBHA Contractors were able to achieve statistically significant improvement for Performance Indicator 1 (*Breast Cancer Screening [BCS]*) when comparing the baseline rate to the Remeasurement 2 rate. **[Quality, Access]** Note: Care1st ACC-RBHA was not required to participate in the *Preventive Screening* PIP for the SMI-Designated population as the PIP was initiated prior to Care1st being awarded the ACC-RBHA contract. Care1st merged with AzCH-CCP ACC-RBHA effective October 1, 2024. HSAG identified the following strengths related to compliance: • The ACC-RBHA Program Contractors' average compliance score was at or above 95 percent in the following compliance focus areas: – Corporate Compliance (CC) **[Quality, Access]** – Claims and Information Standards (CIS) **[Access]** – Delivery Systems (DS) **[Timeliness, Access]** – General Administration (GA) **[Timeliness, Access]** – Grants Management (GM) **[Quality, Access]** – Grievance Systems (GS) **[Timeliness, Access]** – Adult, EPSDT and Maternal Child Health (MCH) **[Quality, Timeliness, Access]** – Medical Management (MM) **[Timeliness, Access]**

Strengths, Opportunities for Improvement, and Recommendations
– Quality Improvement (QI) **[Quality, Access]** – Reinsurance (RI) **[Quality]** – Third-Party Liability (TPL) **[Quality, Timeliness, Access]** – Integrated Systems of Care (ISOC) **[Quality, Access]** • In CYE 2024, two of the three ACC-RBHA Program Contractors successfully completed all outstanding CAPs. HSAG identified the following strengths related to NAV: • The ACC-RBHA Program Contractors received *High Confidence* for both appointment availability and time/distance indicators. **[Access]** • The applicable ACC-RBHA Program Contractors met all minimum time/distance network standards in Cochise, Graham, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. **[Access]** • The ACC-RBHA Program Contractors consistently met Behavioral Health Outpatient and Integrated Clinic, Adult; Behavioral Health Residential Facility (BHRF); Cardiologist, Adult and Pediatric; Crisis Stabilization Facility; Hospital; OB/GYN; PCP, Adult and Pediatric; and Pharmacy standards. **[Access]** HSAG identified the following strengths related to the CAHPS results for the ACC-RBHA SMI-Designated Population Program's adult Medicaid population: • The ACC-RBHA SMI-Designated Population Program's member experience rating for *Discussing Cessation Medications* was at or between the 75th and 89th percentile for the adult Medicaid population. **[Quality]**
Opportunities for Improvement
HSAG identified the following opportunities for improvement related to PMV: • The rates for all of the ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Population Program Aggregate rate did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and fell below the 25th percentile for these measures:* – *Cervical Cancer Screening—21–64 Years* **[Quality]** – *Plan All-Cause Readmissions—O/E Ratio—Total—18–64 Years* **[Quality]** • The rates for two of the ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Population Program Aggregate rate did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and fell below the 25th percentile for these measures: – *Use of Opioids at High Dosage—18+ Years* **[Quality]** – *Breast Cancer Screening—Total (50–74 Years)* **[Quality]**

Strengths, Opportunities for Improvement, and Recommendations
• The rates for one of the ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Population Program Aggregate rate did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and fell below the 25th percentile for these measures: – *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* **[Quality, Timeliness]** Recommendations: • Regarding the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measures, HSAG recommends that these Contractors continue to implement appropriate interventions to improve performance relative to prenatal and postpartum care. HSAG also recommends that the Contractors continue to monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measures. In addition, HSAG recommends that Contractors consider whether there are disparities/social determinants of health (SDOH) within their populations that contributed to lower access to care. A few strategies could include providing expanded access appointments outside of business hours to accommodate work schedules or childcare needs. Further, HSAG recommends that Contractors identify payment structure types that will incentivize quality care. Bundling payments may cause disincentives for postpartum care, as providers might receive the same payment regardless of whether the member attends the postpartum visit.[8] • Regarding the *Use of Opioids at High Dosage—18+ Years* measure, HSAG recommends that these Contractors continue to implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse. HSAG also recommends that the ACC-RBHA Contractors monitor and expand on interventions currently in place to improve performance related to the *Use of Opioids at High Dosage—18+ Years* measure. • Regarding the *Plan All-Cause Readmissions—O/E Ratio—Total—18–64 Years* measure, HSAG recommends that these Contractors continue to follow through on performance improvement strategies to increase provider and member outreach and improve follow-up care after discharge from an acute inpatient admission or observation. HSAG recommends that Contractors consider reviewing the Re-Engineered Discharge (RED), which has been shown to reduce readmissions and posthospital ED visits.[9] Other interventions that might be effective include technology platforms, including AI or machine learning, that can assist the plans in identifying members more at risk of readmission. HSAG recommends that

[8] Centers for Medicare & Medicaid Services. Lessons Learned about Payment Strategies to Improve Postpartum Care in Medicaid and CHIP. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/postpartum-payment-strategies.pdf. Accessed on: Feb 19, 2025.

[9] Agency for Healthcare Research and Quality. Re-Engineered Discharge (RED) Toolkit. Available at: https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool1.html. Accessed on: Feb 13, 2025.

Strengths, Opportunities for Improvement, and Recommendations

Contractors utilize case management strategies which focus on person-centered techniques, addressing barriers and/or SDOH as needed.

- Regarding the *Cervical Cancer Screening—21–64 Years* and *Breast Cancer Screening—Total (50–74 Years)* measures, HSAG recommends that the ACC-RBHA Contractors leverage interventions and root cause analyses identified through the *Preventive Screening* PIP to improve performance related to preventive screenings. HSAG recommends that the Contractors monitor and expand on interventions currently in place to improve performance related to these measures. HSAG recommends that Contractors consider utilizing one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve screening rates. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness.

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

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

HSAG identified the following opportunities for improvement related to PIPs:

- Both ACC-RBHA Contractors' Performance Indicator 2 (*Cervical Cancer Screening [CCS]*) rates demonstrated a decline at Remeasurement 2 compared to the baseline indicator rates for the *Preventive Screening* PIP. **[Quality, Access]**

  Note: Care1st ACC-RBHA was not required to participate in the *Preventive Screening* PIP for the SMI-Designated population as the PIP was initiated prior to Care1st being awarded the ACC-RBHA contract. Care1st merged with AzCH-CCP ACC-RBHA effective October 1, 2024.

  Recommendations:

  - HSAG recommends that the Contractors revisit the causal/barrier analysis used to develop interventions and adjust the existing interventions or develop new interventions to facilitate improvement for the *CCS* performance indicator.
  - HSAG recommends that the Contractors continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.

Strengths, Opportunities for Improvement, and Recommendations

- HSAG recommends that the Contractors seek technical assistance from HSAG to understand the PIP submission requirements, if needed.

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

- The ACC-RBHA Program Contractors' average score was below 95 percent in the following compliance focus areas:
  - Member Information (MI) **[Quality]**
  - Quality Management (QM) **[Quality]**

  Recommendation: HSAG recommends that the ACC-RBHA Program Contractors continue to work on any outstanding CAPs during CYE 2025.

HSAG identified the following opportunities for improvement related to NAV:

- Isolated data issues may have contributed to specific instances affecting the ACC-RBHA Program Contractors' compliance with time/distance standards **[Access]**

  Recommendation: HSAG recommends that AHCCCS support the ACC-RBHA Program Contractors in continuing to monitor their processes for creating the PAT file and review this file for accuracy prior to submitting to AHCCCS.

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

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

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

*Reflective of performance measure rates with sufficient denominators for reporting.

DCS CHP Program

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

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

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths related to PMV: • DCS CHP met or exceeded the NCQA Quality Compass national Medicaid HMO mean and was at or above the 90th percentile for HEDIS MY 2023 for these measures: – *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)* **[Quality]** – *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* **[Quality]** – *Child and Adolescent Well-Care Visits—Total (3–21 Years)* **[Quality, Timeliness]** • DCS CHP met or exceeded the NCQA Quality Compass national Medicaid HMO mean and was at or between the 75th and 89th percentile for HEDIS MY 2023 for these measures: – *Well-Child Visits in the First 30 Months of Life—First 15 Months—Six or More Well-Child Visits* **[Quality, Access]** – *Well-Child Visits in the First 30 Months of Life—15 Months to 30 Months—Two or More Well-Child Visits* **[Quality, Access]** • DCS CHP demonstrated strength in providing pediatric care for members. **[Quality]** HSAG identified the following strengths related to PIPs: • DCS CHP adhered to acceptable methodology through all phases of the *Back to Basics* PIP. The Contractor achieved statistically significant improvement between the baseline rate and the Remeasurement 2 rate for the *Child and Adolescent Well-Care Visits (WCV)* performance indicator. **[Quality, Access]** HSAG identified the following strengths related to compliance reviews: • DCS CHP successfully closed CAPs in the following focus areas: – General Administration (GA) **[Timeliness, Access]** – Medical Management (MM) **[Timeliness, Access]** – Member Information (MI) **[Quality]**

Strengths, Opportunities for Improvement, and Recommendations
HSAG identified the following strengths related to NAV: • The DCS CHP subcontracted health plan received *High Confidence* for both appointment availability and time/distance indicators. **[Access]** • The DCS CHP subcontracted health plan met all minimum time/distance network standards in Cochise, Gila, Graham, Maricopa, Mohave, Navajo, Pinal, Santa Cruz, Yavapai, and Yuma counties. **[Access]** • The DCS CHP subcontracted health plan consistently met Behavioral Health Outpatient and Integrated Clinic, Pediatric; Cardiologist, Pediatric; Hospital; OB/GYN; and PCP, Pediatric standards. **[Access]** HSAG identified the following strengths related to the CAHPS results for DCS CHP**:** • DCS CHP's member experience rating for *Customer Service* was at or above the 90th percentile for the general child and CCC populations. **[Quality]** • DCS CHP's member experience ratings for *Rating of All Health Care*, *Rating of Personal Doctor*, and *Getting Care Quickly* were at or between the 75th and 89th percentile for the general child population. **[Quality, Timeliness]** • DCS CHP's 2024 score for *Customer Service* was statistically significantly higher than the 2023 score for the general child and CCC populations. **[Quality]**
Opportunities for Improvement and Recommendations
HSAG identified no opportunities for improvement related to PMV. Recommendations: Although there were no opportunities for improvement identified, HSAG recommends that: • DCS CHP continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. • DCS CHP continue to ensure that the mapping of provider specialties to HEDIS provider types is compliant with AHCCCS' requirements for PMV reporting. • DCS CHP continue to maintain its partnership with Mercy Care which allows DCS CHP to appropriately report the AHCCCS PMV measures. • DCS CHP continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES. HSAG identified no opportunities for improvement related to the *Back to Basics* PIP. Recommendation: Although there were no opportunities for improvement identified, HSAG recommends that DCS CHP continue to implement identified interventions with clearly defined

Strengths, Opportunities for Improvement, and Recommendations

intervention effectiveness measures to assess the effectiveness of each intervention as the PIP progresses.

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

- DCS CHP has remaining CAPs in the following focus areas:
  - Delivery Systems (DS) **[Timeliness, Access]**
  - Adult, EPSDT and Maternal Child Health (MCH) **[Quality, Timeliness, Access]**
  - Quality Management (QM) **[Quality]**
  - Quality Improvement (QI) **[Quality, Access]**

Recommendation: HSAG recommends that DCS CHP continue to work on outstanding CAP items and submit to AHCCCS in the approved time frame.

HSAG identified the following opportunities for improvement related to NAV:

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

Recommendation: The DCS CHP subcontracted health plan should maintain current compliance and continue to address network gaps for Dentist, Pediatric in Apache, Greenlee, and La Paz counties.

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

- DCS CHP's member experience rating for *Rating of Specialist Seen Most Often* was below the 25th percentile for the general child population. **[Quality]**
- DCS CHP's member experience ratings for *Rating of Health Plan*, *Rating of Specialist Seen Most Often, Getting Needed Care*, *Getting Care Quickly*, *Coordination of Care, Access to Specialized Services*, *FCC: Personal Doctor Who Knows Child, Coordination of Care for Children with Chronic Conditions*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information* were below the 25th percentile for the CCC population. **[Quality, Timeliness, Access]**
- DCS CHP's member experience ratings for *Rating of Health Plan*, *Getting Needed Care*, and *Coordination of Care* were at or between the 25th and 49th percentile for the general child population. **[Quality, Access]**
- DCS CHP's member experience rating for *How Well Doctors Communicate* was at or between the 25th and 49th percentile for the CCC population. **[Quality]**
- DCS CHP's 2024 score for *How Well Doctors Communicate* was statistically significantly lower than the 2023 score for the general child population. **[Quality]**

Strengths, Opportunities for Improvement, and Recommendations
• DCS CHP's 2024 scores were not statistically significantly lower than the 2023 scores; therefore, no substantial weaknesses were identified for trend results for the CCC population. **[Quality]** Recommendation: HSAG recommends that DCS CHP explore what may be driving lower experience scores and develop initiatives designed to improve the quality of and access to care, including a focus on improving parents'/caretakers' overall experiences with the health plan, specialist seen most often, getting needed care/information, access to care in a timely manner, access to prescription medicines, and coordination of care for child members.

ALTCS-EPD Program

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

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

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths related to PMV: • All three ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 for these measures: – *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total (18+ Years)* measure rates **[Quality]** – *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total (13+ Years)* measure rate **[Quality, Timeliness, Access]** – *Controlling High Blood Pressure—18–85 Years)* measure rate **[Quality]** – *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%))—Total (18–75 Years)* and *HbA1c Poor Control (>9.0%))—Total (18–75 Years)* measure rates **[Quality]** – *Plan All-Cause Readmissions—O/E Ratio—Total (18–64 Years)* measure rate **[Quality]** HSAG identified the following strengths related to PIPs: • All ALTCS-EPD Contractors adhered to acceptable methodology through all phases of the *Breast Cancer Screening* PIP and were able to achieve improvement when comparing the baseline rate to the Remeasurement 2 rate. **[Quality, Access]**

Strengths, Opportunities for Improvement, and Recommendations
HSAG identified the following strengths related to compliance reviews: • One of the three ALTCS-EPD Program Contractors that underwent compliance reviews in CYE 2023 successfully completed all remaining CAPs during CYE 2024. **[Quality]** HSAG identified the following strengths related to NAV: • The ALTCS-EPD Program Contractors received *High Confidence* for both appointment availability and time/distance indicators. **[Access]** • The ALTCS-EPD Program Contractors met all minimum time/distance network standards for all assigned counties. **[Access]**
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement related to PMV: • All three ALTCS-EPD Program Contractors' rates and the ALTCS-EPD Program Aggregate rate failed to meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and fell below the 25th percentile for these measures: – *Initiation and Engagement of Substance Abuse Disorder Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* **[Quality, Timeliness, Access]** – *Breast Cancer Screening—Total (50–74 Years)* **[Quality]** – *Cervical Cancer Screening—21–64 Years* **[Quality]** – *Use of Opioids at High Dosage—18+ Years* **[Quality]** Recommendations: • *Initiation and Engagement of Substance Abuse Disorder Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* measure, HSAG recommends that the ALTCS-EPD Program Contractors continue all efforts being made to conduct a root cause analysis or focus study to determine why some members are not accessing SUD services or MAT following their initiation visit. HSAG recommends that the ALTCS-EPD Program Contractors review patient data for any patterns present by ZIP Code and other demographics for case management prioritization. One study suggests that members who are male and have a schizophrenia spectrum disorder diagnosis are less likely to initiate treatment, while current drug dependence and recent arrest were associated with lowered odds of engaging in treatment. Current drug dependence is associated with factors that make scheduling and attending treatment appointments difficult, such as severe symptoms, chaotic living situations, and self-care and life functioning issues.[10]

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

Strengths, Opportunities for Improvement, and Recommendations
• Regarding the *Use of Opioids at High Dosage—18+ Years* measure, HSAG recommends that the ALTCS-EPD Program Contractors continue to evaluate their opioid prescription monitoring efforts to identify opportunities to enhance oversight of prescription opioids at a high dosage. Through this process, each ALTCS-EPD Program Contractor should determine if it is necessary to deploy additional mechanisms to identify members who may be at high risk for opioid overuse and misuse, as literature suggests there is a correlation between high dosages of prescription opioids and the risk of both fatal and nonfatal overdoses.[11] Each ALTCS-EPD Program Contractor should continue to report any completed prescription opioid monitoring effort enhancements to AHCCCS. HSAG also recommends that ALTCS-EPD Program Contractors identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts. • Regarding the *Breast Cancer Screening—Total (50–74 Years)* measure, ALTCS-EPD Program Contractors are currently conducting the *Breast Cancer Screening* PIP, which includes a root cause analysis and interventions to address this measure; therefore, HSAG recommends that the ALTCS-EPD Program Contractors continue all efforts being made to conduct a root cause analysis or focus study to determine why some female members are not receiving timely screenings for breast cancer. • Regarding the *Cervical Cancer Screening—21–64 Years* measure, HSAG recommends that ALTCS-EPD Program Contractors consider utilizing one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve cervical cancer screening rates. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that ALTCS-EPD Program Contractors provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge. • Starting in CY 2022 performance measure reporting, RES is required based on NCQA HEDIS specifications. While HSAG noted that two of the three ALTCS-EPD Contractors could benefit from improvement in performance measure reporting using RES, all ALTCS-EPD Contractors could benefit from continuing to focus on refining RES reporting where required in keeping with measure specifications. **[Quality]** Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors continue to explore data sources for the capture of race and ethnicity data to support performance measure reporting that requires stratifications related to RES. The ALTCS-EPD Program Contractors should continue to work with AHCCCS on collaborative efforts to improve the completion and

[11] National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/ Accessed on: Feb 23, 2025.

Strengths, Opportunities for Improvement, and Recommendations
accuracy of race and ethnicity data and explore other methods to augment enrollment data information. HSAG identified no program-level opportunities for improvement or recommendations related to the *Breast Cancer Screening* PIP. HSAG identified the following opportunities for improvement related to compliance reviews: • Two of the three ALTCS-EPD Program Contractors have remaining CAPs in the following focus areas: – Case Management (CM) **[Quality, Access]** – Quality Management (QM) **[Quality]** Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors continue to work on outstanding CAP items and submit updates to AHCCCS in the approved time frame, as applicable. HSAG identified the following opportunities for improvement related to NAV: • Isolated data issues may have contributed to specific instances affecting the ALTCS-EPD Program Contractors' compliance with time/distance standards **[Access]** Recommendation: HSAG recommends that AHCCCS support the ALTCS-EPD Program Contractors in continuing to monitor their processes for creating the PAT file and review this file for accuracy prior to submitting to AHCCCS.

ALTCS-DD Program

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

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

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths related to PMV: • DES/DDD's performance measure rates were at or above the 90th percentile for these measures:

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– *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)—Total (18–75 Years)* and *HbA1c Poor Control (>9.0%)—Total (18–75 Years)* **[Quality]** – *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* **[Quality, Timeliness, Access]** – *Controlling High Blood Pressure—18—85 Years* **[Quality]** • DES/DDD's performance measure rates were at or between the 75th and 89th percentile for these measures: – *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)* **[Quality]** – *Antidepressant Medication Management—Effective Continuation Phase Treatment—Total (18+ Years)* **[Quality]** HSAG identified the following strengths related to the *Back to Basics* PIP: • The DES/DDD Contractor adhered to acceptable methodology through all phases of the PIP and was able to achieve statistically significant improvement at Remeasurement 2 when compared to the baseline rate, sustaining the statistically significant improvement achieved at Remeasurement 1. **[Quality, Access]** HSAG identified the following strengths related to compliance reviews: • AHCCCS conducted a compliance review of DES/DDD during CYE 2024 and the final results will be reported in CYE 2025 EQR Technical Report. **[Quality]** HSAG identified the following strengths related to NAV: • The DES/DDD subcontracted health plans received *High Confidence* for both appointment availability and time/distance indicators. **[Access]** • The DES/DDD subcontracted health plans met all minimum time/distance network standards for Cochise, Coconino, Graham, Maricopa, Mohave, Navajo, Pinal, Santa Cruz, Yavapai, and Yuma counties. **[Access]** • The DES/DDD subcontracted health plans consistently met Cardiologist, Pediatric; Hospital; and OB/GYN standards. **[Access]**
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement related to PMV: • DES/DDD performance measure rates fell below the 25th percentile for these measures: – *Childhood Immunization Status—Combination 7* **[Quality]** – *Cervical Cancer Screening—21–64 Years* **[Quality]**

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Recommendations:

- Regarding the *Cervical Cancer Screening—21–64 Years* measure, HSAG recommends that DES/DDD consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended cancer screenings and make appropriate health decisions. HSAG recommends that DES/DDD consider utilizing one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve cervical cancer screening rates. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that DES/DDD provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge. In addition, HSAG recommends that DES/DDD work with its subcontracted health plans to analyze their data and consider if there are disparities within DES/DDD's populations that contributed to lower screening rates.
- Regarding the *Childhood Immunization Status—Combination 7* measure, HSAG continues to recommend that DES/DDD identify best practices to support children in receiving preventive vaccinations according to recommended schedules. HSAG recommends that DES/DDD provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.

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

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

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

Recommendation: Although there were no opportunities for improvement identified, HSAG recommends that DES/DDD continue to implement identified interventions with clearly defined

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intervention effectiveness measures to assess the effectiveness of each intervention as the PIP progresses.

HSAG identified no opportunities for improvement related to compliance reviews as the results from the CYE 2024 compliance review of DES/DDD were not available at the time this report was being written.

HSAG identified the following opportunities for improvement related to NAV:

- Isolated data issues may have contributed to specific instances affecting the DES/DDD subcontracted health plans' compliance with time/distance standards **[Access]**
- Based on the NAV results, neither of the DES/DDD subcontracted health plans met these standards: Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult; and Dentist, Pediatric. **[Access]**

Recommendations:

- HSAG recommends that AHCCCS support the DES/DDD subcontracted health plans in continuing to monitor their processes for creating the PAT file and review this file for accuracy prior to submitting to AHCCCS.
- HSAG recommends that AHCCCS support each DES/DDD subcontracted health plan in continuing to monitor and maintain its existing provider network coverage as of CYE 2024 S1, with specific attention to ensuring the availability of the following provider categories where both DES/DDD subcontracted health plans did not meet the network requirement:
  - Behavioral Health Outpatient and Integrated Clinic, Adult in Apache County.
  - Cardiologist, Adult in Apache County.
  - Dentist, Pediatric in Apache, Gila, Greenlee, and La Paz counties.

2. Introduction to the EQR Technical Report

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

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

ACC Program

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

Table 2-1 presents the EQR activities reviewed in this report for ACC Program Contractors. In addition to the activities listed in the table below, CAHPS survey results for the KidsCare and ACC populations are presented at the aggregate level in Section 4. ACC Program-Level Comparative Results.

Table 2-1—EQR Activities Presented in the CYE 2024 External Quality Review Annual Technical Report for the ACC Program

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

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

[1] Care1st ACC-RBHA merged with AzCH-CCP ACC-RBHA effective October 1, 2024.

For additional information and Contractor-specific findings for PMV (performance measure list beginning on page A-9), PIP validation, compliance reviews, and NAV, see Section 5. ACC Program Contractor-Specific Results.

ACC-RBHA SMI-Designated Population Program

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

Table 2-2 presents the EQR activities reviewed in this report for ACC-RBHA Program Contractors. In addition to the activities listed in the table below, CAHPS survey results for the ACC-RBHA SMI-Designated Population Program are presented at the aggregate level in Section 6—ACC-RBHA SMI-Designated Population Program-Level Comparative Results.

Table 2-2—EQR Activities Presented in the CYE 2024 External Quality Review Annual Technical Report for the ACC-RBHA Program

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

* Care1st ACC-RBHA was not required to participate in the *Preventive Screening* PIP for the SMI-Designated population as the PIP was initiated prior to Care1st being awarded the ACC-RBHA contract. The *Prenatal and Postpartum Care* PIP was not validated by HSAG in CYE 2024. Care1st ACC-RBHA merged with AzCH-CCP ACC-RBHA effective October 1, 2024.

For additional information and Contractor-specific findings, see Section 7. ACC-RBHA SMI-Designated Population Program Contractor-Specific Results.

DCS CHP Program

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

Table 2-3 presents the EQR activities reviewed in this report for the DCS CHP Program. In addition to the activities listed in the table below, CAHPS survey results for the DCS CHP population are presented at the aggregate level in Section 8. DCS CHP Program Results.

Table 2-3—EQR Activities Presented in the CYE 2024 External Quality Review Annual Technical Report for the DCS CHP Program

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

For additional information and Contractor-specific findings for PMV, PIP validation, compliance reviews, and NAV, see Section 8. DCS CHP Program Results.

ALTCS-EPD Program

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

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

Table 2-4—EQR Activities Presented in the CYE 2024 External Quality Review Annual Technical Report for the ALTCS-EPD Program

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

For additional information and Contractor-specific findings for PMV, PIP validation, compliance reviews, and NAV, see Section 10. ALTCS-EPD Program Contractor-Specific Results.

ALTCS-DD Program

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

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

Table 2-5—EQR Activities Presented in the CYE 2024 External Quality Review Annual Technical Report for the ALTCS-DD Program

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

For additional information and Contractor-specific findings for PMV, PIP validation, compliance reviews, and NAV, see Section 11. ALTCS-DD Program Results.

Assessing Quality, Timeliness, and Access

HSAG used the following definitions to evaluate and draw conclusions about the performance of the Medicaid Contractors in each of the domains of Quality, Timeliness, and Access. For more information on how HSAG assessed the Quality, Timeliness, and Access domains for each activity, see the How Conclusions Were Drawn subsection for each EQR-related activity in Appendix A. Methodology.

Quality

CMS defines "Quality" in 42 CFR 438.320 as follows:

> Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or primary care case management (PCCM) entity (described in 438.310[c][2]) increases the likelihood of desired outcomes of its enrollees through:
>
> - Its structural and operational characteristics
> - The provision of services that are consistent with current professional, evidence-based knowledge
> - Interventions for performance improvement[12]

Timeliness

NCQA defines "Timeliness" relative to utilization decisions as follows:

> The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation.[13] NCQA further discusses the intent of this standard as being to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other managed

[12] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.
[13] National Committee for Quality Assurance. 2024 Standards and Guidelines for Accreditation of Health Plans.

care provisions that impact services to beneficiaries and that require timely response by the Contractor—e.g., processing expedited appeals and providing timely follow-up care.

AHRQ defines "Timeliness" as follows:

> Timeliness is the health care system's capacity to provide health care quickly after a need is recognized. Timeliness includes the interval between identifying a need for specific tests and treatments and receiving those services.[14]

Access

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).[15]

Overview of the Report Sections

Section 1—Executive Summary describes the authority under which the report must be provided, as well as the Contractors reviewed during calendar year (CY) 2024. In addition, this section includes a program-level summary of strengths, opportunities for improvement, and recommendations for program-level performance improvement.

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

Section 3—Overview of AHCCCS provides a description of AHCCCS':

- Medicaid Managed Care Program History
- Waivers and Legislative Updates
- Strategic Plan
- Key Initiatives and Accomplishments

[14] Agency for Healthcare Research and Quality. *National Healthcare Quality and Disparities Reports.* Elements of Access to Health Care: Timeliness. Available at: https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/access/elements3.html. Accessed on: Jan 13, 2025.

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

- Medicaid and CHIP Quality Strategy as well as HSAG's recommendations for targeting goals and objectives for QI

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

Section 5—ACC Program Contractor-Specific Results provides, by ACC and ACC-RBHA Contractor, activity-specific strengths, opportunities for improvement, and HSAG's recommendations for performance improvement for the ACC population. This section also includes information about the extent to which each Contractor was able to address the prior year's recommendations for each activity. ACC and ACC-RBHA Contractors are responsible for the provision of services under the ACC Program.

Section 6—ACC-RBHA SMI-Designated Population Program-Level Comparative Results includes ACC-RBHA program-level comparative results for the SMI-Designated population, organized by EQR-related activity, which includes strengths, opportunities for improvement, and HSAG's recommendations for program-level performance improvement. This section also includes aggregate CAHPS survey results for the ACC-RBHA SMI-Designated population.

Section 7—ACC-RBHA SMI-Designated Population Program Contractor-Specific Results provides, by ACC-RBHA Contractor, activity-specific strengths, opportunities for improvement, and HSAG's recommendations for performance improvement. This section also includes information about the extent to which each Contractor was able to address the prior year's recommendations for each activity, as applicable.

Section 8—DCS CHP Program Results provides, by EQR activity, DCS CHP activity-specific strengths, opportunities for improvement, and HSAG's recommendations for performance improvement. This section also includes information about the extent to which DCS CHP was able to address the prior year's recommendations for each activity. This section also includes CAHPS survey results for the DCS CHP Program. DCS CHP provides services through a subcontracted health plan, Mercy Care DCS CHP.

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

Section 10—ALTCS-EPD Program Contractor-Specific Results provides, by ALTCS-EPD Contractor, activity-specific strengths, opportunities for improvement, and HSAG's recommendations (as applicable) for performance improvement. This section also includes information about the extent to which each Contractor was able to address the prior year's recommendations.

Section 11—ALTCS-DD Program Results provides, by EQR activity, ALTCS-DD activity-specific strengths, opportunities for improvement, and HSAG's recommendations for performance improvement.

This section also includes information about the extent to which DES/DDD was able to address the prior year's recommendations.

Appendix A. Methodology presents, for each EQR activity:

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

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

Appendix B—Acknowledgements and Copyrights

3. Overview of AHCCCS

This section provides a description of AHCCCS':

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

AHCCCS Medicaid Managed Care Program History

Since 1982, AHCCCS, the single state Medicaid agency for Arizona, has operated under the authority of the federal Medicaid Demonstration 1115 Waiver under Section 1115 of the Social Security Act, which has allowed for the operation of an integrated managed care model. AHCCCS uses federal, State, and county funds to administer pediatric, acute, long-term, and behavioral healthcare programs to the State's Medicaid members. AHCCCS has an appropriated budget of approximately $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 individuals who are elderly and/or who have physical disabilities. ALTCS provides physical health services, behavioral health services, long-term care services, and Contractor-provided case management to AHCCCS members who are elderly, physically disabled, or developmentally disabled and who meet the criteria for receiving care in a home and community based setting. Services for individuals with IDD in ALTCS are offered through the Arizona Department of Economic Security, Division of Developmental Disabilities (DES/DDD). Members in the ALTCS programs account for less than 4.0 percent of the AHCCCS population, with approximately 28 percent of the costs. American Indian/Alaska Native (AI/AN) members may choose to receive services through the managed care structure or may opt to receive services through the fee-for-service (FFS) program. Services for children in the foster care system are offered through the DCS CHP Program (previously Comprehensive Medical and Dental Program or CMDP).

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

KidsCare Program. Children who qualify for KidsCare receive care through AHCCCS Contractors.[16] In October 2013, children enrolled in the Acute Care Program who had a Children's Rehabilitative Services (CRS) qualifying diagnosis were enrolled into one integrated CRS Contractor, UHCCP. This was done to decrease fragmentation and reduce member confusion; ensure optimal access to primary, specialty, and behavioral health care; enhance coordination of all service delivery; improve member outcomes and satisfaction; and streamline administration. At the same time, children with CRS qualifying conditions who were enrolled in the ALTCS Program, other than in DDD, were fully integrated into their ALTCS-EPD Contractors' provided services, including all primary, specialty, long-term, and behavioral health care related to the members' CRS conditions. Beginning October 1, 2019, members enrolled with DES/DDD began to use their assigned DES/DDD subcontracted health plan for all of their CRS services. DES/DDD continues to provide long-term care services for these members.

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

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

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

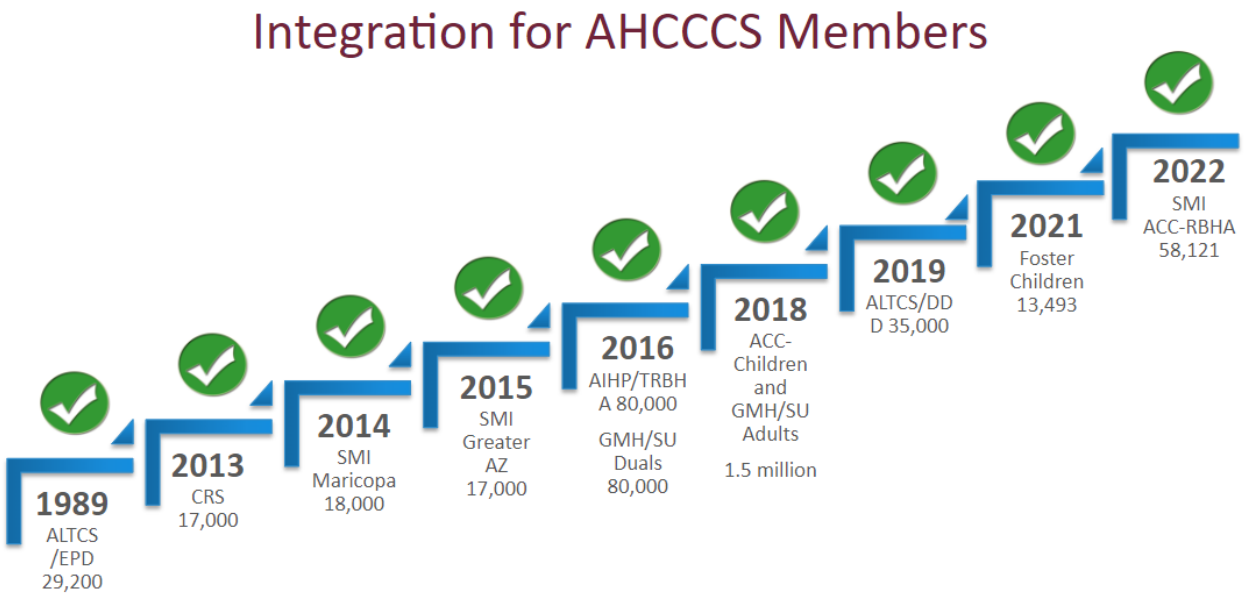
Effective October 1, 2018, AHCCCS implemented a delivery system reform that allowed members who were not enrolled in an ALTCS-EPD Program to access physical as well as general mental health and substance use behavioral healthcare services, previously provided through a RBHA, through a single integrated delivery system model, ACC, with seven Contractors. In addition, on October 1, 2018, service

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

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

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

Effective October 1, 2022, AHCCCS, through its competitive contract expansion (CCE), expanded the contracts for three ACC Contractors to include RBHA services, thus furthering integration efforts, under the AHCCCS Complete Care–Regional Behavioral Health Agreement (ACC-RBHA) Program. ACC-RBHAs continue to provide specific services to individuals with an SMI designation who are not in an ALTCS Program, as well as the first 24 hours of crisis services.[17]



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

AHCCCS Waivers and Legislative Updates

1115 Waiver Update

On October 14, 2022, AHCCCS received approval for its five-year renewal of Arizona's Demonstration project under Section 1115 of the Social Security Act. This renewal is effective through September 30, 2027. The current Demonstration exempts Arizona from particular provisions of the Social Security Act and also includes expenditure authority permitting federal financial participation (FFP) for State expenditures that would not otherwise qualify for federal participation. Moreover, Demonstration projects must be budget neutral, meaning Medicaid costs to the federal government must not exceed the costs incurred in the absence of the Demonstration.

The current 1115 Waiver approval continues the long-standing authorities and programs that have made Arizona's Medicaid program innovative, effective, and efficient. This includes integrated managed care for AHCCCS populations through ACC; ALTCS; DCS CHP for children in foster care; and ACC-RBHAs for individuals with an SMI designation, payments to providers participating in the Targeted Investments 2.0 (TI 2.0) Program, and Waiver of Prior Quarter Coverage for specific populations.

More details on Arizona's Section 1115 Waiver renewal approval (2022–2027), along with the proposal, approval letter, Special Terms and Conditions (STCs), and supplemental documentation can be found on the AHCCCS Section 1115 Demonstration Waiver (2022–2027) webpage.[18]

In addition to renewing these historic programs, this 1115 Waiver includes approval for transformative projects intended to advance member health outcomes including:

- Authority to enhance and expand housing services and interventions for AHCCCS members who are homeless or at risk of becoming homeless through the Housing and Health Opportunities (H2O) program with a target implementation date of October 1, 2024.
- Authority to direct Contractors to make specific incentive payments to providers who meet the criteria for receiving these payments with the goal of improving health equity for target populations by addressing health-related social needs (HRSN) through the TI 2.0 Program.
- Authority to reimburse IHS and Tribal 638 facilities to cover the cost of adult dental services that are eligible for 100 percent FFP, that are in excess of the $1,000 emergency dental limit for adult members in Arizona's State Plan, and that are in excess of the $1,000 dental limit for individuals ages 21 years or older enrolled in AHCCCS.
- Authority to increase the upper income limit of CHIP, otherwise known as KidsCare in Arizona, from 200 percent of the Federal Poverty Level (FPL) to 225 percent of the FPL.

[18] Arizona Section 1115 Demonstration Waiver. Available at: https://www.azahcccs.gov/Resources/Federal/waiver.html. Accessed on: Jan 13, 2025.

- Authority to make permanent AHCCCS' ability to reimburse parents as paid caregivers of their ALTCS-enrolled minor children with disabilities.

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

On December 3, 2024, AHCCCS submitted an amendment to this existing waiver application wherein the agency intends to extend eligibility for full Medicaid state plan benefits to FFY who are under age 26, who turned 18 on or before December 31, 2022, who were in foster care under the responsibility of another state or tribe on the date of attaining 18 years of age, were enrolled in Medicaid on the date of aging out of foster care, and are now applying for Medicaid in Arizona. The public comment period on the latest amendment request concluded on October 10, 2024. The application is currently under review by CMS, and negotiations with AHCCCS are underway. If approved, the amendment will run concurrently with AHCCCS' requested renewal period through September 30, 2027.

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

New Waiver Program Implementation Updates

Housing and Health Opportunities (H2O)

In accordance with STCs, AHCCCS has completed the following H2O-related deliverables and tasks:

- Submitted revised versions of the New Initiatives Implementation Plan and Protocol for Assessment of Beneficiary Eligibility and Needs, Provider Qualifications for H2O services, and Implementation Plan.
- Received CMS approval of the New Initiatives Implementation Plan on May 9, 2024.
- Submitted revised H20 Evaluation Design on May 28, 2024, incorporating CMS' recommendations.
- Continued workgroup meetings with internal AHCCCS subject matter experts (SMEs) to develop items related to the 1115 Waiver and support the implementation of the H2O Program such as establishing rates and payment methodologies, determining HRSN grievance and appeal processes,

establishing internal and external communication strategies, and developing housing-related billing guidance.

- Applied and was accepted into the Housing Accelerator program and continued participation in regular technical assistance (TA) sessions with other states with HRSN waivers and received TA from SMEs, including an in-person convening in Washington, D.C., where AHCCCS staff discussed implementation strategies with federal partners.
- Strategized with CMS about accessing H2O Infrastructure funds prior to receiving approval on H2O Protocol; subsequently received CMS approval to access and began the recruiting process for key H2O administrative personnel.
- Collaborated internally to develop a request for proposal (RFP) for the third party administrator, now known as the H2O program administrator (H2O-PA).
- Developed an internal team of SMEs to score proposals for the H2O program administrator, selected a vendor, and provided notification of the selection.
- Finalized the procurement process to select an H2O program administrator and awarded the contract on June 28, 2024.
- Held community stakeholder sessions to inform shelter providers of the proposed rate for the Enhanced Shelter intervention, receiving feedback to inform the rate methodology for H2O services.
- Received CMS approval of the Protocol for Infrastructure Planning for H2O Services on July 11, 2024.
- Received CMS approval of the Protocol for Assessment of Beneficiary Eligibility and Needs, and Provider Qualifications for H2O Services on August 2, 2024.
- Received CMS approval of the H20 Evaluation Design on August 30, 2024.

On October 1, 2024, AHCCCS began implementation with the most acute member populations, focusing on those with an SMI designation who are also experiencing homelessness (or housing instability) and have an identified chronic health condition, or experienced justice involvement within 90 days.

Targeted Investments (TI) 2.0

A summary of the implementation activities AHCCCS has conducted for the renewal program (TI 2.0):

- Conducted a comprehensive needs assessment via focus groups, surveys, interviews, and other mediums to continue improving program administration and understanding of challenges related to TI 2.0 initiatives from many diverse perspectives.
- On February 5, 2024, hosted the live TI 2.0 kickoff event with 350 representatives from participating organizations, health plans, Accountable Care Organizations (ACOs) and Clinically Integrated Networks (CINs).
- Published milestones reflecting targets and deliverables for the next two years of the program.
- Created and piloted a prototype customer relationship management (CRM) tool to organize and track participation in the program and continued development of core features.

- Coordinated and reviewed 70 justice clinic applications with justice stakeholders and awarded more than 50 clinics statewide.
- Drafted content for computer-based training modules and design of quality improvement project deliverables that participants and stakeholders will reference throughout the program.
- Facilitated ongoing Health Information Exchange (HIE) reports to enrich AHCCCS' race and ethnicity data of AHCCCS members based on electronic medical record (EMR).
- Scrutinized and validated TI 2.0 application data with address, licensing, and other statuses maintained by CMS' National Plan and Provider Enumeration System (NPPES), AHCCCS (provider enrollment), and Arizona Department of Health Services (ADHS-licensure) for nearly 140 organizations and 500 clinics, statewide.
- Created document validation criteria that will be used to identify evidence-based requirements that must be included in Year 2 and Year 3 processes.
- Explored data sharing opportunities with other State agencies (e.g., ADHS, Arizona State University [ASU]) to enrich demographic data and encounter data for claims fully paid for by a primary insurance and to collect data from sensitive registries.
- Prepared the design plan for the TI 2.0 Waiver Evaluation incorporating CMS' recommendations.
- Supported participants with quarterly Quality Improvement Collaboratives, optional Office Hours for any participants and partners to ask questions, and Information Sessions to provide guidance and answer questions specific to each milestone.
- Updated AHCCCS policy, application systems, and website materials.
- Formed a workgroup to begin coordinating Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) Reach-In for Targeted Investment Program (TIP) Justice participants in Maricopa County.
- Finalized Milestone Documents, including annual weighting to determine the amount of payment associated with each milestone and Document Validation criteria that specify requirement elements each policy/procedure must contain to satisfy the milestone.
- Explored interest and finalized contracting and guidance for 27 provider organizations to pursue NCQA Health Equity (HE) Accreditation.
- Created performance measure dashboards for AHCCCS, MCOs, and providers, and engaged ACOs/CINs to visualize month-over-month trends in their performance on a dozen NCQA HEDIS measures, stratified by one of several demographic factors, with a six-month lag.
- Built and refined a large language model using a "chain-of-thought" approach to systematically review and provide feedback on participants' process improvement projects.
- Coordinated with several stakeholders and SMEs to incorporate evidence-based practices into milestone requirements and support partners' related initiatives such as:
  - Postpartum Support International for the postpartum behavioral health screening milestones.
  - The University of Colorado Behavioral Health and Wellness Program, ADHS, and local public health authorities for the tobacco cessation milestones.

  - Health plans and ACOs for tracking HRSN screening and referral results through claims (i.e., the use of G and Z codes).
  - Health plans' cultural competency coalition for Culturally and Linguistically Appropriate Services (CLAS) standards milestones.
  - NCQA related to HE accreditation and the HE milestones.
  - The Contexture and the CommunityCares teams for the HIE requirement and closed-loop referral system (CLRS) milestones.
- Engaged stakeholders and participants in the community to understand and share best practices, such as:
  - Visiting a new Valleywise clinic that will support their TI 2.0 Justice initiatives, and planning to visit the other TI Justice clinics.
  - Touring Community 43 as an exemplar of culturally sensitive services when engaging and treating members released from hospital psychiatric wards.
  - Leading a panel regarding Health Equity at the State of Reform Conference.
  - Leading a four-hour workshop on quality improvement techniques to improve integration and coordination of services at the Institute of Healthcare Improvement's Annual Forum.
  - Presenting as SMEs on statewide collaboration to add health disparities at NCQA's Annual Health Innovation Summit.
  - Publishing the intent and assessment of the TI programs, including evaluation of PCP assignment accuracy in relation to improving quality outcomes and optimizing value-based-purchasing arrangements, in two peer-reviewed journals.
  - Virtually presenting the impact of the TI programs at the International Consortium of Health Outcomes Measurement conference—the largest gathering of value-based healthcare professionals world-wide.

Parents as Paid Caregivers (PPCG)

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

AHCCCS began implementation planning, including the formation and initial meetings of a multi-stakeholder workgroup composed of family members, providers, MCOs and AHCCCS personnel. The workgroup initiated discussions and deliberations on the development of tools necessary to support operationalization of the Waiver requirements, including incorporating an extraordinary care test to the service assessment and considerations for the selection of the service model. The workgroup has leveraged state research and examples of other similar implementations.

KidsCare Expansion

On February 16, 2024, AHCCCS received approval from CMS on the KidsCare Expansion Section 1115 Demonstration Amendment Proposal to raise the CHIP, KidsCare in Arizona, eligibility thresholds from 200 percent of the FPL to 225 percent of the FPL with the flexibility for KidsCare coverage to go up to and include 300 percent of the FPL, subject to approval by the State legislature. The KidsCare Expansion demonstration is in alignment with Arizona Senate Bill (SB) 1726. The expanded income limit was implemented effective March 1, 2024. Since KidsCare eligibility is prospective, the earliest effective date of eligibility for expansion was April 1, 2024. The number of children eligible under the expanded income limit is reported monthly in the AHCCCS Population Highlights report found on the population reports page.[19]

1115 Waiver Evaluation Update

In accordance with the STCs of the 2016–2022 and 2022–2027 1115 Waiver Demonstrations, AHCCCS must submit a Waiver Evaluation Design and Interim and Summative Evaluation Reports. AHCCCS has contracted with HSAG to serve as the independent evaluator for both of Arizona's 1115 Waiver Demonstrations.

AHCCCS worked with HSAG and submitted the first draft of the Demonstration's 2016–2022 Summative Evaluation Report on April 3, 2024. AHCCCS received initial feedback from CMS in July, and a second draft of the report was submitted on September 20, 2024, incorporating CMS' feedback.

On June 6, 2023, CMS approved Arizona's application for continuous coverage for individuals determined ineligible for CHIP due to a change of circumstances. This amendment allowed Arizona to align its policies for young adults in Medicaid and CHIP, thereby preventing gaps in coverage during the coronavirus disease 2019 (COVID-19) public health emergency (PHE) unwinding and redetermination period. AHCCCS is working with HSAG to put together a final evaluation report of this flexibility, due in March 2025.

AHCCCS worked with HSAG and submitted the COVID-19 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Dental Amendment on May 10, 2024, due to CMS 12 months after the PHE. The amendment is currently under CMS review.

CMS has approved the Evaluation Design for the legacy Section 1115 Waiver Demonstration projects. A separate 1115 Waiver Evaluation Design was also created for the TI 2.0 Program and was originally submitted to CMS in February 2024. AHCCCS received initial feedback from CMS in May and submitted a revised draft of the TI 2.0 Evaluation Design on July 19, 2024. After further review, CMS approved the TI 2.0 Evaluation Design on October 3, 2024. Additionally, the Evaluation Design plans

[19] AHCCCS Population Statistics. Available at: https://www.azahcccs.gov/Resources/Reports/population.html. Accessed on: Mar 11, 2025.

for the two newly approved Waiver initiatives (i.e., PPCG Program and the expansion of KidsCare eligibility) were approved by CMS on September 17, 2024.

Legislative Update

The 56th Arizona Legislature, Second Regular Session, adjourned Sine Die on June 16, 2024. The General Effective Date (GED) is September 13, 2024. The Arizona Legislature passed a number of bills in the 2024 legislative session that impacted the agency, including:

- HB 2764 ("long-term care; enforcement; memory care") contains a number of provisions including, but not limited to the establishment of additional enforcement, licensure and penalty authorities to ADHS for oversight of health care institutions/facilities; relating to Adult Protective Services (APS), provides additional oversight and penalty provisions related to abuse and neglect of vulnerable adults; and establishes rules for a licensure subclass for assisted living facilities that provide memory care services.
- HB 2520 ("community health centers; graduate education") contingent on the approval of CMS, directs AHCCCS to distribute monies appropriated for primary care graduate medical education (GME) services to qualifying community health centers and rural health clinics for direct and indirect costs.
- SB 1250 ("AHCCCS; claims") updates Arizona Statute to comply with new federal requirements relating to state laws pertaining to Medicaid Third Party Liability.
- HB 2897/HB 2903 (Budget Bills)
  - Continues state funding for AHCCCS' multi-year Medicaid Enterprise System (MES) Modernization, to come into compliance with federal interoperability regulations.
  - Provides ongoing funding for 101 AHCCCS Full Time Employees (FTEs) to reduce fraud, waste, and abuse.
  - Provides $1 million in one-time State funding for AHCCCS to distribute to entities that provide case management for persons with SMI.

The next legislative session will begin in mid-January 2025.

AHCCCS' Strategic Plan

AHCCCS has outlined its Strategic Plan for State Fiscal Year (SFY) 2025,[20] setting the direction for healthcare initiatives, programs, and priorities. This plan aligns with AHCCCS' mission and vision:

[20] AHCCCS Fiscal Year 2025–2029 Strategic Plan. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/Plans/AHCCCS5YearStrategicPlanStateFiscalYears20252029.pdf. Accessed on: Jan 13, 2025.

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

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

Annual Initiatives for SFY 2025:

1. Enhancing Member Access to Whole-Person Care
   - Strengthen partnerships with community-based organizations (CBOs) to improve referral processes and ensure members receive comprehensive services.
   - Expand efforts to address SDOH and remove barriers to care.
2. Addressing Enrollment Challenges
   - Develop targeted outreach initiatives to connect uninsured individuals with AHCCCS programs.
   - Streamline enrollment processes to improve accessibility and participation.
3. Improving Provider Satisfaction
   - Establish a structured approach to assess provider experiences and address key challenges.
   - Enhance provider engagement efforts to support workforce retention and service quality.
4. Promoting Utilization of Preventive Care
   - Strengthen provider initiatives to encourage preventive care, ensuring early intervention and improved health outcomes.
   - Implement strategies to enhance patient awareness of preventive health services.
5. Enhancing Quality of Care and Reducing Fraud, Waste, and Abuse
   - Implement new systems to strengthen claims evaluation and ensure payment integrity.
   - Expand training and technical support for providers to promote best practices in service delivery.

Overarching Outcomes for SFY 2025:

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

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

Key Initiatives and Accomplishments for AHCCCS

AHCCCS' current initiatives are aimed at building a more cohesive and effective healthcare system in Arizona by reducing fragmentation, structuring provider reimbursements to incentivize quality outcomes, leveraging health information technology (HIT), and working with private sector partners to further innovation . The AHCCCS webpage highlights ongoing and completed initiatives with links to more detailed information and is updated as more information becomes available. Following are highlights of AHCCCS' key initiatives and accomplishments in CYE 2024.[21]

Accessing Behavioral Health Services in Schools

AHCCCS covers medically necessary behavioral health services for Medicaid-enrolled students. Many of these services are provided directly on school campuses, making it easier for students to get services where they are, and as soon as they need help.[22]

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

In 2020, the Arizona State Legislature allocated $8 million in school settings for students who are underinsured or uninsured. This special allocation of one-time State funding, known as the Children's Behavioral Health Services fund, or Jake's Law, allows schools to refer students for behavioral health services for anxiety, depression, social isolation, stress, behavioral issues, or any other mental health concern. Families will not receive a bill for these services; they are covered by tax dollars. Jake's Law requires that schools develop a policy to refer students for behavioral health services, and to allow families to opt in or out of the referral process each year. behavioral health services under this funding are provided to students by participating healthcare providers contracted with AHCCCS through the three ACC-RBHAs, Mercy Care (in Central Arizona), AzCH-CCP (in Southern Arizona), and Care1st (in Northern Arizona). Jake's Law was exhausted in May 2024. The Arizona legislature has not appropriated further funds for the Children's Behavioral Health Services Fund (CBHSF) for SFY 2024; therefore, there will not be any additional CBHSF allocation by AHCCCS in the foreseeable future.

Resource Guide

The Arizona Department of Education (ADE) and AHCCCS created the School and Behavioral Health Partnerships Resource Guide for principals, other education administrators, school mental health

[21] Arizona Health Care Cost Containment System. AHCCCS Initiatives and Best Practices (azahcccs.gov). Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/. Accessed on: Jan 13, 2025.
[22] Arizona Health Care Cost Containment System. Accessing Behavioral Health Services in Schools (azahcccs.gov). Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/BehavioralHealthServices/. Accessed on: Jan 13, 2025.

professionals and anyone who wishes to be a voice that promotes the need for school mental health resources in Arizona. Seven AHCCCS Contractors collaborated to provide a resource for each designated health plan's point of contact for Behavioral Health Services in Schools.[23]

American Rescue Plan Allocations

AHCCCS is working to implement the recently passed federal law, American Rescue Plan (ARP) Act of 2021.[24] The ARP is an emergency legislative package to fund vaccinations; provide immediate, direct relief to families impacted by the COVID-19 PHE; and support struggling communities.

Home and Community Based Services Enhanced Federal Match

The Home and Community Based Services Enhanced Federal Match[25] provision allows states to supplement existing funding. AHCCCS' ARP spending plan can be found on the AHCCCS website.[26]

Services eligible to claim the ARP 10 percent Federal Medical Assistance Percentage (FMAP) increase:

- Rehabilitative Services (including mental health and SUD services)
- Private Duty Nursing
- Alternative Benefit Plans
- Home Health Care
- Personal Care Services
- Self-Directed Personal Care Services
- Case Management
- School Based Services

The funding is short-term and must be spent by March 31, 2024 (three years). These efforts cannot negatively impact current HCBS; but can only add programs, services, and activities that are completed by March 2024 or have an additional plan for funding or sustainability beyond March 2024.

[23] Arizona Health Care Cost Containment System. School & Behavioral Health Partnerships: A Resource Guide. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/Initiatives/BehavioralHealthServices/SBH_ResourceGuide.pdf. Accessed on: Jan 13, 2025.
[24] Arizona Health Care Cost Containment System. American Rescue Plan Allocations. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/ARPA/index.html. Accessed on: Jan 13, 2025.
[25] Ibid.
[26] Arizona Health Care Cost Containment System. Spending Plan for Implementation of the American Rescue Plan Act of 2021, Section 9817: Revised Spending Plan: July 18, 2022. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/Initiatives/ARPA/AHCCCS_ARPA_HCBS_SpendingPlan_Revised.pdf. Accessed on: Jan 13, 2025.

SAMHSA Block Grants to Address Addiction, Mental Health Crisis

ARP also allocated $71 million of additional Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant (MHBG) and Substance Abuse Block Grant funding to Arizona. SAMHSA encourages states to consider a focus on support of a behavioral health crisis continuum. Arizona's key planned programs address:[27]

- Children Designated with SED
- Adults Designated with SMI
- Crisis System Services
- First Episode Psychosis

ARP Provider Payment Information

In its ARP Act HCBS spending plan, AHCCCS received federal approval to allocate almost $1.3 billion over three years in one-time provider payments to recruit and retain a knowledgeable and well-trained workforce. This amount is subject to change pending additional modifications made to the HCBS Spending Plan. These time-limited payments were made in SFYs 2022 and 2023, with the final payment in the Spring of 2024.

The SFY 2024 provider payments totaled more than $387 million and were paid by the AHCCCS Contractors and the FFS administration to providers serving members enrolled in all AHCCCS programs who were active providers in good standing at the time.

The AHCCCS managed care provider payments, called "directed payments," are computed by applying a flat percentage rate to eligible providers' prior Title XIX Medicaid payments from a specified time period for select ARP qualifying codes.[28]

Arizona Olmstead Plan

Olmstead is a 1999 U.S. Supreme Court decision that provided a legal framework for the efforts of federal and state governments to integrate persons with disabilities into the communities in which they live. Olmstead is intended to remove unnecessary segregation of members from the broader community and to ensure that members receive services in the most integrated setting appropriate to their needs. In October 2023, the current Arizona Olmstead Plan (the Plan) was launched to enhance the service delivery system through integrated care and further ensure members live and receive services in the

[27] Arizona Health Care Cost Containment System. Spending Plan Proposal for the Implementation of the American Rescue Plan Act of 2021, Mental Health Block Grant (MHBG); July 30, 2021. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/Initiatives/ARPA/MHBG_ARPA_Plan.pdf. Accessed on: Jan 13, 2025.

[28] Arizona Health Care Cost Containment System. ARP Provider Payment Information 2024 (Updated 04/05/2024). Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/ARPA/providerPayment.html. Accessed on: Jan 13, 2025.

most appropriate integrated setting in their community. The population targeted to benefit from the Plan consists of individuals who may be at risk of institutionalization, including individuals with behavioral health needs and members of the ALTCS program, collectively referred to as "members" throughout the Plan. The intent of the design of the Plan is for it to be both an actionable and "living" plan that contains specific timelines for objectives that are directed at completing a specified process while also including, as applicable, performance targets to measure positive change resulting from the objectives. The Plan is updated and posted to the AHCCCS website quarterly. Since its launch, there have been five updates made to the Plan with a number of accomplishments already made. For additional information and to view the Plan, see the AHCCCS website.[29]

Building an Integrated Health Care System and Improving Care Coordination

Today's health care system is a series of parts not yet connected to each other. Improving care coordination and communication, while reducing fragmentation, can weave these parts together to create a health care system with more effective outcomes. AHCCCS continues to integrate the care delivery systems and align incentives that are designed to transform the structure of the Medicaid program, improve health outcomes, and better manage limited resources.[30]

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

On October 1, 2022, AHCCCS updated its contracts with health plans for health insurance coverage for individuals with an SMI designation. The contracts expanded select ACC Contractor responsibilities and designated these Contractors as ACC-RBHA Contractors. The contracts also include the provision of integrated care addressing physical and behavioral health and the first 24 hours of crisis services for members with an SMI designation. AHCCCS will continue to work collaboratively with the ACC-RBHAs to evaluate methods to reduce program complexity, administrative burden, and unnecessary administrative and medical costs; and to improve care coordination and disease/chronic care management.[31]

Medicare and Medicaid Alignment Makes a Difference

Medicare presents one of the greatest challenges to states serving individuals dually eligible for Medicaid and Medicare. Medicare is its own distinct, complex system of care operated by the federal government with little to no interface with state Medicaid programs. For the over 165,000 Arizonans that are eligible for both Medicare and Medicaid, navigating these two separate systems of care can be

[29] Arizona Health Care Cost Containment System. Arizona Olmstead Plan. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/ArizonaOlmsteadPlan/. Accessed on: Mar 11, 2025.
[30] Arizona Health Care Cost Containment System. Building an Integrated Health Care System and Improving Care Coordination. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/. Accessed on: Jan 13, 2025.
[31] Ibid.

overwhelming. Under these circumstances, it is more likely for people to be overlooked or forgotten, receive inefficient care, and not achieve optimal health outcomes.

AHCCCS continues developing integration initiatives to increase alignment and improve service delivery for individuals covered by both Medicare and Medicaid. This health system fragmentation often results in poor communication, uncoordinated health care decisions and a lack of a patient-centered perspective. AHCCCS has moved toward increasing the coordination of health service delivery between these two health programs by contracting with Medicare Advantage Dual Special Needs Plans (D-SNPs) that are each affiliated with its ACC Medicaid Contractors. Requiring each ACC Medicaid Contractor to offer a partner Medicare D-SNP promotes the enrollment or alignment of dual eligible members with the same Contractor for both Medicare and Medicaid services to the greatest possible extent. Enrolling in specialized Medicare plans allows dual eligible members to receive all of their health care services, including prescription drug benefits, from a single, integrated Contractor.[32]

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

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

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

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

Members who qualify for a CRS designation and who are not enrolled with DES/DDD may receive integrated services through an ACC or ACC-RBHA Contractor in their service area for provision of CRS services; or Mercy Care DCS CHP for foster care members.[33]

[32] Arizona Health Care Cost Containment System. Individuals Covered By Both Medicare and Medicaid (Dual Eligible Members). Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/duals.html. Accessed on: Jan 13, 2025.

[33] Arizona Health Care Cost Containment System. What is a Children's Rehabilitative Services (CRS) Designation? Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/CRS.html. Accessed on: Jan 13, 2025.

Justice System Transitions

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

A significant number of justice-involved individuals are in critical need of health care services, supports, and resources, and may be eligible for assistance through AHCCCS. Available services may include help with physical and behavioral health (e.g., mental health or substance use treatment), housing assistance, employment assistance, crisis services, and other supportive services.[34]

Electronic Visit Verification

AHCCCS uses electronic visit verification (EVV) to help track and monitor timely service delivery and access to care for members. In addition, EVV reduces provider administrative burden associated with scheduling and hard copy timesheet processing, as well as prevent, detect, and recover improper payments due to fraud, waste, and abuse.

Members and family members have the opportunity to choose which device is used to verify whether a service was received. Services subject to EVV include Attendant, Personal, and Companion Care; Homemaker; Home Health Services; Habilitation and Respite.[35]

AHCCCS Housing Programs

AHCCCS provides several permanent supportive housing programs throughout Arizona alongside supportive health services to members experiencing homelessness or housing instability. Housing programs are provided to members with an SMI designation, and some services are provided for members with a General Mental Health/Substance Use Disorder (GMH/SUD). Providing supportive housing services supports members in gaining and maintaining stable housing. It also helps lower utilization of emergency and crisis services. AHCCCS provides supportive housing services to approximately 3,000 members across the State.[36]

[34] Arizona Health Care Cost Containment System. Support for Individuals Involved in the Justice System. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/justiceinitiatives.html. Accessed on: Jan 13, 2025.
[35] Arizona Health Care Cost Containment System. Electronic Visit Verification. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/EVV/. Accessed on: Jan 13, 2025.
[36] Arizona Health Care Cost Containment System. AHCCCS Housing Programs. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/AHP/. Accessed on: Jan 13, 2025.

AHCCCS Payment Modernization

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

AHCCCS is continuing its pursuit to implement long-term strategies that bend the cost curve while improving member health outcomes. The overall mission is to leverage the AHCCCS managed care model toward value-based healthcare systems where patients' experiences and population health are improved through aligned incentives with Contractors and provider partners, and when there is a commitment to continuous QI and learning.[37]

Medicaid Enterprise System (MES) Modernization Program

The AHCCCS MES Modernization Program started in 2019 to enhance understanding and optimize the utilization of healthcare access, services, and outcomes for our members. The goal of the program is to bring innovation to business and technical operations that provide high quality healthcare to AHCCCS communities. The work includes replacing legacy applications and processes by implementing modern technology solutions, implementing state-of-the-art systems and processes to improve business standards, bringing a strong and sturdy foundation to business and technical assets, and improving data accessibility.[38]

Targeted Investments Program

TI 2.0 aligns with AHCCCS' strategic plan and Arizona's Section 1115 Waiver to support and incentivize providers to develop and enhance comprehensive whole-person care systems that effectively address the social risk factors that adversely affect health. Eligible Medicaid provider organizations that meet certain benchmarks will receive financial incentives through managed care plans for developing infrastructure and protocols to optimize coordination of services designed to meet the member's acute, behavioral, and HRSN as well as address identified health inequities among their patient population.[39]

[37] Arizona Health Care Cost Containment System. AHCCCS Payment Modernization. Available at: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/PaymentModernization/. Accessed on: Jan 13, 2025.
[38] Arizona Health Care Cost Containment System. Medicaid Enterprise System (MES) Modernization Program. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/MES/. Accessed on: Mar 11, 2025.
[39] Arizona Health Care Cost Containment System. Targeted Investments 2.0 Program Overview. Available at: https://www.azahcccs.gov/PlansProviders/TargetedInvestments/. Accessed on: Jan 13, 2025.

Telehealth Services

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

AHCCCS covers all major forms of telehealth services. Asynchronous (also called "store and forward") occurs when services are not delivered in real-time, but clinical information or images are uploaded by a provider and then retrieved for review and recommendation, usually by a specialist. Telephonic services (audio-only) use a traditional telephone to conduct healthcare appointments. Telemedicine involves interactive audio and video, in a real-time, synchronous communication. AHCCCS also covers telehealth for remote patient monitoring and teledentistry.[40]

Using Technology to Improve Patient Care

AHCCCS envisions a whole-person integrated healthcare system in which HIT and HIE improve population health, enhance the patient experience, and lower costs. AHCCCS encourages all eligible laboratories, physical and behavioral health providers, State/local government agencies, and Contractors to adopt HIT resources that securely store and share EHRs, streamline the delivery of healthcare services, and improve member health outcomes.[41]

Whole Person Care Initiative

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

- Homelessness and Housing Instability
- Food Insecurity
- Employment Instability
- Social Isolation and Social Support
- Interpersonal Safety
- Environmental Safety
- Justice or Legal Involvement

[40] Arizona Health Care Cost Containment System. Telehealth Services. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/Telehealth/. Accessed on: Jan 13, 2025.
[41] Arizona Health Care Cost Containment System. Using Technology to Improve Patient Care. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/HIT/. Accessed on: Jan 13, 2025.

- Education and Childhood Development
- Access to Outdoor Spaces and Parks

Research shows that HRSN contribute to 80 percent of health outcomes, while only 20 percent of health outcomes are from direct healthcare services. Across the Medicaid delivery system, AHCCCS is working to improve members' access to resources that can address their HRSN, and therefore improve health equity in Arizona. For additional information about how AHCCCS is addressing HRSN, see the AHCCCS website.[42]

Awards, Studies, and Highlights

Access to a comprehensive behavioral health crisis response system can lessen demand for more restrictive and costly emergency department and inpatient services, according to a new research study published in the journal *Psychiatric Services*. The study was conducted by a team that included researchers from Arizona State University Center for Health Information and Research and Connections Health Solutions.

The study examined how people flow through the crisis system in Arizona, which over the past several decades has built a comprehensive infrastructure that heavily influenced SAMHSA's national vision for crisis care ensuring people in crisis have someone to call, someone to respond (mobile crisis response teams), and a safe place to go for help (specialized crisis facilities). Additional information on the study and study results can be found on the AHCCCS website.[43]

2024 AHCCCS Year in Review

AHCCCS achieved significant accomplishments and innovations in technology, policy, and service delivery that streamlined business processes and improved quality of care.

Unwinding From the Pandemic

- Awarded for unwinding efforts by Information Technology Solutions Management for Human Services (ISM)'s Award of Excellence in the Best Use of Technology-External showcasing AHCCCS' comprehensive plan centered on the deployment of innovative technology solutions to address the dual challenges of scalability while improving outreach to its customers.
- Recognized by the 2024 National Association of Medicaid Directors (NAMD) Spotlight Award for its standing achievement in member communication strategies and exceptional success in keeping

[42] Arizona Health Care Cost Containment System. AHCCCS Whole Person Care Initiative (WPCI). Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/AHCCCSWPCI/. Accessed on: Jan 13, 2025.
[43] Arizona Health Care Cost Containment System. Awards, Studies, and Highlights 2024. Available at: https://www.azahcccs.gov/AHCCCS/AboutUs/awardsandstudies.html. Accessed on: Jan 13, 2025.

qualified members enrolled in the program, highlighted by consistently high average auto-renewal rates in the 70th percentile.

- Released a monthly interactive Eligibility Dashboard to share member eligibility data on Arizona's Medicaid and CHIP application activity to provide details on eligibility outcomes, outreach information, and other data related to the eligibility application process.

Member and Provider Services

- Distributed $2.5 million to four community health centers (Mariposa Community Health Center, San Luis Walk-In Clinic, Little Colorado Medical Center, and Canyonlands Healthcare) for on-call maternity care services in rural communities which often have little to no maternity care available.
- Launched a social outreach campaign to help rebuild trust and strengthen its commitment to Arizona's Tribal communities statewide. The campaign, which includes physical, digital, and social media messages that inform members of the warning signs of fraud and guides them to a list of AHCCCS-approved health resources, follows the agency's year-long initiative to combat provider fraud that disproportionately impacted members of the American Indian Health Program (AIHP).
- Launched an interactive dashboard to share monthly member eligibility data in a visual and interactive way. The Eligibility Dashboard reports on Arizona's Medicaid and CHIP application activity and contains detailed information including demographics and application types (initial applications, changes, and renewals). AHCCCS publishes this dashboard monthly to provide details on eligibility outcomes, outreach information, and other data related to the eligibility application process.
- Selected to join the Building State Capacity for Community-Informed Policymaking Learning and Action Series through the Center for Health Care Strategies (CHCS) on July 17, 2024. This learning collaborative is an innovative initiative to assist states in creating or enhancing Medicaid member advisory groups. This project will support participants in developing approaches that align with the CMS final regulations on Medicaid Advisory Committees (MAC) and Beneficiary Advisory Councils (BAC) to support more equitable, effective, and community-informed Medicaid programs and policies.

Waiver, Policy, and Covered Service Enhancements

- Began reimbursement for Medicaid members who use doula services, marking a crucial step toward improving maternal and infant health in Arizona. More than half of Arizona's births are covered by AHCCCS. Doula reimbursement is available to any doula certified through ADHS' voluntary doula certification program and registered with AHCCCS as a provider.
- Launched coverage of the first Food and Drug Administration (FDA)-approved medication for postpartum depression.
- Launched the Housing and Health Opportunities (H2O) Program on October 1, 2024. The goal of the AHCCCS H2O demonstration is to enhance and expand housing services and interventions for AHCCCS members who are experiencing both homeless and one or more chronic diseases or conditions. Nearly 250 members are receiving or have received H2O services since its launch.

- Received CMS approval to cover Traditional Healing Services in 2024, after AHCCCS had been working to add traditional health reimbursement through Medicaid since 2015.
- Received CMS approval to cover Reentry Services for eligible individuals who are inmates residing in qualified correctional facilities and have an expected release date within 90 days.
- Expanded the income limit for KidsCare, Arizona's CHIP, to 225 percent (from 200 percent) of the FPL beginning March 1, 2024. AHCCCS originally estimated up to 12,000 additional youth would benefit from the expansion. To date, more than 18,000 additional Arizonan children are covered through KidsCare thanks to this expansion.

Technology Enhancements

- Encountered significant challenges as the COVID-19 pandemic unfolded. Medicaid enrollment in Arizona surged by more than 30 percent, placing unprecedented stress on an already overburdened infrastructure. The influx of new members combined with the ongoing needs of existing members created an urgent need for cohesive, dependable solutions that could maintain service continuity while enhancing the overall customer experience. This multifaceted approach included solutions such as a Surge Call Center, Robotic Process Automation (RPA), SAM the Virtual Agent, AHCCCS Connect, QR codes, and Social Awareness, which helped with timely communications and to address urgent needs, provide assistance, and offer awareness/educational outreach to members.

AHCCCS' Medicaid and CHIP Quality Strategy

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

The AHCCCS Quality Strategy is a coordinated, comprehensive, 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 public comments and additional feedback obtained following stakeholder presentations.

The AHCCCS Quality Strategy Evaluation is a companion document to the AHCCCS Quality Strategy that is used to evaluate the effectiveness of the AHCCCS Quality Strategy. AHCCCS completed its evaluation of quality strategy effectiveness in March 2024. Based on results of the Quality Strategy Evaluation, updates to the AHCCCS Quality Strategy were completed in July 2024.

Quality Strategy Goals and Objectives

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

AHCCCS' Quality Strategy identifies the following four goals and associated objectives:[44]

Table 3-1—Quality Strategy Goals and Objectives

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

[44] Arizona Health Care Cost Containment System. Quality Strategy. July 1, 2024. Available at: https://www.azahcccs.gov/PlansProviders/Downloads/QualityStrategyJuly2024Final.pdf. Accessed on: Jan 14, 2025.

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

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

Recommendations

- HSAG recommends that AHCCCS engage with its Contractors to target lower-scoring Preventive Screening measures. Based on performance measure rate comparisons to national benchmarks, the ACC, ACC-RBHA, ALTCS-EPD, and ALTCS-DD programs could benefit from QI activities to target *Cervical Cancer Screening.* Additionally, the ACC and ACC-RBHA programs could benefit from QI activities to target Maternal and Perinatal Care measures.
- Network adequacy activities revealed data issues that affected Contractors' compliance with time/distance standards. HSAG recommends that AHCCCS engage with its Contractors to brainstorm ideas for increasing accuracy of data submitted to AHCCCS.
- Behavioral health measures, specifically the *Use of Opioids at High Dosage* measure, continue to present an opportunity of improvement for the ACC, ACC-RBHA, ALTCS-EPD, and ALTCS-DD programs. HSAG recommends that AHCCCS work with Contractors to utilize process improvement techniques to identify gaps and develop strategies to improve these metrics.

4. ACC Program-Level Comparative Results

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

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

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2024, HSAG evaluated each ACC Program Contractor's data system for processing of each data type used for reporting the Contractor's CY 2023 performance measure data in alignment with the CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023 audit requirements.[45] A summary of these findings by ACC Program Contractor is provided in Table 4-1. Table 4-1 also displays whether or not each ACC Program Contractor met the assessed Information Systems (IS) standards, which demonstrates whether or not the Contractor had effective IS practices and control procedures for data reporting. Additional information about each ACC Program Contractor's general findings for each data type reviewed can be found in Section 5. ACC Program Contractor-Specific Results. Additional information regarding the CMS EQR Protocol 2 audit requirements, including more information about the levels of scoring, can be found in the Validation of Performance Measures section of Appendix A. Methodology.

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

Data Type	AzCH–CCP ACC-RBHA	BUFC ACC	Care1st ACC-RBHA	HCA ACC	Mercy Care ACC-RBHA	Molina ACC	UHCCP ACC
Medical Services Data	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*
Enrollment Data	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*
Provider Data	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*

[45] The Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Feb 23, 2025.

Data Type	AzCH–CCP ACC-RBHA	BUFC ACC	Care1st ACC-RBHA	HCA ACC	Mercy Care ACC-RBHA	Molina ACC	UHCCP ACC
Medical Record Review Processes	*Met*	*Not Met*	*Met*	*Met*	*Met*	*Met*	*Met*
Supplemental Data	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*
Data Preproduction Processing	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*
Data Integration and Reporting	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*

ACC Program-Level Results

Performance Measure Results

Table 4-2 presents the CY 2023 performance measure rates for each ACC Program Contractor and the ACC Program Aggregate for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. Performance measure rate cells shaded green indicate that the Contractor met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the national Medicaid HMO mean are shaded green. Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 4-2—CY 2023 Performance Measure Results for ACC Program Contractors

Measure	AzCH–CCP ACC-RBHA	BUFC ACC	Care1st ACC-RBHA	HCA ACC	Mercy Care ACC-RBHA	Molina ACC	UHCCP ACC	Aggregate
Maternal and Perinatal Care								
Prenatal and Postpartum Care								
Timeliness of Prenatal Care	76.6%+	81.5%+	81.5%+	87.4%+	89.8%#	85.4%+	82.7%+	81.5%+
Postpartum Care	76.6%+	70.8%+	62.0%+	79.2%+	79.3%#	66.4%+	71.8%+	73.4%+
Behavioral Health								
Antidepressant Medication Management								
Effective Acute Phase Treatment—Total (18+ Years)	62.2%	64.3%	61.6%	62.0%	51.3%	57.3%	63.0%	60.5%
Effective Continuation Phase Treatment—Total (18+ Years)	43.3%	48.1%	44.7%	43.7%	35.7%	37.5%	44.5%	42.8%

Measure	AzCH–CCP ACC-RBHA	BUFC ACC	Care1st ACC-RBHA	HCA ACC	Mercy Care ACC-RBHA	Molina ACC	UHCCP ACC	Aggregate
Follow-Up After ED Visit for Substance Use								
7-Day Follow-Up—Total (13+ Years)	29.0%	27.1%	30.3%	33.0%	31.3%	30.3%	28.5%	29.7%
30-Day Follow-Up—Total (13+ Years)	39.4%	37.6%	42.0%	48.3%	41.3%	37.6%	39.5%	40.8%
Follow-Up After Hospitalization for Mental Illness								
7-Day Follow-Up—Total (6+ Years)	45.7%	36.9%	48.8%	57.9%	52.3%	46.3%	49.5%	48.5%
30-Day Follow-Up—Total (6+ Years)	63.9%	54.5%	67.9%	74.2%	69.6%	63.3%	67.0%	66.0%
Follow-Up After ED Visit for Mental Illness								
7-Day Follow-Up—Total (6+ Years)	48.6%	43.6%	52.1%	35.5%	51.1%	42.0%	42.7%	44.9%
30-Day Follow-Up—Total (6+ Years)	59.3%	54.2%	62.0%	49.9%	60.2%	64.0%	54.7%	56.4%
Use of Opioids at High Dosage								
*18+ Years**	6.3%	10.9%	5.9%	4.9%	8.6%	2.2%	10.5%	8.4%
Initiation and Engagement of Substance Use Disorder (SUD) Treatment								
Initiation of SUD Treatment—Total—Total (13+ Years)	48.9%	50.9%	40.6%	48.7%	52.4%	56.7%	50.3%	49.9%
Engagement of SUD Treatment—Total—Total (13+ Years)	18.2%	21.3%	15.4%	18.4%	20.0%	24.0%	18.6%	19.1%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia								
18+ Years	43.7%	53.0%	50.3%	47.9%	41.6%	41.7%	47.7%	46.8%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications								
18–64 Years	81.5%	81.9%	82.7%	80.7%	83.2%	76.7%	79.8%	81.3%
Care of Acute and Chronic Conditions								
Controlling High Blood Pressure								
18–85 Years	65.2%$^{+}$	58.9%$^{+}$	63.3%$^{+}$	64.3%$^{+}$	67.6%$^{+}$	57.7%	65.2%$^{+}$	65.6%$^{+}$
Hemoglobin A1c Control for Patients With Diabetes								
HbA1c Control (<8.0%)—Total (18–75 Years)	62.0%$^{+}$	67.6%$^{+}$	50.1%$^{+}$	55.5%$^{+}$	64.0%$^{+}$	46.2%$^{+}$	58.6%$^{+}$	61.2%$^{+}$
*HbA1c Poor Control (>9.0%)—Total (18–75 Years)**	30.7%$^{+}$	32.4%$^{+}$	40.9%$^{+}$	31.6%$^{+}$	28.2%$^{+}$	44.0%$^{+}$	30.4%$^{+}$	31.1%$^{+}$
Pediatric Health								
Metabolic Monitoring for Children and Adolescents on Antipsychotics								

Measure	AzCH–CCP ACC-RBHA	BUFC ACC	Care1st ACC-RBHA	HCA ACC	Mercy Care ACC-RBHA	Molina ACC	UHCCP ACC	Aggregate
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	54.5%	48.3%	46.0%	49.6%	52.5%	41.4%	49.3%	50.5%
Childhood Immunization Status**								
Combination 3	62.5%+	59.6%+	48.9%+	53.0%+	62.5%+	58.9%+	67.2%+	61.6%+
Combination 7	56.0%+	51.8%+	42.3%+	44.8%+	51.3%+	50.1%+	61.3%+	53.7%+
Combination 10	24.1%+	22.9%+	16.5%+	17.8%+	24.3%+	18.2%+	29.9%+	24.3%+
Immunizations for Adolescents								
Combination 1 (Meningococcal, Tdap)	87.1%+	84.7%+	73.2%+	83.5%+	87.1%+	80.5%+	82.7%+	84.6%+
Combination 2 (Meningococcal, Tdap, HPV)	41.8%+	44.0%+	28.5%+	35.5%+	41.4%+	27.7%+	40.4%+	40.1%+
Oral Evaluation, Dental Services								
Total (0–20 Years)[N]	46.7%	34.2%	39.9%	50.6%	71.9%	3.3%	48.6%	44.3%
Well-Child Visits in the First 30 Months of Life								
First 15 Months—Six or More Well-Child Visits	66.5%	63.6%	54.8%	63.3%	67.9%	63.1%	65.2%	65.2%
15 Months to 30 Months—Two or More Well-Child Visits	63.1%	59.9%	59.2%	59.4%	66.3%	67.3%	66.8%	63.9%
Child and Adolescent Well-Care Visits								
Total (3–21 Years)	53.2%	44.0%	41.8%	43.2%	53.6%	43.5%	50.7%	49.6%
Preventive Screening								
Breast Cancer Screening								
Total (50–74 Years)	54.6%	53.2%	36.4%	45.8%	55.3%	49.1%	57.4%	53.1%
Cervical Cancer Screening								
21–64 Years	51.8%+	48.4%+	36.0%+	47.9%+	60.8%+	43.6%+	51.6%+	51.7%+
Appropriate Utilization of Services								
Ambulatory Care								
Emergency Department (ED) Visits—Total (0–85+ Years)[F]	492.2	440.6	485.3	507.3	510.9	515.9	480.4	487.3
Plan All-Cause Readmissions								
*Observed/Expected (O/E) Ratio—Total (18–64 Years)**	1.0311	1.0738	0.9087	0.9941	0.9682	1.1562	0.9494	1.0016

* A lower rate indicates better performance for this measure.
+ Indicates the measure was reported using hybrid methodology.

** Table A-2 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
# Rate is as reported by the MCO in the NCQA HEDIS Interactive Data Submission System (IDSS), which may influence comparability to the MCO rates reported through PMV.
D DNR indicates the measure received a Do Not Report designation for CY 2023.
F NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. This measure is not compared to national benchmarks as NCQA does not view higher or lower service counts as indicating better or worse performance.
N Measure has no NCQA Medicaid mean for comparison.
Cells shaded green indicate that the rate met or exceeded the MY 2023 national Medicaid mean.

Table 4-3 presents the CY 2022 and CY 2023 ACC Program Aggregate results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and MY 2023. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and/or MY 2023. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 4-3—CY 2022 and CY 2023 Performance Measure Aggregate Results for ACC Program Contractors

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care ≥	83.2%	81.5%	↓	★★
Postpartum Care ≥	69.8%	73.4%	↑	★
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	59.0%	60.5%	↑	★★
Effective Continuation Phase Treatment—Total (18+ Years)	40.5%	42.8%	↑	★★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	31.2%	29.7%	→	★★★★
30-Day Follow-Up—Total (13+ Years)	40.9%	40.8%	→	★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	46.5%	48.5%	↑	★★★★
30-Day Follow-Up—Total (6+ Years)	63.2%	66.0%	↑	★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	46.4%	44.9%	→	★★★
30-Day Follow-Up—Total (6+ Years)	56.6%	56.4%	→	★★★
Use of Opioids at High Dosage				
*18+ Years**	8.7%	8.4%	→	★

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Initiation and Engagement of Substance Use Disorder (SUD) Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	51.8%	49.9%	↓	★★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	19.9%	19.1%	↓	★★★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	50.5%	46.8%	↓	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	78.7%	81.3%	↑	★★
Care of Acute and Chronic Conditions				
Controlling High Blood Pressure				
18–85 Years+	58.7%	64.4%	↑	★★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0%)—Total (18–75 Years)+	55.0%	61.2%	↑	★★★★
Poor HbA1c Control (>9.0%)—Total (18–75 Years)+*	36.5%	31.1%	↑	★★★
Pediatric Health				
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	48.1%	50.5%	↑	★★★★
Childhood Immunization Status**				
Combination 3+	59.5%	61.6%	↑	★★
Combination 7+	53.5%	53.7%	→	★★
Combination 10+	26.2%	24.3%	↓	★★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)+	86.4%	84.6%	↓	★★★
Combination 2 (Meningococcal, Tdap, HPV)+	40.2%	40.1%	→	★★★
Oral Evaluation, Dental Services				
*Total (0–20 Years)*N	45.7%	44.3%	↓	—
Well-Child Visits in the First 30 Months of Life				
First 15 Months—Six or More Well-Child Visits	60.8%	65.2%	↑	★★★★
15 Months–30 Months—Two or More Well-Child Visits	59.6%	63.9%	↑	★
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	45.0%	49.6%	↑	★★
Preventive Screening				
Breast Cancer Screening				

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Total (50–74 Years)	50.9%	53.1%	↑	★★★
Cervical Cancer Screening				
21–64 Years+	53.1%	51.7%	↓	★★
Appropriate Utilization of Services				
Ambulatory Care				
Emergency Department (ED) Visits—Total (0–85+ Years)[F]	487.8	487.3	—	—
Plan All-Cause Readmissions				
*Observed/Expected (O/E) Ratio—Total (18–64 Years)**	1.0138	1.0016	—	★★

* A lower rate indicates better performance for this measure.
**Table A-2 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
+ Indicates the measure was reported using hybrid methodology.
≥ Indicates the measure had variation in reporting designation or methodology in CY 2023 (each applicable program contracted MCO performance measure table should be reviewed for specifics) and hybrid methodology in CY 2022.
Cells shaded green indicate that the rate met or exceeded the MY 2022 and/or MY 2023 and/or national Medicaid mean.
— Indicates a 2022–2023 comparison is not presented in the CYE 2024 Annual Technical Report because either the CY 2022 rate was not presented in the CYE 2023 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
[1]Aggregated rates were calculated and compared from CY 2022 to CY 2023, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.
[2] Performance Levels for CY 2023 were based on comparisons of the HEDIS MY 2023 measure rates to national Medicaid Quality Compass HEDIS MY 2023 benchmarks.
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.
[N] Measure has no NCQA Medicaid mean for comparison.
↑ Indicates statistically significant improvement of measure rates.
↓ Indicates statistically significant decline of measure rates.
→ Indicates no statistically significant change in measure rates.
Performance Levels for 2023 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Table 4-4 highlights the ACC Program Contractors' performance for the current year by measure group. The table illustrates the Contractors' CY 2023 measure rates and their performance relative to the NCQA national Medicaid Quality Compass HEDIS MY 2023 percentiles, where applicable. The performance level star ratings are defined as follows:

★★★★★ = 90th percentile and above
★★★★ = 75th percentile to 89th percentile
★★★ = 50th percentile to 74th percentile
★★ = 25th percentile to 49th percentile
★ = Below the 25th percentile

Table 4-4—CY 2023 National Percentiles Comparison for ACC Program Contractors

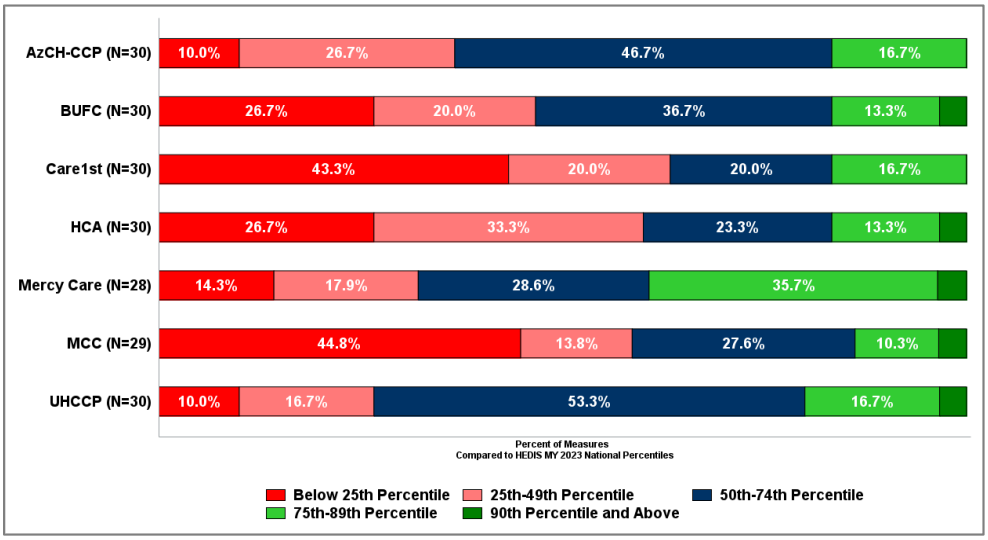
Measure	AzCH–CCP ACC-RBHA	BUFC ACC	Care1st ACC-RBHA	HCA ACC	Mercy Care ACC-RBHA	Molina ACC	UHCCP ACC	Aggregate
Maternal and Perinatal Care								
Prenatal and Postpartum Care								
Timeliness of Prenatal Care	★	★★	★★	★★★	★★★★ #	★★★	★★	★★
Postpartum Care	★★	★	★	★★	★★ #	★	★	★
Behavioral Health								
Antidepressant Medication Management								
Effective Acute Phase Treatment—Total (18+ Years)	★★	★★★	★★	★★	★	★★	★★★	★★
Effective Continuation Phase Treatment—Total (18+ Years)	★★	★★★	★★★	★★	★	★	★★★	★★
Follow-Up After ED Visit for Substance Use								
7-Day Follow-Up—Total (13+ Years)	★★★	★★★	★★★★	★★★★	★★★★	★★★★	★★★	★★★★
30-Day Follow-Up—Total (13+ Years)	★★★	★★★	★★★★	★★★★	★★★	★★★	★★★	★★★
Follow-Up After Hospitalization for Mental Illness								
7-Day Follow-Up—Total (6+ Years)	★★★	★★	★★★★	★★★★★	★★★★	★★★	★★★★	★★★★
30-Day Follow-Up—Total (6+ Years)	★★★	★★	★★★	★★★★	★★★★	★★★	★★★	★★★
Follow-Up After ED Visit for Mental Illness								
7-Day Follow-Up—Total (6+ Years)	★★★	★★★	★★★★	★★	★★★★	★★★	★★★	★★★
30-Day Follow-Up—Total (6+ Years)	★★★	★★★	★★★	★★	★★★	★★★★	★★★	★★★
Use of Opioids at High Dosage								
18+ Years	★★	★	★★	★★	★	★★★	★	★
Initiation and Engagement of Substance Use Disorder (SUD) Treatment								
Initiation of SUD Treatment—Total—Total (13+ Years)	★★★	★★★★	★★	★★★	★★★★	★★★★★	★★★★	★★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	★★★	★★★★	★★★	★★★	★★★★	★★★★	★★★	★★★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia								
18+ Years	★	★	★	★	★	★	★	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications								
18–64 Years	★★★	★★★	★★★	★★	★★★	★	★★	★★
Care of Acute and Chronic Conditions								
Controlling High Blood Pressure								

Measure	AzCH–CCP ACC-RBHA	BUFC ACC	Care1st ACC-RBHA	HCA ACC	Mercy Care ACC-RBHA	Molina ACC	UHCCP ACC	Aggregate
18–85 Years	★★★	★	★★	★★	★★★	★	★★★	★★
Hemoglobin A1c Control for Patients With Diabetes								
HbA1c Control (<8.0%)—Total (18–75 Years)	★★★★	★★★★★	★	★★	★★★★★	★	★★★	★★★★
*Poor HbA1c Control (>9.0%)—Total (18–75 Years)**	★★★	★★★	★	★★★	★★★★	★	★★★	★★★
Pediatric Health								
Metabolic Monitoring for Children and Adolescents on Antipsychotics								
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	★★★★	★★★★	★★★★	★★★★	★★★★	★★★	★★★★	★★★★
Childhood Immunization Status**								
Combination 3	★★	★★	★	★	★★	★	★★★	★★
Combination 7	★★★	★★	★	★	★★	★	★★★★	★★
Combination 10	★★	★★	★	★	★★	★	★★★	★★
Immunizations for Adolescents								
Combination 1 (Meningococcal, Tdap)	★★★★	★★★	★	★★★	★★★★	★★	★★★	★★★
Combination 2 (Meningococcal, Tdap, HPV)	★★★★	★★★★	★	★★★	★★★	★	★★★	★★★
Well-Child Visits in the First 30 Months of Life								
First 15 Months—Six or More Well-Child Visits	★★★★	★★★	★★	★★★	★★★★	★★★	★★★★	★★★★
15 Months to 30 Months—Two or More Well-Child Visits	★	★	★	★	★★	★★	★★	★
Child and Adolescent Well-Care Visits								
Total (3–21 Years)	★★★	★	★	★	★★★	★	★★	★★
Preventive Screening								
Breast Cancer Screening								
Total (50–74 Years)	★★★	★★★	★	★	★★★	★★	★★★	★★★
Cervical Cancer Screening								
21–64 Years	★★	★	★	★	★★★	★	★★	★★
Appropriate Utilization of Services								
Plan All-Cause Readmissions								
Observed/Expected (O/E) Ratio—Total (18–64 Years)	★★	★	★★★	★★	★★	★	★★★	★★

[#] Rate is as reported by the MCO in the NCQA HEDIS Interactive Data Submission System (IDSS), which may influence comparability to the MCO rates reported through PMV.
* A lower rate indicates better performance for this measure.
**Table A-2 in *Appendix A. Methodology* outlines which immunizations are included within each combination.

Figure 4-1 displays the ACC Program Contractors' HEDIS MY 2023 performance compared to NCQA MY 2023 National Percentiles. HSAG analyzed results from 20 performance measures for HEDIS MY 2023 for a total of 31 measure rates.

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



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

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

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

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group: • The *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total* and *Follow-Up After ED Visit for Substance Use—30-Day Follow-Up—Total* measure rates for all seven ACC Program Contractors and the ACC Program Aggregate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. In 2022, 48.7 million Americans over 12 years of age (about 17.3 percent of the population) were classified as having an SUD within the

Strengths, Opportunities for Improvement, and Recommendations

past year.[46] High ED use for individuals with substance use may signal a lack of access to care or issues with continuity of care. Timely follow-up care helps individuals with SUD stay connected with the healthcare system. **[Quality, Timeliness, Access]**

- The *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total (6+ Years)* measure rates for six of the seven ACC Program Contractors and the ACC Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. These results may indicate that members were receiving important timely follow-up visits for mental illness after an ED visit. Research suggests that follow-up care for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function, and increased compliance with follow-up instructions.[47] The MY 2023 results in this measure continued the prior year's high performance related to ensuring timely follow-up for members in accessing care after an ED visit for mental illness. **[Quality, Timeliness, Access]**
- The *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *Follow-Up After Hospitalization Visit for Mental Illness—30-Day Follow-Up—Total (6+ Years)* measure rates for six of the seven ACC Program Contractors and the ACC Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. In 2019, nearly one in five adults ages 18 years and older in the U.S. had a diagnosed mental health disorder, but many of these individuals do not receive adequate follow-up care. Research suggests that follow-up care for individuals with mental illness after psychiatric hospitalization can improve overall outcomes, decrease the likelihood of rehospitalization, and reduce the cost of outpatient care.[48] **[Quality, Timeliness, Access]**
- The *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* measure rate for six of the seven ACC Program Contractors and the ACC Program Aggregate rate, and the *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* measure rate for all seven ACC Program Contractors and the ACC Program Aggregate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. In 2022, 48.7 million individuals in the United States 12 years of age or older (approximately 17.3 percent of the population) were classified as having had an SUD within the past year.[49] Individuals with SUD

[46] National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Substance Use. Available at: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-substance-use/. Accessed on: Feb 7, 2025.
[47] National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Mental Illness. Available at: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/. Accessed on: Feb 13, 2025.
[48] National Committee for Quality Assurance. Follow-Up After Hospitalization for Mental Illness. Available at: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/. Accessed on: Feb 7, 2025.
[49] National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Substance Use. Available at: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-substance-use/. Accessed on: Feb 7, 2025.

Strengths, Opportunities for Improvement, and Recommendations
are at increased risk of overdose, injury, soft tissue infections, and mortality. In 2021, drug overdose accounted for 106,699 deaths, representing a 14 percent increase in overdose deaths compared to 2020. Similarly, over 140,000 people die each year from excessive alcohol use. Early and regular SUD treatment, including medication therapy, has been demonstrated to improve outcomes for individuals with SUD, but less than 20 percent of individuals with a SUD receive this important specialty care. These results indicate that most members diagnosed with SUD may have initiated SUD treatment and had two or more additional SUD services or MAT within 34 days of the initiation visit, which, in conjunction with counseling or other behavioral therapies, has been shown to reduce SUD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.[50] **[Quality, Timeliness, Access]**
In the Pediatric Health measure group, the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)* measure rates for all seven ACC Program Contractors and the ACC Program Aggregate. In addition, the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* measure rates for six of the seven ACC Program Contractors and the ACC Program Aggregate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023, and the *Well-Child Visits in the First 30 Months of Life—First 15 Months—Six or More Well-Child Visits* measure rates for six of the seven ACC Program Contractors and the ACC Program Aggregate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. These results suggest that most children and adolescents with ongoing antipsychotic medication use had appropriate metabolic testing performed, which is consistent with the MY 2022 results as well. Antipsychotic prescribing for children and adolescents has increased rapidly in recent decades. These medications can elevate a child's risk for developing serious metabolic health complications associated with poor cardiometabolic outcomes in adulthood. Metabolic monitoring (blood glucose and cholesterol testing) is an important component of ensuring appropriate management of children and adolescents on antipsychotic medications.[51] The results also indicate that many adolescents are receiving the recommended Combination 1 vaccination. Receiving recommended vaccinations is the best defense against serious vaccine-preventable diseases. In addition, the results demonstrate that most children are receiving six or more well-child visits in their first 30 months of life. [**Quality**]
Opportunities for Improvement and Recommendations
In the Maternal and Perinatal Care measure group, rates for four out of seven ACC Program Contractors and the ACC Program Aggregate for the *Prenatal and Postpartum Care—Postpartum Care* measure indicator fell below both the NCQA Quality Compass national Medicaid HMO mean

[50] National Committee for Quality Assurance. Diagnosed Substance Use Disorders. Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-substance-use-disorder-treatment/. Accessed on: Feb 7, 2025.

[51] National Committee for Quality Assurance. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM). Available at: https://www.ncqa.org/hedis/measures/metabolic-monitoring-for-children-and-adolescents-on-antipsychotics/ Accessed on: Feb 13, 2025.

Strengths, Opportunities for Improvement, and Recommendations
for HEDIS MY 2023 and the 25th percentile, indicating a continued opportunity to increase access to timely postpartum care. **[Quality, Timeliness, Access]** Recommendation: As noted by the American College of Obstetricians (ACOG), all women should have contact with their obstetrician/gynecologist or other obstetric provider within three weeks postpartum, followed by ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth.[52] To positively impact women in need of postpartum care, ACC Program Contractors are currently conducting the *Prenatal and Postpartum Care* PIP, which includes a root cause analysis and interventions to address this measure. HSAG recommends that ACC Program Contractors continue monitoring interventions' success should be conducted, and the ACC Program Contractors should submit results as required by AHCCCS.
In the Behavioral Health measure group, the rates for five of the seven ACC Program Contractors and the ACC Program Aggregate rate for the *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* measure indicator fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. These results indicate that some members with a diagnosis of major depression were not receiving continuous medication treatment, which is consistent with the MY 2022 results as well. 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.[53] **[Quality]** Recommendation: HSAG recommends that the ACC Program Contractors consider clinical recommendations shown to improve adherence to antidepressants, such as assessing depressive symptoms at baseline and each follow-up, as well as providing psychoeducation to the member and family.[54]
In the Pediatric Health measure group: • The rates for all seven ACC Program Contractors and the ACC Program Aggregate rate for the *Well-Child Visits in the First 30 Months of Life- 15 Months to 30 Months—Two or More Well-Child Visits* measure fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023, indicating that children who turned 30 months old during the measurement year

[52] National Committee for Quality Assurance. Prenatal and Postpartum Care. Available at: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/ Accessed on: Feb 13, 2025.
[53] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Feb 13, 2025.
[54] Solmi M, Miola A, Croatto G, et al. How can we improve antidepressant adherence in the management of depression? A targeted review and 10 clinical recommendations. *Brazilian Journal of Psychiatry*. 2021;43(2):189–202.

Strengths, Opportunities for Improvement, and Recommendations
did not have at least two well-child visits with a primary care physician in the prior 15 months.[55] **[Quality, Access]** Recommendation: HSAG recommends that the ACC Program Contractors identify performance improvement efforts to improve well child visits, which ACC Program Contractors are already doing through the *Back to Basics* PIP, which includes a root cause analysis and interventions to address this measure. HSAG recommends that the ACC Program Contractors draw as needed from other states' performance improvement initiatives as is helpful. For instance, as part of a federal performance initiative to improve well-child care, California and Virginia have focused on delays in newborn enrollment data, and Missouri and Texas focused on beneficiary barriers and implemented interventions such as utilizing patient portals and phone outreach. HSAG recommends that plans identify other barriers to care and conducting a focus group on identifying abilities to address barriers.[56]
In the Preventive Screening measure group, the rates for six of the seven ACC Program Contractors and the ACC Program Aggregate rate for the *Cervical Cancer Screening—21–64 Years* measure indicator fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. These results indicate that women aged 21-64 years old did not have adequate screening rates for cervical cancer. **[Quality]** Recommendation: HSAG recommends that the ACC Program Contractors consider utilizing one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve cervical cancer screening rates. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends ACC Program Contractors provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge.

Validation of Performance Improvement Projects

Back to Basics PIP

[55] 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: Feb 13, 2025

[56] Centers for Medicare & Medicaid Services. Well-Child Care. Available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html. Accessed on: Feb 12, 2025.

Well-care visits for children and adolescents aim to promote optimal health and development.[57] Ensuring that children and adolescents receive regular well-care visits is critical in disease prevention, early detection, and treatment. There are many benefits of well-child/well-care visits, including disease prevention, tracking growth and development, raising concerns, and establishing a team approach to assist with the development of optimal physical, mental, and social health of a child.[58] Adolescence is a critical stage of development during which physical, intellectual, emotional, and psychological changes occur.[59] Adolescent well-care visits assist with promoting healthy choices and behaviors, preventing risky behaviors, and detecting early the conditions that can inhibit an adolescent's development.

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

ACC Program-Level Validation Results

Table 4-6 presents the ACC program-level overall validation results for each Contractor for the *Back to Basics* PIP. Confidence levels for PIP methodology and significant improvement are described in the PIP section of Appendix A. Methodology.

[57] American Academy of Pediatrics. AAP Schedule of Well-Child Care Visits. Available at: https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx. Accessed on: Feb 13, 2025.
[58] Ibid.
[59] Centers for Disease Control and Prevention. Adolescence: Preparing for Lifelong Health and Wellness. Available at: https://archive.cdc.gov/#/details?url=https://www.cdc.gov/grand-rounds/pp/2015/20150818-adolescent-wellness.html. Accessed on: Feb 13, 2025.

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

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]
AzCH-CCP ACC-RBHA	*High Confidence*	100%	100%	*High Confidence*	100%	100%
BUFC ACC	*High Confidence*	100%	100%	*Low Confidence*	33%	100%
Care1st ACC-RBHA	*High Confidence*	100%	100%	*No Confidence*	33%	100%
HCA ACC	*High Confidence*	100%	100%	*No Confidence*	33%	100%
Mercy Care ACC-RBHA	*Low Confidence*	80%	89%	*High Confidence*	100%	100%
Molina ACC	*Low Confidence*	87%	89%	*High Confidence*	100%	100%
UHCCP ACC	*High Confidence*	100%	100%	*No Confidence*	33%	100%

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

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

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

ACC Program-Level Measure Results

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

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

Contractor	PIP Indicator 1: *Well-Child Visits in the First 30 Months of Life (W30 Rate 1)*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
AzCH-CCP ACC-RBHA	63.2%	60.7%	66.5%
BUFC ACC	63.5%	58.1%	63.6%
Care1st ACC-RBHA	70.5%	53.5%	54.8%
HCA ACC	59.4%	56.1%	63.3%
Mercy Care ACC-RBHA	65.0%	65.1%	67.9%
Molina ACC	49.1%^	56.0%	63.1%
UHCCP ACC	65.6%	61.9%	65.2%

HSAG rounded percentages to the first decimal place.

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

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

Contractor	PIP Indicator 2: *Child and Adolescent Well-Care Visits (WCV)*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
AzCH-CCP ACC-RBHA	46.9%	46.4%	53.2%
BUFC ACC	46.6%	39.6%	44.0%
Care1st ACC-RBHA	51.4%	33.7%	41.8%
HCA ACC	43.6%	39.8%	43.2%
Mercy Care ACC-RBHA	52.9%	49.6%	53.6%
Molina ACC	33.9%	39.6%	43.5%
UHCCP ACC	52.7%	47.4%	50.7%

HSAG rounded percentages to the first decimal place.

ACC Program-Level Interventions

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

message campaigns; emails; member events; and mailing materials. Additionally, several Contractors had physician and/or member incentives in place directly tied to closing gaps in care. Opportunity for Care reports were utilized to inform providers of members in need of well-care visits. These interventions were able to impact indicator performance during this validation cycle. For further descriptions of each Contractor's interventions, see Section 5—ACC Program Contractor-Specific Results.

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

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

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

Strengths, Opportunities for Improvement, and Recommendations
Strengths
Three ACC Program Contractors were able to achieve statistically significant improvement for both performance indicators when comparing baseline rates to Remeasurement 2 rates. Additionally, another ACC Program contractor had statistically significant improvement for one of the two performance indicators. At Remeasurement 2, one ACC Program Contractor sustained the statistically significant improvement that it achieved at Remeasurement 1 for both performance indicators. [**Quality**, **Access**]
Opportunities for Improvement and Recommendations
HSAG identified no opportunities for improvement related to the *Back to Basics* PIP. Recommendations: Although there were no opportunities for improvement identified, HSAG recommends that: • The Contractors seek technical assistance from HSAG to understand the requirements for statistical testing, if needed. • The Contractors ensure that all interventions are evaluated for effectiveness through a measure directly linked to the intervention.

Prenatal and Postpartum Care PIP

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

women."[60] Every death related to pregnancy is a tragedy, especially considering the CDC found that four in five of the deaths are preventable.[61]

According to Healthy People 2030, "women's health before, during, and after pregnancy can have a major impact on infants' health and well-being."[62] Strategies such as maintaining a healthy lifestyle, receiving proper health care, and adopting healthy habits before and during pregnancy help prevent pregnancy complications and improve health outcomes for women and their babies. In addition, these strategies may assist in promoting infant health, development, and overall well-being.

In CYE 2022 (October 1, 2021, through September 30, 2022), AHCCCS implemented the *Prenatal and Postpartum Care* PIP for the ACC-RBHA population. The objective of the *Prenatal and Postpartum Care* PIP is to improve health outcomes for members and infants. This PIP focuses on increasing the number and percentage of members with live birth deliveries that 1) received a prenatal care visit, and 2) received a postpartum visit. HSAG did not conduct a validation of the *Prenatal and Postpartum Care* PIP in CYE 2024 as the PIP was in an intervention year (for CY 2023), in alignment with the *CMS External Quality Review (EQR) Protocols, February 2023*.[63]

ACC Program-Level Interventions

For the *Prenatal and Postpartum Care* PIP, all Contractors provided AHCCCS lists of interventions that were in place for CYE 2024. These lists detailed the identified population, the intervention(s) in place, and whether or not the interventions(s) will be continued. The most common new interventions across Contractors included data dashboards, health equity committees, and technology advancements to support members' access to care and education materials. The most common continued interventions across Contractors included targeting members and providers for outreach and education related to prenatal and postpartum care visits. Outreach methods included person-to-person and automated phone calls; text message campaigns; emails; member events; and mailing materials. Additionally, several Contractors had physician and/or member incentives in place directly tied to closing gaps in care. Opportunity for Care reports and Notification of Pregnancy (NOP) reports through provider portals were utilized to inform providers of members in need of well-care visits. Transportation assistance and pregnancy care programs were offered to pregnant women. The most common enhancements made to interventions included updated education, expanded audience for outreach efforts, increased frequency

[60] Centers for Disease Control and Prevention. Hear Her Campaign. Pregnancy-Related Deaths in the United States. Available at: https://www.cdc.gov/hearher/pregnancy-related-deaths/index.html. Accessed on: Feb 13, 2025.
[61] Ibid.
[62] U.S. Department of Health and Human Services. Healthy People 2030. Pregnancy and Childbirth. Available at: https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth#:~:text=Women's%20health%20before%2C%20during%2C%20and%20after%20pregnancy%20can%20have%20a,and%20to%20have%20healthy%20babies. Accessed on: Feb 13, 2025.
[63] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 13, 2025.

of notifications to members and providers, and improved processes to receive incentives for members and providers.

For further description of each Contractor's interventions, see Section 5. ACC Program Contractor-Specific Results.

Compliance Reviews

For the ACC Program, AHCCCS includes the following focus areas in its compliance review activity. Table 4-10 presents the focus areas, including each associated acronym, used by AHCCCS during its compliance review.

Table 4-10—Focus Areas and Associated Acronyms

Focus Area	Acronym
Corporate Compliance	CC
Claims and Information Standards	CIS
Delivery Systems	DS
General Administration	GA
Grants Management	GM*
Grievance Systems	GS
Adult; EPSDT; and Maternal Child Health	MCH
Medical Management	MM
Member Information	MI
Quality Management	QM
Quality Improvement	QI
Reinsurance	RI
Third-Party Liability	TPL
Integrated Systems of Care	ISOC

*Grants Management (GM) applies to ACC-RBHA Contractors only.

ACC Program-Level Results

AHCCCS conducts a full compliance review for each Contractor every three years. This current three-year review cycle spans from CYE 2022 to CYE 2024. In December 2023, AHCCCS conducted compliance reviews for AzCH-CCP ACC-RBHA and Care1st ACC-RBHA and conducted a compliance review for Mercy Care ACC-RBHA in February 2024. AHCCCS also assessed CAPs for these three Contractors for standards with a total score of less than 95 percent. Table 4-11 presents program-level

and comparative results for the ACC Program for compliance reviews based on the review of all focus areas.

Table 4-11—ACC Program-Level Compliance Review Results

Focus Areas	AzCH-CCP ACC-RBHA	Care1st ACC-RBHA	Mercy Care ACC-RBHA	CYE 2024 Program-Level Average
CC	93%	93%	100%	95%
CIS	100%	99%	99%	99%
DS	100%	97%	97%	97%
GA	98%	98%	96%	97%
GM*	100%	100%	100%	100%
GS	100%	100%	100%	100%
MCH	97%	97%	96%	96%
MM	98%	93%	97%	95%
MI	99%	96%	90%	94%
QM	85%	89%	95%	89%
QI	100%	100%	100%	100%
RI	100%	100%	100%	100%
TPL	100%	100%	100%	100%
ISOC	99%	99%	99%	99%

*Grants Management (GM) applies to ACC-RBHA Contractors only.

During CYE 2024, AHCCCS also assessed BUFC ACC, HCA ACC, Molina ACC, and UHCCP ACC CAPs for standards with a total score of less than 95 percent during CYE 2022. All four Contractors successfully completed all outstanding CAPs during CYE 2024. Results and CAP updates for all Contractors are available in Section 5. ACC Program Contractor-Specific Results.

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

Table 4-12 presents program-level strengths, opportunities for improvement, and recommendations for the ACC Program related to compliance.

Table 4-12—ACC Program Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
The ACC Program-level average score was at or above 95 percent in the following focus areas: • Corporate Compliance (CC) [Quality, Access] • Claims and Information Standards (CIS) [Access] • Delivery Systems (DS) [Timeliness, Access] • General Administration (GA) [Timeliness, Access] • Grants Management (GM) [Quality, Access] • Grievance Systems (GS) [Timeliness, Access] • Adult, EPSDT, and Maternal Child Health (MCH) [Quality, Timeliness, Access] • Medical Management (MM) [Timeliness, Access] • Quality Improvement (QI) [Quality, Access] • Reinsurance (RI) [Quality] • Third-Party Liability (TPL) [Quality, Timeliness, Access] • Integrated Systems of Care (ISOC) **[Quality, Access]** Two of the three ACC Program Contractors that underwent compliance reviews in CYE 2024 successfully completed all CAPs. All four of the ACC Program Contractors that underwent compliance reviews in CYE 2022 successfully completed all remaining CAPs during CYE 2024.
Opportunities for Improvement and Recommendations
The ACC Program-level average score was below 95 percent in the following focus areas: • Member Information (MI) **[Quality]** • Quality Management (QM) **[Quality]** Recommendation: HSAG recommends that the ACC Program Contractors continue to work on any outstanding CAPs during CYE 2025.

Network Adequacy Validation

ACC Program-Level Results

ISCA Results

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

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

NAV Results

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

Table 4-13 summarizes HSAG's assessment of each ACC Program Contractor's compliance with AHCCCS' minimum time/distance network standards. A check mark indicates that the ACC Program Contractor met the minimum network standard for all assigned counties during the CYE 2024 S1 assessment, and an "X" indicates that the ACC Program Contractor did not meet one or more minimum network standards in any assigned county. Section 5. ACC Program Contractor-Specific Results contains NAV results specific to each ACC Program Contractor.

Table 4-13—Summary of CYE 2024 Compliance With Minimum Time/Distance Network Requirements for ACC Program Contractors

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

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

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

Isolated data issues may have contributed to specific instances affecting ACC Program Contractors' compliance with time/distance standards. Specific examples include the following:

- In CYE 2024 S1, one ACC Program Contractor's data included decreased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; Behavioral Health Residential Facility; and Hospital. When contacted, the ACC Program Contractor indicated its query parameters for including these providers in its reporting were too narrow, resulting in the exclusion of some providers who should have been included in its reporting. The ACC Program Contractor has taken steps to correct the query before the next submission. The decreased number of providers potentially influenced the validated compliance for these provider categories.
- In CYE 2024 S1, the data for one ACC Program Contractor included substantially increased numbers of providers used to measure the following standards, as compared to prior submissions:

Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; and Hospital. When contacted, the ACC Program Contractor indicated that it inadvertently included home office addresses in its report of service addresses, raising the number of providers in the count. This potentially influenced the validated compliance for these provider categories.

- In CYE 2024 S1, data for one ACC Program Contractor included decreased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; Behavioral Health Residential Facility; and Hospital. When contacted, the ACC Program Contractor indicated the reduction was a result of a coding error in how the system identifies these providers, resulting in failure to report the Contractor's complete network. The ACC Program Contractor corrected the issue and identified steps to prevent this in the future. The decreased number of providers potentially influenced the validated compliance for these provider categories.

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

Overall, the applicable ACC Program Contractors met all minimum time/distance network standards in Cochise, Graham, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. Based on the CYE 2024 S1 NAV results, Mercy Care ACC was the only ACC Program Contractor that met all requirements for all standards in its respective counties.

Each ACC Program Contractor should continue to monitor and maintain its existing provider network as of CYE 2024 S1, with specific attention to ensuring the availability of the following provider categories where more than one ACC Program Contractor did not meet the network requirement:

- Behavioral Health Outpatient and Integrated Clinic, Pediatric in Apache, Gila, and Maricopa counties.
- Dentist, Pediatric in Apache, Coconino, Gila, Greenlee, and La Paz counties.
- Pharmacy in La Paz County.

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

Table 4-14 presents program-level strengths, opportunities for improvement, and recommendations for the ACC Program related to NAV.

Table 4-14—ACC Program Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • The ACC Program Contractors received *High Confidence* for both appointment availability and time/distance indicators. **[Access]** • The applicable ACC Program Contractors met all minimum time/distance network standards in Cochise, Graham, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. **[Access]** • The ACC Program Contractors consistently met Cardiologist, Adult and Pediatric; Hospital; OB/GYN; and PCP, Adult and Pediatric standards. **[Access]**
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: • Isolated data issues may have contributed to specific instances affecting ACC Program Contractors' compliance with time/distance standards. **[Access]** • Based on the NAV results, more than one ACC Program Contractor did not meet the standards for Behavioral Health Outpatient and Integrated Clinic, Pediatric; Dentist, Pediatric; and Pharmacy. **[Access]** Recommendations: • HSAG recommends that AHCCCS support the ACC Program Contractors in continuing to monitor their processes for creating the PAT file and review this file for accuracy prior to submitting to AHCCCS. • HSAG recommends that AHCCCS support each ACC Program Contractor in continuing to monitor and maintain its existing provider network coverage as of CYE 2024 S1, with specific attention to ensuring the availability of the following provider categories where more than one ACC Program Contractor did not meet the network requirement: – Behavioral Health Outpatient and Integrated Clinic, Pediatric in Apache, Gila, and Maricopa counties. – Dentist, Pediatric in Apache, Coconino, Gila, Greenlee, and La Paz counties. – Pharmacy in La Paz County.

Consumer Assessment of Healthcare Providers and Systems Results

ACC Program Adult Medicaid Results

HSAG administered member experience surveys on AHCCCS' behalf to adult members enrolled with an ACC Contractor from the statewide sample and the ACC oversample provided by AHCCCS.

HSAG calculated results for four global rating questions, four composite measures, one individual item measure, and three medical assistance with smoking and tobacco use cessation items.

Table 4-15 shows the 2024 scores and overall member experience ratings on each CAHPS measure for the adult Medicaid population.

Table 4-15—National Comparisons

Measures	Adult Medicaid
Global Ratings	
Rating of Health Plan	★★★ 63.6%
Rating of All Health Care	★★ 52.4%
Rating of Personal Doctor	★★★ 71.6%
Rating of Specialist Seen Most Often	★★ 65.2%
Composite Measures	
Getting Needed Care	★ 76.6%
Getting Care Quickly	★★ 77.0%
How Well Doctors Communicate	★★★ 93.9%
Customer Service	★ 85.9%
Individual Item Measure	
Coordination of Care	★★★ 86.1%
Medical Assistance With Smoking and Tobacco Use Cessation Items	
Advising Smokers and Tobacco Users to Quit	★ 67.1%+

Measures	Adult Medicaid
Discussing Cessation Medications	★ 45.7%+
Discussing Cessation Strategies	★ 37.0%+

Star Assignments Based on Percentiles:
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Table 4-16 shows the results of the trend analysis wherein the 2024 CAHPS results were compared to their corresponding 2023 CAHPS results on each CAHPS measure for the adult Medicaid population.

Table 4-16—Trend Analysis

Measure	Adult Medicaid		
	2023	2024	Trend Results (2024 Compared to 2023)
Global Ratings			
Rating of Health Plan	68.0%	63.6%	—
Rating of All Health Care	56.9%	52.4%	—
Rating of Personal Doctor	70.1%	71.6%	—
Rating of Specialist Seen Most Often	67.3%	65.2%	—
Composite Measures			
Getting Needed Care	81.3%	76.6%	—
Getting Care Quickly	76.1%+	77.0%	—
How Well Doctors Communicate	92.0%	93.9%	—
Customer Service	84.1%	85.9%	—
Individual Item Measure			
Coordination of Care	81.0%+	86.1%	—
Medical Assistance with Smoking and Tobacco Use Cessation Items			
Advising Smokers and Tobacco Users to Quit	61.4%+	67.1%+	—
Discussing Cessation Medications	47.7%+	45.7%+	—
Discussing Cessation Strategies	38.6%+	37.0%+	—

— Indicates the 2024 score is not statistically significantly higher or lower than the 2023 score.
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

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

Table 4-17 presents program-level strengths, opportunities for improvement, and recommendations for the ACC Program related to the 2024 ACC program-level CAHPS results for adult Medicaid.

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

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths for the ACC Program's adult Medicaid population: • The ACC Program's member experience ratings did not meet or exceed the 75th percentile for any measure; therefore, no substantial strengths were identified for national comparison results for the adult Medicaid population. • The adult ACC Program's 2024 scores were not statistically significantly higher than the 2023 scores; therefore, no substantial strengths were identified for trend results for the adult Medicaid population.
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement for the ACC Program's adult Medicaid population: • The ACC Program's member experience ratings *for Getting Needed Care, Customer Service, Advising Smokers and Tobacco Users to Quit, Discussing Cessation Medications,* and *Discussing Cessation Strategies* were below the 25th percentile for the adult Medicaid population. **[Quality, Access]** • The ACC Program's member experience ratings for *Rating of All Health Care*, *Rating of Specialist Seen Most Often,* and *Getting Care Quickly* were at or between the 25th and 49th percentile for the adult Medicaid population. **[Quality, Timeliness]** • The ACC Program's 2024 scores were not statistically significantly lower than the 2023 scores; therefore, no substantial weaknesses were identified for trend results for the adult Medicaid population. **[Quality]** Recommendation: HSAG recommends that the ACC Program Contractors explore what may be driving lower experience scores and develop initiatives designed to improve the quality of and access to care, including a focus on improving adult members' overall experiences with their health care, customer service, and medical assistance with smoking and tobacco use.

ACC Program Child Medicaid Results

HSAG administered member experience surveys on AHCCCS' behalf to child members enrolled with an ACC Contractor from the statewide sample and the ACC oversample provided by AHCCCS.

HSAG calculated results for four global rating questions, four composite measures, one individual item measure, and five CCC composites/items (CCC population only).

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

Table 4-18 shows the 2024 scores and overall member experience ratings on each CAHPS measure for both the general child and CCC populations.

Table 4-18—National Comparisons

Measure	2024 General Child Medicaid	2024 CCC Medicaid
Global Ratings		
Rating of Health Plan	★★★★ 77.1%	★★★★ 73.4%
Rating of All Health Care	★★★★ 71.7%	★★★★★ 77.1%
Rating of Personal Doctor	★★★ 77.6%	★★★★ 78.3%
Rating of Specialist Seen Most Often	★★ 70.5%+	★★★★ 78.9%+
Composite Measures		
Getting Needed Care	★★★ 85.6%	★★★ 86.8%+
Getting Care Quickly	★★★★★ 91.4%+	★★★★ 91.9%+
How Well Doctors Communicate	★★★ 94.5%	★★★ 95.2%+
Customer Service	★★★★★ 93.6%+	★ 81.0%+

Measure	2024 General Child Medicaid	2024 CCC Medicaid
Individual Item Measure		
Coordination of Care	★★ 82.5%+	★★ 83.6%+
CCC Composite Measures and Items		
Access to Specialized Services	NA	★ 62.5%+
Family-Centered Care (FCC): Personal Doctor Who Knows Child	NA	★ 88.0%+
Coordination of Care for Children with Chronic Conditions	NA	★★★★★ 81.8%+
Access to Prescription Medicines	NA	★★★★★ 99.1%
FCC: Getting Needed Information	NA	★★★★★ 96.2%

Star Assignments Based on Percentiles:
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
NA Indicates that this measure is not applicable for the population.

Table 4-19 shows the results of the trend analysis wherein the 2024 CAHPS results were compared to their corresponding 2023 CAHPS results on each CAHPS measure for both the general child and CCC populations.

Table 4-19—Trend Analysis

Measure	General Child Medicaid			CCC Medicaid		
	2023	2024	Trend Results (2024 Compared to 2023)	2023	2024	Trend Results (2024 Compared to 2023)
Global Ratings						
Rating of Health Plan	73.8%	77.1%	—	59.9%	73.4%	▲
Rating of All Health Care	68.6%	71.7%	—	57.4%	77.1%	▲
Rating of Personal Doctor	75.7%	77.6%	—	67.1%	78.3%	▲
Rating of Specialist Seen Most Often	63.9%+	70.5%+	—	61.6%+	78.9%+	▲
Composite Measures						
Getting Needed Care	82.7%+	85.6%	—	83.7%	86.8%+	—
Getting Care Quickly	86.6%	91.4%+	—	89.7%+	91.9%+	—

Measure	General Child Medicaid			CCC Medicaid		
	2023	2024	Trend Results (2024 Compared to 2023)	2023	2024	Trend Results (2024 Compared to 2023)
How Well Doctors Communicate	94.3%	94.5%	—	93.1%	95.2%+	—
Customer Service	92.7%+	93.6%+	—	85.8%+	81.0%+	—
Individual Item Measure						
Coordination of Care	79.6%+	82.5%+	—	70.6%+	83.6%+	—
CCC Composite Measures and Items						
Access to Specialized Services	NA	NA	NA	67.7%+	62.5%+	—
FCC: Personal Doctor Who Knows Child	NA	NA	NA	87.5%	88.0%+	—
Coordination of Care for Children with Chronic Conditions	NA	NA	NA	75.1%+	81.8%+	—
Access to Prescription Medicines	NA	NA	NA	89.4%	99.1%	▲
FCC: Getting Needed Information	NA	NA	NA	91.1%	96.2%	—

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.
— Indicates the 2024 score is not statistically significantly higher or lower than the 2023 score.
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
NA Indicates that this measure is not applicable for the population.

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

Table 4-20 presents program-level strengths, opportunities for improvement, and recommendations for the ACC Program related to the 2024 ACC program-level CAHPS results for child Medicaid.

Table 4-20—ACC Program Strengths, Opportunities for Improvement, and Recommendations Related to CAHPS

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths for the ACC Program's child Medicaid population:

Strengths, Opportunities for Improvement, and Recommendations
• The ACC Program's member experience ratings were at or above the 90th percentile for *Getting Care Quickly* and *Customer Service* for the general child population. **[Quality, Timeliness]** • The ACC Program's member experience ratings were at or between the 75th and 89th percentile for *Rating of Health Plan* and *Rating of All Health Care* for the general child population. **[Quality]** • The ACC Program's member experience ratings were at or above the 90th percentile for *Rating of All Health Care*, *Coordination of Care for Children with Chronic Conditions*, *Access to Prescription Medicines,* and *FCC: Getting Needed Information* for the CCC population. **[Quality, Access]** • The ACC Program's member experience ratings were at or between the 75th and 89th percentile for *Rating of Health Plan*, *Rating of Personal Doctor, Rating of Specialist Seen Most Often,* and *Getting Care Quickly* for the CCC population. **[Quality]** • The ACC Program's 2024 scores were statistically significantly higher than the 2023 scores for *Rating of Health Plan*, *Rating of All Health Care, Rating of Personal Doctor*, *Rating of Specialist Seen Most Often,* and *Access to Prescription Medicines* for the CCC population. **[Quality, Access]**
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement for the ACC Program's child Medicaid population: • The ACC Program's member experience rating for *Rating of Specialist Seen Most Often* was at or between the 25th and 49th percentile for the general child population. **[Quality]** • The ACC Program's member experience rating for *Coordination of Care* was at or between the 25th and 49th percentile for the general child population. **[Quality]** • The ACC Program's member experience rating for *Coordination of Care* was at or between the 25th and 49th percentile for the CCC population. **[Quality]** • The ACC Program's member experience ratings for *Customer Service, Access to Specialized Services*, and *FCC: Personal Doctor Who Knows Child* were below the 25th percentile for the CCC population. **[Quality, Access]** • The ACC Program's 2024 scores were not statistically significantly lower than the 2023 scores; therefore, no substantial weaknesses were identified for trend results for the general child population. **[Quality]** • The ACC Program's 2024 scores were not statistically significantly lower than the 2023 scores; therefore, no substantial weaknesses were identified for trend results for the CCC population. **[Quality]** Recommendation: HSAG recommends that the ACC Program Contractors explore what may be driving lower experience scores and develop initiatives designed to improve the quality of and access to care, including a focus on improving parents'/caretakers' overall experiences with their child's specialist, personal doctor who knows child, coordination of care, customer service, and access to specialized services, for child members.

KidsCare Results

HSAG administered member experience surveys on AHCCCS' behalf to members enrolled in the AHCCCS' KidsCare program. KidsCare is Arizona's CHIP for eligible children (under 19 years of age) who do not qualify for other AHCCCS health insurance. AHCCCS contracted with HSAG to administer and report the results of the CAHPS Health Plan Survey for the KidsCare program. The goal of the CAHPS Health Plan Survey is to provide performance feedback that is actionable and will aid in improving overall member experience.

HSAG calculated results for four global ratings, four composite measures, one individual item measure, and five CCC composites/items (CCC population only).

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

Table 4-21 shows the 2024 scores and overall member experience ratings on each CAHPS measure for both the general child and CCC populations.

Table 4-21—National Comparisons

Measure	2024 General Child Medicaid	2024 CCC Medicaid
Global Ratings		
Rating of Health Plan	★★★★ 76.1%	★★★★ 71.3%
Rating of All Health Care	★★★★ 71.7%	★★★ 68.8%
Rating of Personal Doctor	★★★ 78.5%	★★★★ 80.2%
Rating of Specialist Seen Most Often	★★★ 73.5%	★★★★ 77.2%+
Composite Measures		
Getting Needed Care	★★★ 86.2%	★★★ 87.1%
Getting Care Quickly	★★★★ 90.2%	★★★ 90.6%+

Measure	2024 General Child Medicaid	2024 CCC Medicaid
How Well Doctors Communicate	★★★★★ 96.9%	★★★★★ 97.9%
Customer Service	★★★★★ 91.5%	★★ 88.6%+
Individual Item Measure		
Coordination of Care	★★★ 85.8%	★★ 82.9%+
CCC Composite Measures and Items		
Access to Specialized Services	NA	★ 58.8%+
FCC: Personal Doctor Who Knows Child	NA	★★★★ 92.5%+
Coordination of Care for Children with Chronic Conditions	NA	★★★★★ 82.9%+
Access to Prescription Medicines	NA	★★ 89.9%
FCC: Getting Needed Information	NA	★★★★ 93.6%

Star Assignments Based on Percentiles:
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
NA Indicates that this measure is not applicable for the population.

Table 4-22 shows the results of the trend analysis wherein the 2023 CAHPS results were compared to their corresponding 2023 CAHPS results on each CAHPS measure for both the general child and CCC populations.

Table 4-22—Trend Analysis

Measure	General Child Medicaid			CCC Medicaid		
	2023	2024	Trend Results (2024 Compared to 2023)	2023	2024	Trend Results (2024 Compared to 2023)
Global Ratings						
Rating of Health Plan	68.5%	76.1%	▲	67.8%	71.3%	—
Rating of All Health Care	63.5%	71.7%	—	61.5%	68.8%	—
Rating of Personal Doctor	73.7%	78.5%	—	74.3%	80.2%	—

Measure	General Child Medicaid			CCC Medicaid		
	2023	2024	Trend Results (2024 Compared to 2023)	2023	2024	Trend Results (2024 Compared to 2023)
Rating of Specialist Seen Most Often	76.0%+	73.5%	—	67.1%+	77.2%+	—
Composite Measures						
Getting Needed Care	87.5%+	86.2%	—	84.3%+	87.1%	—
Getting Care Quickly	83.7%+	90.2%	—	94.3%+	90.6%+	—
How Well Doctors Communicate	94.9%	96.9%	—	95.3%	97.9%	—
Customer Service	86.7%+	91.5%	—	86.1%+	88.6%+	—
Individual Item Measure						
Coordination of Care	75.4%+	85.8%	—	76.3%+	82.9%+	—
CCC Composite Measures and Items						
Access to Specialized Services	NA	NA	NA	72.9%+	58.8%+	—
FCC: Personal Doctor Who Knows Child	NA	NA	NA	85.2%+	92.5%+	▲
Coordination of Care for Children with Chronic Conditions	NA	NA	NA	78.0%+	82.9%+	—
Access to Prescription Medicines	NA	NA	NA	90.6%	89.9%	—
FCC: Getting Needed Information	NA	NA	NA	94.3%	93.6%	—

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.
— Indicates the 2024 score is not statistically significantly higher or lower than the 2023 score.
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
NA Indicates that this measure is not applicable for the population.

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

Table 4-23 presents program-level strengths, opportunities for improvement, and recommendations for the ACC Program related to the 2024 KidsCare Program-Level CAHPS results.

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

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths for KidsCare: • KidsCare's member experience ratings for *How Well Doctors Communicat*e and *Customer Service* were at or above the 90th percentiles for the general child population. **[Quality]** • KidsCare's member experience ratings for *Rating of Health Plan*, *Rating of All Health Care*, and *Getting Care Quickly* were at or between the 75th and 89th percentile for the general child population. **[Quality, Timeliness]** • KidsCare's member experience ratings for *How Well Doctors Communicat*e and *Coordination of Care for Children with Chronic Conditions* were at or above the 90th percentile for the CCC population. **[Quality]** • KidsCare's member experience ratings for *Rating of Health Plan*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *(FCC): Personal Doctor Who Knows Child*, and *FCC: Getting Needed Information* were at or between the 75th and 89th percentile for the CCC population. **[Quality]** • KidsCare's 2024 scores were statistically significantly higher than the 2023 scores for *Rating of Health Plan* for the general child population and *FCC: Personal Doctor Who Knows Child* for the CCC population. **[Quality]**
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement for KidsCare: • KidsCare's member experience ratings did not fall below the 50th percentile; therefore, no substantial weaknesses were identified for national comparison results for the general child population. **[Quality]** • KidsCare's member experience ratings for *Customer Service*, *Coordination of Care*, and *Access to Prescription Medicines* were at or between the 25th and 49th percentile for the CCC population. **[Quality, Access]** • KidsCare's member experience rating for *Access to Specialized Services* was below the 25th percentile for the CCC population. **[Quality, Access]** • KidsCare's 2024 scores were not statistically significantly lower than the 2023 scores; therefore, no substantial weaknesses were identified for trend results for the general child or CCC population. **[Quality]** Recommendation: HSAG recommends that the KidsCare Contractors explore what may be driving lower experience scores and develop initiatives designed to improve the quality of and access to care, including a focus on improving parents'/caretakers' overall experiences with coordination of care, customer service, access to prescription medicines, and access to specialized services for child members.

5. ACC Program Contractor-Specific Results

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

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

AzCH-CCP ACC-RBHA

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2024, HSAG evaluated AzCH-CCP ACC-RBHA's data system for processing of each data type used for reporting the Contractor's CY 2023 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that AzCH-CCP ACC-RBHA followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-1 displays HSAG's PMV findings for each data type reviewed during CYE 2024 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 5-1—CYE 2024 PMV Findings

Data Type	HSAG Findings
Medical Services Data	*No identified concerns*
Enrollment Data	*No identified concerns*
Provider Data	*No identified concerns*
Medical Record Review Process	*No identified concerns*
Supplemental Data	*No identified concerns*
Data Integration	*No identified concerns*

Results for Performance Measures

Table 5-2 presents the CY 2022 and CY 2023 AzCH-CCP ACC-RBHA performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for

HEDIS MY 2022 and MY 2023. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and/or MY 2023. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 5-2—CY 2022 and CY 2023 AzCH-CCP ACC-RBHA Performance Measure Results

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	82.7%+	76.6%+	↓	★
Postpartum Care	66.4%+	76.6%+	↑	★★
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	60.5%	62.2%	→	★★
Effective Continuation Phase Treatment—Total (18+ Years)	41.4%	43.3%	↑	★★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	30.6%	29.0%	→	★★★
30-Day Follow-Up—Total (13+ Years)	39.7%	39.4%	→	★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	44.5%	45.7%	→	★★★
30-Day Follow-Up—Total (6+ Years)	61.3%	63.9%	↑	★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	50.8%	48.6%	→	★★★
30-Day Follow-Up—Total (6+ Years)	60.0%	59.3%	→	★★★
Use of Opioids at High Dosage				
*18+ Years**	6.8%	6.3%	→	★★
Initiation and Engagement of Substance Use Disorder (SUD) Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	52.3%	48.9%	↓	★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	21.2%	18.2%	↓	★★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	43.5%	43.7%	→	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	78.2%	81.5%	↑	★★★

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Care of Acute and Chronic Conditions				
Controlling High Blood Pressure				
18–85 Years[+]	50.6%[+]	65.2%[+]	↑	★★★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0%)—Total (18–75 Years)	51.6%[+]	62.0%[+]	↑	★★★★
*Poor HbA1c Control (>9.0%)—Total (18–75 Years)**	36.3%[+]	30.7%[+]	→	★★★
Pediatric Health				
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	52.7%	54.5%	→	★★★★
Childhood Immunization Status**				
Combination 3	64.0%[+]	62.5%[+]	→	★★
Combination 7	56.2%[+]	56.0%[+]	→	★★★
Combination 10	28.5%[+]	24.1%[+]	→	★★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	84.9%[+]	87.1%[+]	→	★★★★
Combination 2 (Meningococcal, Tdap, HPV)	46.0%[+]	41.8%[+]	→	★★★★
Oral Evaluation, Dental Services				
Total (0–20 Years)[N]	46.2%	46.7%	↑	—
Well-Child Visits in the First 30 Months of Life				
First 15 Months—Six or More Well-Child Visits	60.7%	66.5%	↑	★★★★
15 Months to 30 Months—Two or More Well-Child Visits	58.1%	63.1%	↑	★
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	46.4%	53.2%	↑	★★★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	53.9%	54.6%	→	★★★
Cervical Cancer Screening				
21–64 Years	53.3%[+]	51.8%[+]	→	★★
Appropriate Utilization of Services				
Ambulatory Care				
Emergency Department (ED) Visits —Total (0–85+ Years)[F]	482.7	492.2	—	—

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Plan All-Cause Readmissions				
*Observed/Expected (O/E) Ratio—Total (18–64 Years)**	1.1185	1.0311	—	★★

* A lower rate indicates better performance for this measure.
** Table A-2 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
+ Indicates the measure was reported using hybrid methodology.
Cells shaded green indicate that the rate met or exceeded the MY 2022 and/or MY 2023 national Medicaid mean.
— Indicates a 2022–2023 comparison is not presented in the CYE 2024 Annual Technical Report because either the CY 2022 rate was not presented in the CYE 2023 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
[1] Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.
[2] Performance Levels for CY 2023 were based on comparisons of the HEDIS MY 2023 measure rates to national Medicaid Quality Compass HEDIS MY 2023 benchmarks.
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.
[N] Measure has no NCQA Medicaid mean for comparison.
↑ Indicates statistically significant improvement of measure rates.
↓ Indicates statistically significant decline of measure rates.
→ Indicates no statistically significant change in measure rates.
Performance Levels for 2023 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

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

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

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group: • Nine of 13 AzCH-CCP ACC-RBHA measure rates (69.23 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 **[Quality, Timeliness, Access]** – *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)* and *30-Day Follow-Up—Total (13+ Years)*

Strengths, Opportunities for Improvement, and Recommendations
– *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* – *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* – *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* and *Engagement of SUD Treatment—Total—Total (13+ Years)* – *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (18–64 Years)* • AzCH-CCP ACC-RBHA's performance measure rates for these measures were at or between the 50th and 74th percentile, indicating good follow-up and continuity of care provided to members with substance use or mental illness, whether hospitalized or in the ED. In addition, the results indicate that most members diagnosed with SUD initiated treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth treatment, or MAT within 14 days of diagnosis and had two more or more additional SUD services or medications within 34 days of the initiation visit.[64] **[Quality, Timeliness, Access]**
In the Pediatric Health measure group: • Six of 11 AzCH-CCP ACC-RBHA measure rates (54.55 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 **[Quality, Timeliness, Access]** – *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)* – *Childhood Immunization Status—Combination 7* – *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* • *Well-Child Visits in the First 30 Months of Life—First 15 Months—Six or More Well-Child Visits* – *Child and Adolescent Well-Care Visits—Total (3–21 Years)* • AzCH-CCP ACC-RBHA's performance measure rates for *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* were at or between the 75th and 89th percentile, indicating that most adolescents were receiving one dose of meningococcal vaccine, one Tdap [tetanus, diphtheria, pertussis] vaccine, and the complete HPV vaccine series by their 13th birthday. Receiving recommended vaccinations is the best defense against serious vaccine-preventable diseases, including meningococcal meningitis, tetanus, diphtheria, pertussis (whooping cough), and HPV.[65] In addition, AzCH-CCP ACC-RBHA's

[64] National Committee for Quality Assurance. Initiation and Engagement of Substance Use Disorder (IET). Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-substance-use-disorder-treatment/. Accessed on: Feb 13, 2025.

[65] National Committee for Quality Assurance. Immunizations for Adolescents. Available at: https://www.ncqa.org/hedis/measures/immunizations-for-adolescents/. Accessed on: Feb 13, 2025.

Strengths, Opportunities for Improvement, and Recommendations
performance measure rate for *Well-Child Visits in the First 30 Months of Life—Six or More Well-Child Visits* was at or between the 75th and 89th percentile, indicating that most children who turned 15 months old during the measurement year had at least six well-child visits with a PCP. [66] [**Quality, Access**] • AzCH-CCP ACC-RBHA's performance measure rates for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)* were at or between the 75th and 89th percentile, indicating that most children and adolescents with ongoing antipsychotic medication use had metabolic testing performed. Metabolic monitoring (blood glucose and cholesterol testing) is an important component of ensuring appropriate management of children and adolescents on antipsychotic medications[67] [**Quality**]
In the Care of Acute and Chronic Conditions measure group: • All three AzCH-CCP ACC-RBHA measure rates (100 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. **[Quality]** • AzCH-CCP ACC-RBHA's performance measure rate for *Hemoglobin A1c Control for Patients With Diabetes— HbA1c Control (<8.0%)—Total (18–75 Years)* was between the 75th and 89th percentile, indicating that most members had good control over diabetes. **[Quality]**
Opportunities for Improvement and Recommendations
While AzCH-CCP ACC-RBHA was successful in reporting valid rates for all AHCCCS-required performance measures for its ACC population, the audit identified some considerations and recommendations for future years' reporting. **[Quality]** Recommendations: HSAG recommends that AzCH-CCP ACC-RBHA continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES. In addition, HSAG recommends that AzCH-CCP ACC-RBHA continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes AHCCCS' requirements for MCO-enrolled members who switch product lines or MCOs and members for whom AzCH-CCP ACC-RBHA does not hold the primary insurance contract.
In the Maternal and Perinatal Care measure group, AzCH-CCP ACC-RBHA's performance measure rate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* fell below the 25th percentile, while the *Prenatal and Postpartum Care—Postpartum Care* rate fell at or between the 25th and 49th percentile, indicating an opportunity to increase access to timely prenatal and postpartum care. **[Quality, Timeliness, Access]**

[66] 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: Feb 13, 2025.

[67] National Committee for Quality Assurance. Metabolic Monitoring for Children and Adolescents on Antipsychotics. Available at: https://www.ncqa.org/hedis/measures/metabolic-monitoring-for-children-and-adolescents-on-antipsychotics/. Accessed on: Feb 13, 2025.

Strengths, Opportunities for Improvement, and Recommendations
Recommendations: AzCH-CCP ACC-RBHA reported implementing several interventions to target performance on *Prenatal and Postpartum Care—Timeliness of Prenatal Care,* including the Start Smart for Your Baby (SSFB) program, a mobile application with specialized care plans, and identifying an internal workgroup to improve performance. HSAG recommends that AzCH-CCP ACC-RBHA continue to implement appropriate interventions to improve performance relative to prenatal and postpartum care. HSAG also recommends that AzCH-CCP ACC-RBHA monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Postpartum Care* measure indicator, while adding interventions as appropriate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care*.
In the Behavioral Health measure group, AzCH-CCP ACC-RBHA's performance measure rate for *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (18+ Years)* fell below the 25th percentile and fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and MY 2023, indicating opportunities to improve psychotropic medication compliance for members. **[Quality]** Recommendations: Schizophrenia is a chronic and disabling psychiatric disorder that requires ongoing treatment and monitoring. Symptoms include hallucinations, illogical thinking, memory impairment, and incoherent speech. Medication nonadherence is common and a major concern in the treatment of schizophrenia. Using antipsychotic medications as prescribed reduces the risk of relapse or hospitalization.[68] In a systematic review of medication adherence studies, several interventions that worked in studies were motivational interviewing, daily texts to individuals with schizophrenia, and other medication reminders. Other effective studies utilized Meds-Help, a pharmacy-based intervention, environmental support through home visits and reminders to adhere to medication, a psychoeducational program (Family Schizophrenia Psychoeducation Program [FSPP]), an intervention called Supervised Treatment in Outpatients for Schizophrenia (STOPS) that focuses on the importance of the supervisor's role for patients during treatment, and an individualized occupational therapy (IOT) program.[69] HSAG recommends that AzCH-CCP ACC-RBHA consider implementing one or more of these interventions that have been associated with increased medication adherence for members with schizophrenia. In addition, HSAG recommends that AzCH-CCP ACC-RBHA consider utilizing financial incentives offered to patients with severe mental illness to improve treatment adherence.
In the Pediatric Health measure group, AzCH-CCP ACC-RBHA's performance measure rate for *Well-Child Visits in the First 30 Months of Life—15 Months to 30 Months—Two or More Well-Child Visits*

[68] National Committee for Quality Assurance. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA). Available at: https://www.ncqa.org/hedis/measures/adherence-to-antipsychotic-medications-for-individuals-with-schizophrenia/. Accessed on: Feb 13, 2025.

[69] Cahaya N, Kristina SA, Widayanti AW, et al. Interventions to Improve Medication Adherence in People with Schizophrenia: A Systematic Review. Patient preference and adherence vol. 16 2431-2449. 1 Sep. 2022, doi:10.2147/PPA.S378951. Available at: https://pubmed.ncbi.nlm.nih.gov/36072918/. Accessed on: Feb 13, 2025.

Strengths, Opportunities for Improvement, and Recommendations
fell below the 25th percentile, indicating opportunities for children who turned 30 months old during the measurement year to have at least two well-child visits with a PCP in the prior 15 months.[70] **[Quality, Access]** Recommendations: Notably, while the performance measure rate was below the 25th percentile for MY 2023, the AzCH-CCP ACC-RBHA rate did improve from MY 2022. HSAG recommends that AzCH-CCP ACC-RBHA continue implementing interventions as part of the *Back to Basics* PIP, which includes a root cause analysis and interventions to address this measure. HSAG recommends that AzCH-CCP ACC-RBHA draw as needed from other states' performance improvement initiatives. For instance, as part of a federal performance initiative to improve well-child care, California and Virginia have focused on delays in newborn enrollment data, and Missouri and Texas focused on beneficiary barriers and implemented interventions such as utilizing patient portals and phone outreach. HSAG recommends that plans identify other barriers to care and conduct a focus group on identifying ways to address barriers.[71]
In the Appropriate Utilization of Services measure group, AzCH-CCP ACC-RBHA's performance measure rate for *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total (18–64 Years)* fell at or between the 25th and 49th percentile, indicating that members who were admitted for an acute inpatient and observation stay might have followed that stay with an unplanned acute readmission for any diagnosis within 30 days.[72] **[Quality]** Recommendations: HSAG recommends that AzCH-CCP ACC-RBHA consider reviewing the Re-Engineered Discharge (RED), which has been shown to reduce readmissions and posthospital ED visits.[73] Other interventions that might be effective include technology platforms, including AI or machine learning, that can assist the plan in identifying members more at risk of readmission. HSAG recommends that AzCH-CCP ACC-RBHA utilize case management strategies that focus on person-centered techniques, addressing barriers and/or SDOH as needed.

[70] 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: Feb 13, 2025.
[71] Centers for Medicare & Medicaid Services. Well-Child Care. Available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html. Accessed on: Feb 12, 2025.
[72] National Committee for Quality Assurance. Plan All-Cause Readmissions. Available at: Plan All-Cause Readmissions - NCQA. Accessed on: Feb 12, 2025.
[73] Agency for Healthcare Research and Quality. Re-Engineered Discharge (RED) Toolkit. Available at: https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool1.html. Accessed on: Feb 12, 2025.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-4 presents performance measure recommendations made to AzCH-CCP ACC-RBHA in the CYE 2023 Annual Technical Report[74] and AzCH-CCP ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which AzCH-CCP ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-4—AzCH-CCP ACC-RBHA Follow-Up to CYE 2023 Performance Measure Recommendations

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Recommendation 1:
HSAG recommended that AzCH-CCP ACC-RBHA continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. Additionally, HSAG recommended that AzCH-CCP ACC-RBHA continue to 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.
AzCH-CCP ACC-RBHA's Response:
AzCH-CCP ACC-RBHA is continuing to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. AzCH-CCP ACC-RBHA continues to conduct and complete formal reviews of the source code, including a complete test plan, and live system validation of data, and correct any discrepancies identified.
HSAG's Assessment: HSAG determined that AzCH-CCP ACC-RBHA satisfactorily addressed these prior year's recommendations.
Recommendation 2:
While AzCH-CCP ACC-RBHA conducted a root cause analysis and implemented targeted interventions specific to the CY 2021 *Prenatal and Postpartum Care—Postpartum Care* rate, this rate remained low in CY 2022; therefore, HSAG recommended that AzCH-CCP ACC-RBHA continue to implement appropriate interventions to improve performance relative to prenatal and postpartum care. HSAG also recommended that AzCH-CCP ACC-RBHA monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Postpartum Care* measure indicator.
AzCH-CCP ACC-RBHA's Response:
The performance measure rate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC)* fell below the 25th percentile, indicating an opportunity to increase access to timely prenatal

[74] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf Accessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures

care. The root cause analysis focuses on increasing access to prenatal care by identifying those barriers, such as collaboration with providers and the health plan, successful communication with members, and effective gap lists. Interventions in place include:

- Start Smart for Your Baby (SSFB) effectively educates and encourages members via text messaging and emails.
- IPPC Provider Forum supplies providers with material and engages providers with education, technical assistance, and performance improvement.
- Implementation of a mobile application that provides a specialized care plan for members with tailored daily health check lists, provides alerts, care gaps, progress tracking to CMS, and allows for two-way video/text communication with care management.
- Implementation of a new NCQA accredited self-management tool on the member portal in Quarter 1 (Q1) 2023 to increase members' confidence and positive improvement in members' health.
- Weekly newborn calls outreach to birthing parents and educate and assist with scheduling postpartum appointments. In Q4 CY 2023, 1,843 calls were attempted with a 22 percent reach rate, with a total of 4,128 calls completed throughout the year.
- Weekly Notice of Pregnancy (NOP) reports are sent to strategic partners and provider groups for member outreach. The goal of this report is to create a proactive outreach list so members can be engaged early with prenatal care and educated about the importance of postpartum care, available resources, and community supports.
- An internal workgroup to identify additional opportunities, identify/address racial disparities, and increase prenatal/postpartum outcome measures.
- In addition, in CY 2024 AzCH-CCP ACC implemented a Health Equity committee, a cross-functional monthly committee convened to review identified measures by contract stratified by race and ethnicity to determine opportunities to close disparity gaps and implement health equity-focused interventions.

AzCH-CCP ACC has implemented the following interventions to increase member engagement around *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*:

- SSFB program, enrollment into care management (until six weeks after delivery), effectively educates and encourages members via text messaging and emails.
  - In Q2 CY 2023, 71 percent of ACC members who were identified as having a high-risk pregnancy were enrolled in the SSFB Care Management Program. Quality Improvement (QI) and Maternal Child Health (MCH)/Case Management (CM) collaborated to create reports to build a proactive outreach program including weekly NOP reports to providers and SSFB packets sent to members in CY 2023. Totals include:
    - NOP reports (Q4 CY 2023): 1,606; Pregnancy packet: 1,167; and Newborn packet: 1,355—Please note this is inclusive of both ACC and RBHA members.
- AzCH-CCP ACC's Prenatal and Postpartum Work Group continues to meet monthly to discuss initiatives to increase related measures and has begun to review high-level member data stratified

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
by race/ethnicity to identify any potential disparities. AzCH-CCP ACC will explore possible implementations as a result of collaboration with other plans. • The Digital Care Management (DCM) team was fully staffed at four care managers by the end of 2023, addressing the needs of both our obstetric (OB) and adult Non-SMI-Designated population. Wellframe was a successful tool in communicating with members and disease management. The various care programs educate and coach members to improve their self-management of conditions.
HSAG's Assessment: HSAG determined that AzCH-CCP ACC-RBHA satisfactorily addressed prior year's recommendations. Although performance remained low for MY 2023 for the *Prenatal and Postpartum Care—Prenatal Care* and *Postpartum Care* measures, AzCH-CCP ACC-RBHA implemented performance improvement initiatives.
Recommendation 3:
HSAG recommended that AzCH-CCP ACC-RBHA monitor and expand on its previously implemented interventions to members optimally managing their high blood pressure. AzCH-CCP ACC-RBHA should continue to assess new barriers that members experience related to controlling high blood pressure and submit the results of its continuous barrier assessments and implemented interventions as required by AHCCCS.
AzCH-CCP ACC-RBHA's Response: AzCH-CCP ACC's performance measure rates for *Controlling High Blood Pressure (CBP)* fell below the 25th percentile, indicating that most members were not managing their high blood pressure properly. The root cause analysis focuses on assisting members in maintaining their chronic health conditions at optimal levels. The barriers identified were minimal member-focused interventions, lack of provider utilization with supplemental feeds, and lack of current procedural terminology (CPT) II code utilization to close care gaps. In response to identified barriers, the following interventions were implemented: • Supplemental data feeds have been effective in providing additional clinical data about a member beyond claims data. Supplemental data feeds may include the use of CPT II codes for reporting a clinical result, such as blood pressure. • Coding for quality reference guide is distributed to providers during provider meetings. Identified opportunity to increase education to providers by incorporating into Path to 5 to target a larger audience. • Implementation of member-facing educational material to educate on the importance of engaging with their provider and having their blood pressure checked regularly. AzCH-CCP ACC has implemented the following interventions to increase high blood pressure management: • Supplemental data feeds have been effective in supplying additional clinical data about a member beyond claims data. Supplemental data feeds may include the use of CPT II codes for reporting a clinical result, such as blood pressure.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
– In CY 2023, AzCH-CCP ACC saw an increase in supplemental data that were received via EMR connectivity feeds. There is an opportunity to encourage providers to submit data via supplemental data feeds, either with EMR connectivity or via traditional safety data sheet (SDS) flat files. • Coding for quality reference guide is distributed to providers during provider meetings. Identified opportunity to increase education to providers by incorporating into Path to 5 to target a larger audience. • During CY 2023, a total of 39,331 CBP mailers were sent out to members in need of a CBP reading. A second version of the letter was created, approved, and scheduled to go out in Q1 CY 2024. • In Q1 CY 2024, AzCH-CCP ACC will begin to conduct targeted member outreach to members in behavioral health residential facilities (BHRFs) to assist with closing care gaps. The following provider education and outreach interventions cross all performance measures: • Provider Outreach Campaign – Community meetings – Provider panels – Regular provider outreach and education • Supply frequent support to strategic partners to increase performance by providing progress via monthly quality meetings, provision of performance measure reports, references, and tools. – Strategic Partner support was provided monthly with offered performance scorecards, care gap lists, and educational materials. These meetings provided opportunities for strategic partners to identify and discuss opportunities as well as review health plan data for inconsistencies with their own. • Provider Education Materials – Path to 5 quick reference guide (QRG), inclusive of current and baseline performance measures. • Presentations on preventive care and well visits during the provider essential communication call. • The provider quality liaisons (PQLs) who are building relationships with the top providers to increase performance and member satisfaction, improve knowledge, and provide technical assistance. – PQLs noted a successful increase in primary care provider (PCP) outreach and overall resources shared throughout CY 2023 with a total of 1,001 PCP visits completed in Q4 CY 2023.
HSAG's Assessment: HSAG determined that AzCH-CCP ACC-RBHA satisfactorily addressed prior year's recommendations. AzCH-CCP ACC-RBHA implemented performance improvement interventions, and performance on this measure did improve in MY 2023.

Validation of Performance Improvement Projects

Back to Basics PIP

In CYE 2024, AzCH-CCP ACC-RBHA continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 2, PIP validation activities focused on improvement from the baseline results. AzCH-CCP ACC-RBHA submitted Remeasurement 2 performance indicator results and interventions implemented during CY 2023 along with the status of interventions, focus, and rationale for changes to or discontinuation of the interventions.

HSAG conducted an annual validation of the second remeasurement year reflective of CY 2023 (January 1, 2023, through December 31, 2023) using AHCCCS-calculated and validated indicator rates. HSAG evaluated AzCH-CCP ACC-RBHA's performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

Validation Results

Table 5-5 displays the overall confidence levels for the AzCH-CCP ACC-RBHA *Back to Basics* PIP.

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

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

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

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

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

Measure Results

Table 5-6 and Table 5-7 provide the *Back to Basics* PIP baseline, Remeasurement Year 1, and Remeasurement Year 2 rates for each indicator for AzCH-CCP ACC-RBHA.

Table 5-6—AzCH-CCP ACC-RBHA *Back to Basics* PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: *W30 Rate 1*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
AzCH-CCP ACC-RBHA	63.2%	60.7%	66.5%

HSAG rounded percentages to the first decimal place.

Table 5-7—AzCH-CCP ACC-RBHA *Back to Basics* PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: *WCV*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
AzCH-CCP ACC-RBHA	46.9%	46.4%	53.2%

HSAG rounded percentages to the first decimal place.

Interventions

Table 5-8 presents PIP interventions for AzCH-CCP ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-8—AzCH-CCP ACC-RBHA *Back to Basics* PIP Interventions

Contractor	Interventions
AzCH-CCP ACC-RBHA	• AzCH-CCP ACC Data Analytics provided a report indicating all children and adolescents who completed their well visits and dental visits, and the percentage of children who completed their well visits and dental visits. The EPSDT team and the Quality Improvement team analyzed the data quarterly. • Revamped the EPSDT first and second reminder and changed it from a letter to an age-specific postcard, adding developmental screenings at appropriate periodicity. • The outreach call spreadsheet now includes a reminder task for the EPSDT coordinator to remind the parent of a developmental screening. • The EPSDT coordinator conducts 20 provider site visits per month. These visits educate providers about scheduling well visits, completing developmental screenings, and referring children to the dentists for their

Contractor	Interventions
	assigned members. During the site visit, the EPSDT coordinator gives the PCP a list of their members with a periodicity schedule and EPSDT materials. • The EPSDT team presents about completing well visits, referring to the dentist, and completing a developmental tool at the provider forums. • Retrained the EPSDT staff to engage the member by conducting a three-way call to the doctor's office. • Addressed barriers when a member did not show up to a scheduled appointment, including transportation. • Promoted the AzCH My Health Pays Rewards (MHP) program. • Conducted provider fax blast communications which educated providers about the available developmental screening tools. • Utilized community outreach workers to engage members in the community. • Path to 5 was distributed to providers to educate them on quality and performance measures. • Outreached to members via Short Message Service (SMS) text messaging. • Conducted dental workgroups which reviewed ongoing provider performance. • Back to School event outreached members to encourage them to attend events to help complete needed screenings. • Medicaid Push Project is a collaboration with strategic partners to implement a multi-prong outreach campaign to reach members to close *W15* and *WCV* gaps through in-home visits or telehealth visits. • Population Health Workgroup to advance the health of populations, improve member experience, and deliver systemwide transformation to better serve member population health needs. • The health plan maintains a report gap analysis on KidsCare versus ACC to complete specific outreach to KidsCare members with open care gaps. • Collaborated with providers through Provider Office Outreach and looked closely at KidsCare engagement around annual visits. • Through member outreach (e.g., SMS texts, emails, postcards, and telephone) identified KidsCare members and encouraged and educated on the importance of annual visits.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-9 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC-RBHA related to the *Back to Basics* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-9—AzCH-CCP ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • AzCH-CCP ACC-RBHA adhered to acceptable methodology through all phases of the PIP. **[Quality, Access]** • AzCH-CCP ACC-RBHA developed and implemented interventions that led to statistically significant improvement in indicator outcomes between the baseline and Remeasurement 2. **[Quality, Access]**
Opportunities for Improvement and Recommendations
HSAG identified no opportunities for improvement related to the *Back to Basics* PIP. Recommendation: Although there were no opportunities for improvement identified, HSAG recommends that AzCH-CCP ACC-RBHA continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention as the PIP progresses.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-10 presents PIP recommendations made to AzCH-CCP ACC-RBHA in the CYE 2023 Annual Technical Report[75] and AzCH-CCP ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which AzCH-CCP ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-10—AzCH-CCP ACC-RBHA Follow-Up to CYE 2023 PIP Recommendations

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG recommended that AzCH-CCP ACC-RBHA: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.

[75] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf Accessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for PIPs
• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.

AzCH-CCP ACC-RBHA's Response:

AzCH-CCP ACC identified the following barriers to aid in focusing interventions to better engage members in care:

- Ineffective tracking of healthcare gaps.
- Lack of education on the importance of annual visits.
- Ineffective communication with members.
- Lack of encouragement.
- Member contact information is not always available.
- Need to increase collaboration with providers and the health plan.

AzCH-CCP ACC has assessed the impact and effectiveness of the following interventions during the second remeasurement year:

Interventions Assessment		
Interventions	**Timeline**	**Impact/Effectiveness**
AzCH-ACC Data Analytics will provide a report indicating all children and adolescents who need to complete their well visits and dental visits, and the percentage of children who completed their well visits and dental visits. The EPSDT team and the Quality Improvement team will analyze the data quarterly.	March 2018—Ongoing—This intervention has been incorporated as a standard business practice	This intervention's expected impact is to improve tracking and monitoring via monthly gap reports.
Revamp the EPSDT first and second reminder and change it from a letter to an age-specific postcard, adding developmental screenings at appropriate periodicity.	March 2018 – 12/31/2022—This intervention has been incorporated as a standard business practice.	This intervention's expected impact is to increase well-child visits per the developmental screenings at appropriate periodicity.
The outreach call spreadsheet will now include a reminder task for the EPSDT coordinator	June 2018 – 12/31/2022—This intervention has been incorporated as a standard business practice.	This intervention's expected impact is to ensure EPSDT coordinators are consistently reminding members of

Prior Year's Recommendation From the EQR Technical Report for PIPs		
to remind the parent of a developmental screening.		developmental screenings and their importance.
The EPSDT coordinator will conduct 20 provider site visits per month. These visits educate providers about scheduling well visits, completing developmental screenings, and referring children to the dentist for their assigned members. During the site visit, the EPSDT coordinator gives the PCP a list of its members with a periodicity schedule and EPSDT materials.	April 2018 – 12/31/2022—This intervention has been incorporated as a standard business practice.	This intervention's expected impact is to increase provider education around well-child visits, completing developmental screenings and providing useful EPSDT material to providers.
The EPSDT team will present about completing well visits, referring to the dentist, and completing a developmental tool at the provider forums.	March 2018 – 12/31/2022—This intervention has been incorporated as a standard business practice.	The EPSDT team will present about completing well visits, referring to the dentist, and completing a developmental tool at the provider forums.
Retrain the EPSDT staff to engage the member by conducting a three-way call to the doctor's office.	July 2017 – 12/31/2022—This intervention has been incorporated as a standard business practice.	This intervention's expected impact is to improve EPSDT staff's communication with doctors' offices.
Address barriers when a member does not show up to a scheduled appointment including transportation.	January 2018 – 12/31/2022—This intervention has been incorporated as a standard business practice.	This intervention's expected impact is to address and reduce barriers around no-shows to scheduled appointments.
Promote the AzCH My Health Pays Rewards Program.	CY2019 – 12/31/2022—This intervention has been incorporated as a standard business practice.	This intervention's expected impact is to increase member engagement and increase well-child visits and annual dental visits.
Conduct provider fax blast communications which will educate providers about the available developmental screening tools.	04/01/2018 – 12/31/2022—This intervention has been incorporated as a standard business practice.	This intervention's expected impact is to increase provider engagement around developmental screening tools.

Prior Year's Recommendation From the EQR Technical Report for PIPs		
Utilize community outreach workers to engage members in the community.	09/2018 – 12/31/2022—This intervention has been incorporated as a standard business practice.	This intervention's expected impact is to increase member engagement.
Path to 5 is distributed to providers to educate on quality and performance measures.	January 2022 – Ongoing (annually)	This intervention's expected impact is to educate providers. The Path to 5 that is given to providers has received positive feedback deeming this intervention effective and will continue in CY 2024.
Outreach members via Short Message Service (SMS) text messaging.	January 2022 – Ongoing (annually)	This interventions' expected impact is to improve the Health Plan's communication with members. In CY 2023, for child and adolescent well visit reminders, the SMS text outreach engaged 84.8 percent of members with an open care gap (total of 253,010 attempts), well-child visits for the first 30 months of life (0–15), SMS text outreach had an engagement rate of 85.7 percent (total of 93,018 attempts) and annual dental visit SMS text outreach ended the year with an engagement rate of 86.3 percent (total of 135,015 attempts). Engagement was determined to be effective due to the high engagement rate.
Back-to-school event outreaches members to encourage them to attend events to help complete needed screenings.	January 2022 – Ongoing (annually)	This intervention's expected impact is to increase needed screenings and educate members.

Prior Year's Recommendation From the EQR Technical Report for PIPs		
		Providers who worked with the health plan to complete back-to-school events experienced a 9–31 percent increase in their performance from Q2 to Q3 CY 2023, deeming this intervention as effective.
The health plan will maintain a report gap analysis on KidsCare vs ACC to complete specific outreach to KidsCare members with open care gaps.	Q3 CY 2023 – Ongoing	This intervention's expected impact is to improve tracking of gap analysis for KidsCare members. Gap list reports inclusive of members in the KidsCare population were provided to strategic partners and providers who outreached KidsCare members with an open care gap. Of the members outreached, 7 percent of the members were of the KidsCare population, resulting in 919 exams being completed, a 71 percent gap closure rate for the KidsCare population, deeming this intervention as effective.
Collaborate with providers through Provider Office Outreach and look closely at KidsCare engagement around annual visits.	Q3 CY 2023 – Ongoing	This intervention's expected impact is to improve provider collaboration. In CY 2023, Provider Office Outreach resulted in closing an average of 68 percent of open well visit care gaps with an average of 20 percent of those care gaps closed within 90 days of outreach. Monthly gap reports are provided to providers, inclusive of the KidsCare population, and education was

Prior Year's Recommendation From the EQR Technical Report for PIPs		
		done on a regular basis to include members in the KidsCare population. The high closure rate of open well visit care gaps within 90 days deems this intervention as effective.
Through member outreach (e.g., SMS text, emails, postcards, telephonic) identify KidsCare members and encourage and educate on the importance of annual visits.	Q3 CY 2023 – Ongoing	This intervention's expected impact is to increase and improve education around annual visits. In CY 2023, outreach was inclusive of the KidsCare population to encourage and educate members on the importance of annual visits. Fifty-one members enrolled in KidsCare were outreached to complete a sixth visit to close the *W15* care gap that resulted in a 24 percent reach rate and a 78.4 percent gap closure rate. Two hundred forty-four KidsCare members were outreached for *WCV*, with a reach rate of 36 percent that resulted in a 71 percent open care gap closure rate. The high gap closure rate deems this intervention effective, and member outreach will continue through CY 2024.
WCV on-site collaboration and cross-functional workgroup improves performance and member outcomes through member outreach from PCP offices.	CY 2023 – Ongoing	This intervention's expected impact is to increase member engagement. The *WCV* on-site collaboration, completed in office calls from the PCP offices and outreached a total of 1,444 members, with 426 members reached in Q2 CY 2023. The *WCV* cross-functional

Prior Year's Recommendation From the EQR Technical Report for PIPs		
		workgroup has been postponed and will be reinstated in Q4, with its effectiveness to be determined.
Medicaid Push Project a multi-pronged outreach campaign to reach members to close *W30* and *WCV* gaps through in-home visits or telehealth visits through collaboration with strategic partners.	January 2023 – Ongoing (monthly)	This intervention's expected impact is to increase member engagement. During CY 2023, outreach by strategic partners attributed to the final rate of 53.2 percent performance rate for *WCV*. This intervention is deemed to be effective with the success of such a high average of care gap closure.
Population Health Workgroup aimed to advance the health of populations, improve member experience, and deliver systemwide transformation to better serve member population health needs.	February 2023 – Ongoing (quarterly)	This intervention's expected impact is to improve health outcomes and member experience to better serve the health plan members. In CY 2023, the health plan launched the workgroup which met quarterly to identify data needs and sources in all health plan departments. The goal of the workgroup is to use the data to identify at-risk populations for the purpose of developing and improving initiatives as the workgroup continues to evolve.

AzCH-CCP ACC's plan for sustaining improvement in indicator rates will be analyzed via the PDSA cycle to ensure ongoing improvement and that appropriate corrections are made. Indicator rates along with identified interventions are evaluated via specific intervention PDSA cycles and during Performance Improvement Subcommittees' monthly meetings and quarterly Quality Improvement Committees. Additionally, indicator rates and interventions are monitored through the Performance Measure Monitoring Report (PMMR) to ensure performance improvement during each quarter:

- By the end of CY 2023, the My Health Pays *WCV* reward was the highest obtained reward.

Prior Year's Recommendation From the EQR Technical Report for PIPs
• My Health Pays Dental rewards were earned in CY 2023. • In CY 2023, for child and adolescent well visit reminders, the SMS text outreach engaged 84.8 percent of members with open care gaps (total of 253,010 attempts), well-child visits for the first 30 months of life (0–15), SMS text outreach had an engagement rate of 85.7 percent (total of 93,018 attempts), and annual dental visit SMS text outreach ended the year with an engagement rate of 86.3 percent (total of 135,015 attempts). • In Q2 CY 2023, a back-to-school provider handout was faxed to all providers within the network, 102,529 text messages were sent out, and 4,882 emails were sent out to members in the geographical areas of the events. Additionally, providers who worked with the health plan to complete back-to-school events experienced a 9–31 percent increase in their performance from Q2 to Q3 CY 2023.
HSAG's Assessment: HSAG determined that AzCH-CCP ACC-RBHA satisfactorily addressed these prior year's recommendations.

Prenatal and Postpartum Care PIP

Overview

AHCCCS initiated the implementation of the *Prenatal and Postpartum Care* PIP for the ACC population in CYE 2022. The objective of the *Prenatal and Postpartum Care* PIP is to improve health outcomes for members and infants. This PIP focuses on increasing the number and percentage of members with live birth deliveries that 1) received a prenatal care visit, and 2) received a postpartum visit. In CYE 2024, AzCH-CCP ACC-RBHA continued to implement interventions to improve these outcomes and provided updates on the status of each intervention to AHCCCS.

Interventions

Table 5-11—AzCH-CCP ACC-RBHA *Prenatal and Postpartum Care* PIP Interventions

Contractor	Interventions
AzCH-CCP ACC-RBHA	New interventions to support the *Prenatal and Postpartum Care* PIP in CYE 2024 include:
	• Strategic Partner collaboration to target members for prenatal care. Strategic partner assists by outreaching, scheduling, and completing in-home or telehealth visits with appropriate physician. • PPC Workgroup is an internal monthly workgroup to include case management (CM), QM, and other stakeholders to increase prenatal/postpartum outcome measures. • HEDIS Stratification Dashboard—will provide an NCQA-directed RES of applicable HEDIS performance measures.

Contractor	Interventions
	• Health Equity Committee coordination with the PPC Workgroup—Health Equity meets with the PPC workgroup to review stratified dashboard and address accessibility of care. • Local Health Disparity Dashboard—will allow stratification of performance measures by race/ethnicity, age, sex, county, city and ZIP Code.
	Continued interventions with enhancements made to support the *Prenatal and Postpartum Care* PIP in CYE 2024 include:
	• Wellframe Mobile Application—Mobile app provides specialized care plan (based on certain tracks) for members with specialized daily health check list; provider alerts, care gaps, and progress tracking to CMs; allows for two-way video/text communication with Care Management. • NOP Reports are sent to strategic partners and FQHCs to begin outreach and engage members timely for prenatal and postpartum care. The report is now automated to reduce manual requirements.
	Continued interventions to support the *Prenatal and Postpartum Care* PIP in CYE 2024 include:
	• SSFB program, enrollment into care management (until six weeks after delivery). • Pyx Health, a mobile application to address loneliness, social isolation, assist in developing a support system and support with loneliness and resources. • Member outreach through live calls, SMS text messaging, mailers, emails, and POM campaigns encouraging members with open care gaps to complete PPC visits.

Strengths, Opportunities for Improvement, and Recommendations

HSAG did not conduct validation on the *Prenatal and Postpartum Care* PIP in CYE 2024; therefore, strengths, opportunities for improvement, and recommendations are not provided.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-12 PIP recommendations made to AzCH-CCP ACC-RBHA in the CYE 2023 Annual Technical Report[76] and AzCH-CCP ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which AzCH-CCP ACC-RBHA has effectively addressed the recommendations. Language

[76] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf Accessed on: Feb 23, 2025.

in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-12—AzCH-CCP ACC-RBHA Follow-Up to CYE 2023 PIP Recommendations

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG recommended that AzCH-CCP ACC-RBHA: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. • Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.
AzCH-CCP ACC-RBHA's Response: AzCH-CCP ACC identified the following barriers to aid in focusing interventions to better engage members in care: • Members do not see prenatal and postpartum care as a priority if they are feeling well. • Reduced availability of alternative resource access so members can independently educate and participate fully in their care management. • Lack of alternative methods of engaging members in care management beyond the standard phone and letter outreach. • Lack of ongoing QI and MCH/CM collaboration needed to effectively evaluate and implement interventions. • Traditional gap list reporting is not effective due to measure timelines. • Reduced availability of health equity/disparity actionable data. • Lack of health equity influence. AzCH-CCP ACC has assessed the impact and effectiveness of the following interventions during the intervention year:

Interventions Assessment		
Interventions	**Timeline**	**Impact/Effectiveness**
SSFB program, enrollment into care management (until six weeks after delivery)	Q3 2018 – Ongoing	Educating members on the importance of prenatal and postpartum care even if they are feeling well.
Wellframe mobile application provides specialized care plan (based on certain tracks) for	Q2 2021—Paused Q2 2022 Reinstated in Q3 2023 – Ongoing	Utilizing an application and chat-based system to engage members will increase member

Prior Year's Recommendation From the EQR Technical Report for PIPs		
members with specialized daily health checklist; provider alerts, care gaps, and progress tracking to CMs; allows for two-way video/text communication with care management		engagement for those who prefer such methods.
NOP reports are sent to strategic partners and federally qualified health centers (FQHCs) to begin outreach and engage members in a timely manner for prenatal and postpartum care. Report is now automated to reduce manual requirements.	Q3 2022 – Ongoing	Creating proactive reporting increases the likelihood of member engagement due to being able to leverage strategic partners and FQHCs effectively.
PPC Workgroup is an internal monthly workgroup to include CM, QM, and other stakeholders to increase prenatal/postpartum outcome measures.	Q1 2023 – Ongoing	Increasing effectiveness of implemented interventions by both MCH/CM and QI will reduce overlap, member Abrasion, and missed opportunities of engagement.
HEDIS Stratification Dashboard—will provide an NCQA directed race and ethnicity stratification of applicable HEDIS performance measures.	Q4 2023 – Ongoing	This intervention will provide actionable data about the population served so disparities can be quickly identified and intervention responses coordinated.
Pyx Health, a mobile application to address loneliness, social isolation, assist in developing a support system and support with loneliness and resources.	CY 2020 – Ongoing	Utilizing an application and chat-based system to engage members will increase member engagement for those who prefer such methods.
Member outreach through live calls, SMS text messaging, mailers, emails, and POM campaigns encouraging	CY 2017 – Ongoing	Educating members on the importance of prenatal and postpartum care even if they are feeling well.

Prior Year's Recommendation From the EQR Technical Report for PIPs		
members with open care gaps to complete PPC visits.		
Health Equity Committee Coordination with the PPC Workgroup—Health equity meets with the PPC workgroup to review stratified dashboard and address accessibility of care.	Q3 2023 – Ongoing	This intervention's expected impact is to multilayer coordination between AzCH-CCP ACC's departments to ensure a wide range of input with a direct action path for intervention modification and implementation.
Local Health Disparity Dashboard—will allow stratification of performance measures by race/ethnicity, age, sex, county, city, and ZIP Code.	04/01/2018 – 12/31/2022—This intervention has been incorporated as a standard business practice.	This intervention will provide actionable data about the population served so disparities can be quickly identified and intervention responses coordinated.

AzCH-CCP ACC's plan for sustaining improvement in indicator rates will be analyzed via the PDSA cycle to ensure ongoing improvement and that appropriate corrections are made. Indicator rates along with identified interventions are evaluated via specific intervention PDSA cycles and during Performance Improvement Subcommittees' monthly meetings and quarterly Quality Improvement Committees. Additionally, indicator rates and interventions are monitored through the PMMR to ensure performance improvement during each quarter:

- AzCH-CCP has identified the opportunity to make NOP reports a widespread opportunity for all providers by including in provider portal for all providers to access. For CY 2023, total NOP mailings were 6,940, Guide to Pregnancy booklets 4,504, and Life After Delivery booklets 5,211.
- PPC workgroup has noted effectiveness through the monthly multidisciplinary meetings to facilitate information sharing and brainstorming.

HSAG's Assessment:

HSAG determined that AzCH-CCP ACC-RBHA satisfactorily addressed these prior year's recommendations.

Compliance Reviews

Results

AHCCCS conducted a compliance review of AzCH-CCP ACC-RBHA from December 11, 2023, through December 15, 2023. On March 8, 2024, AHCCCS finalized the report findings, provided AzCH-CCP ACC-RBHA with a CAP submission matrix, and required a CAP for any standard with a

total score of less than 95 percent. On May 31, 2024, AHCCCS accepted AzCH-CCP ACC-RBHA's proposed CAPs and required the Contractor to submit updated policies, manuals, desktop procedures, and other vital documents to provide evidence of CAP completion. On July 31, 2024, AHCCCS reviewed AzCH-CCP ACC-RBHA's CAP status and determined that all CAPs had been completed and approved for closure.

Table 5-13—AzCH-CCP ACC-RBHA Compliance Review Results

Compliance Focus Areas	CYE 2024 AzCH-CCP ACC-RBHA Scores	CYE 2024 Program-Level Average	CYE 2024 AzCH-CCP ACC-RBHA CAP Update
CC	93%	95%	Met
CIS	100%	99%	NA
DS	100%	97%	NA
GA	98%	97%	NA
GM	100%	100%	NA
GS	100%	100%	NA
MCH	97%	96%	NA
MM	98%	95%	NA
MI	99%	94%	NA
QM	85%	89%	Met
QI	100%	100%	NA
RI	100%	100%	NA
TPL	100%	100%	NA
ISOC	99%	99%	NA

NA = Not applicable. A CAP was not required as the CYE 2024 score was 95% or above.
Met = AHCCCS accepted and closed the Contractor's CAP.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-14 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC-RBHA based on compliance activities conducted in CYE 2024, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-14—AzCH-CCP ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
AzCH-CCP ACC-RBHA scored at or above 95 percent in the following focus areas:

Strengths, Opportunities for Improvement, and Recommendations
• Claims and Information Standards (CIS) **[Access]** • Delivery Systems (DS) **[Timeliness, Access]** • General Administration (GA) **[Timeliness, Access]** • Grants Management (GM) **[Quality, Access]** • Grievance Systems (GS) **[Timeliness, Access]** • Adult, EPSDT and Maternal Child Health (MCH) **[Quality, Timeliness, Access]** • Medical Management (MM) **[Timeliness, Access]** • Member Information (MI) **[Quality]** • Quality Improvement (QI) **[Quality, Access]** • Reinsurance (RI) **[Quality]** • Third-Party Liability (TPL) **[Quality, Timeliness, Access]** • Integrated Systems of Care (ISOC) **[Quality, Access]**
Opportunities for Improvement and Recommendations
AzCH-CCP ACC-RBHA scored below 95 percent in the following focus areas: • Corporate Compliance (CC) **[Quality, Access]** • Quality Management (QM) **[Quality]** As a result of its CAP interventions implemented in CYE 2024, Az-CH CCP ACC-RBHA was found to be fully compliant within all focus areas and had no continuing corrective actions or recommendations.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Compliance review recommendations were not included in the CYE 2023 EQR technical report as compliance review activities were not conducted in CYE 2023; therefore, no follow-up was required by AzCH-CCP ACC-RBHA.

Network Adequacy Validation

ISCA Results

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

Table 5-15 summarizes HSAG's validation ratings for AzCH-CCP ACC-RBHA by indicator type.

Table 5-15—Summary of AzCH-CCP ACC-RBHA's Validation Ratings by Indicator Type

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

Of the network adequacy indicators assessed, AzCH-CCP ACC-RBHA received *High Confidence* for both appointment availability and time/distance indicator types. However, there were identified areas for improvement; please refer to the Contractor-specific Strengths, Opportunities for Improvement, and Recommendations section below for more details.

NAV Results

HSAG evaluated AzCH-CCP ACC-RBHA's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents CYE 2024 S1 validation findings specific to the ACC Program, with one results table for each of the following GSAs:

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

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

Table 5-16—Time/Distance Validation Results for AzCH-CCP ACC-RBHA Central GSA—Percentage of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^	99.4^	100.0^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0^	99.3^	100.0^
BHRF	NA	99.2	NA
Cardiologist, Adult	100.0^	100.0^	100.0^
Cardiologist, Pediatric	100.0^	100.0^	100.0^
Dentist, Pediatric	100.0	99.3	100.0
Hospital	100.0	100.0	100.0
OB/GYN	100.0	100.0	100.0
Pharmacy	100.0	99.0	100.0

Minimum Network Requirement	Gila	Maricopa	Pinal
PCP, Adult	100.0^	99.7^	100.0^
PCP, Pediatric	100.0^	99.6^	100.0^

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

Table 5-17—Time/Distance Validation Results for AzCH-CCP ACC-RBHA South GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Cochise	Graham	Greenlee	La Paz	Pima	Santa Cruz	Yuma
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^	100.0^	100.0^	100.0^	99.1^	100.0^	100.0^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0^	100.0^	100.0^	100.0^	99.3^	100.0^	100.0^
BHRF	NA	NA	NA	NA	93.8	NA	NA
Cardiologist, Adult	100.0^	100.0^	99.8	100.0^	99.2^	100.0^	100.0^
Cardiologist, Pediatric	100.0^	100.0^	100.0	100.0^	99.9^	100.0^	100.0^
Dentist, Pediatric	94.7	98.8	63.4	53.1	98.6	100.0	99.9
Hospital	100.0	100.0	100.0	100.0	99.5	100.0	100.0
OB/GYN	100.0	100.0	100.0	100.0	99.7	100.0	100.0
Pharmacy	99.7	99.6	99.7	87.6	98.0	100.0	99.8
PCP, Adult	99.8^	99.7^	99.8^	99.5^	99.8^	100.0^	99.8^
PCP, Pediatric	99.9^	99.7^	99.7^	99.8^	99.8^	100.0^	99.9^

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

Strengths, Opportunities for Improvement, and Recommendations

Table 5-18 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC-RBHA related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-18—AzCH-CCP ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • AzCH-CCP ACC-RBHA had established processes to research daily and monthly missing or incomplete data from the 834 files that included a Queued Error report that captured any critical data elements determined to be missing. **[Access]** • AzCH-CCP ACC-RBHA had established a robust process to maintain data accuracy and completeness by utilizing a reference file and multiple internal reports to compare the provider data loaded into Portico weekly. **[Access]** • AzCH-CCP ACC-RBHA met all minimum network requirements for all assigned counties except Greenlee and La Paz counties. **[Access]** • AzCH-CCP ACC-RBHA met all minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; BHRF; Cardiologist, Adult and Pediatric; Hospital; OB/GYN; and PCP, Adult and Pediatric. **[Access]** Note: AzCH-CCP ACC-RBHA provides coverage in the following counties: Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Santa Cruz, and Yuma.
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: • AzCH-CCP ACC-RBHA did not meet the minimum network requirements for Dentist, Pediatric and Pharmacy. **[Access]** Recommendation: HSAG recommends that AzCH-CCP ACC-RBHA maintain current compliance with network standards and continue to address network gaps, as applicable.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-19 presents NAV recommendations made to AzCH-CCP ACC-RBHA in the CYE 2023 Annual Technical Report[77] and AzCH-CCP ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which AzCH-CCP ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

[77] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf Accessed on: Feb 23, 2025.

Table 5-19—AzCH-CCP ACC-RBHA Follow-Up to CYE 2023 NAV Recommendations

Prior Year's Recommendation From the EQR Technical Report for NAV
HSAG recommended that AzCH-CCP ACC-RBHA maintain current compliance with network standards but continue to address network gaps, as applicable.
AzCH-CCP ACC-RBHA's Response: Outlined below are AzCH-CCP's strategies, efforts, and exception requests as of October 2024, applicable to both the Medicaid and CHIP populations, to address the identified areas of noncompliance: • *Pharmacy—La Paz County (South GSA)*—Currently, 83.4 percent of AzCH-CCP members have access to a pharmacy provider within the defined time and distance standards. The decrease in adequacy is due to a pharmacy being terminated from the network due to past audits and actions from the State Board of Pharmacy, which impacted members. AzCH-CCP outreached members to assist with transferring their medications to either a pharmacy in Parker, AZ, Blythe, CA, or a mail-order pharmacy. AzCH-CCP continues to pursue recruitment efforts for pharmacy providers in La Paz County to add to our network; however, there are currently no providers available to assist with closing the gap. • *Dentist—Pediatric—Greenlee County (South GSA)*—Currently, 67.9 percent of AzCH-CCP pediatric members have access to a dental provider within the defined time and distance standards. On July 17, 2024, AHCCCS approved the AzCH-CCP Network Exception submitted for Dentist—Pediatric—Greenlee County. AzCH-CCP partners with a dental benefits administrator to administer the dental program. We will continue to closely monitor any changes to the network and identify potential recruitment opportunities to close this gap. • *Dentist—Pediatric—La Paz County (South GSA)*—Currently, 52.8 percent of AzCH-CCP pediatric members have access to a dental provider within the defined time and distance standards. On August 25, 2023, AHCCCS approved the AzCH-CCP Network Exception submitted for Dentist—Pediatric—La Paz County. AzCH-CCP partners with a dental benefits administrator to administer the dental program. We will continue to closely monitor any changes to the network and identify potential recruitment opportunities to close this gap. • *Dental—Pediatric—Cochise County (South GSA)*—Currently, 80 percent of AzCH-CCP pediatric members have access to a Dental provider within the defined time and distance standards. The decrease in adequacy for Cochise County is due to member movement. There are pediatric dental members who are outside of time and distance standards, with the first provider being 39.1 miles and 42.6 minutes. AzCH-CCP and its contracted dental benefits administrator utilized the Saturation Report and identified that there were no additional providers within adequacy guidelines to increase adequacy coverage. AzCH-CCP will continue to search for Pediatric Dental providers in Cochise County to add to our network. AzCH-CCP will be submitting an exception request. • *Dental—Pediatric—La Paz County (South GSA)*—Currently, 50 percent of AzCH-CCP pediatric members have access to a Dental provider within the defined time and distance standards. The decrease in adequacy for La Paz County is due to pediatric members being without access to a dental provider within the time and distance standard. AzCH-CCP and its contracted dental

Prior Year's Recommendation From the EQR Technical Report for NAV

benefits administrator identified that there were no additional providers within adequacy guidelines to increase adequacy coverage. AzCH-CCP will continue to search for Pediatric Dental providers in La Paz County to add to our network. AzCH-CCP will be submitting an exception request.

- *Pharmacy—La Paz County (South GSA)*—Currently, 86.8 percent of AzCH-CCP members have access to a Pharmacy provider within the defined time and distance standard. The decrease in adequacy for La Paz County is due to a pharmacy being terminated from the network due to past audits and actions from the State Board of Pharmacy. Members were impacted across all Medicaid products; outreach was made to assist members with transferring their medications to either a pharmacy in Parker, AZ, Blythe, CA, or a mail-order pharmacy. AzCH-CCP and its contracted dental benefits administrator identified that there were no additional providers within adequacy guidelines to increase adequacy coverage. AzCH-CCP and its contracted dental benefits administrator will continue to search for available pharmacy providers in and around La Paz County to add to our network. As an alternative, AzCH-CCP provides mail order home delivery of prescriptions. AzCH-CCP will be submitting an exception request.

Additionally, AzCH-CCP ACC does provide education and awareness of the available telehealth services for all members to utilize. Below are the counties where telehealth services are available:

Provider Types	Cochise	Gila	Graham	Greenlee	La Paz	Maricopa	Pima	Pinal	Santa Cruz	Yuma
Behavioral Health Outpatient Clinic & Integrated Clinic, Adult	X	X	X		X	X	X	X	X	X
Behavioral Health Outpatient Clinic & Integrated Clinic, Pediatric	X	X	X		X	X	X	X	X	X
Cardiologist, Adult	X	X	X		X	X	X	X	X	X
Cardiologist, Pediatric	X	X	X		X	X	X	X	X	X
PCP, Adult	X	X	X	X	X	X	X	X	X	X
PCP, Pediatric	X	X	X	X	X	X	X	X	X	X

Prior Year's Recommendation From the EQR Technical Report for NAV
HSAG's Assessment: HSAG has determined that AzCH-CCP ACC-RBHA has satisfactorily addressed these prior year's recommendations.

BUFC ACC

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2024, HSAG evaluated BUFC ACC's data system for processing of each data type used for reporting the Contractor's CY 2023 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that BUFC ACC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-20 displays HSAG's PMV findings for each data type reviewed during CYE 2024 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 5-20—CYE 2024 PMV Findings

Data Type	HSAG Findings
Medical Services Data	*No identified concerns*
Enrollment Data	*No identified concerns*
Provider Data	*No identified concerns*
Medical Record Review Process	*BUFC ACC had mixed results with the MRRV process. Based on the MRRV failure for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity indicator, the findings were expanded to also include MRRV failure for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutritional Activity indicator. BUFC ACC was required to remove all medical record data and report these indicators with administrative data only.*
Supplemental Data	*No identified concerns*
Data Integration	*No identified concerns*

Results for Performance Measures

Table 5-21 presents the CY 2022 and CY 2023 BUFC ACC performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and MY 2023. Performance measure rate cells shaded green indicate that the rate met or exceeded

the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and/or MY 2023. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 5-21—CY 2022 and CY 2023 BUFC ACC Performance Measure Results

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	81.5%+	81.5%+	→	★★
Postpartum Care	69.8%+	70.8%+	→	★
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	58.9%	64.3%	↑	★★★
Effective Continuation Phase Treatment—Total (18+ Years)	40.6%	48.1%	↑	★★★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	26.5%	27.1%	→	★★★
30-Day Follow-Up—Total (13+ Years)	35.4%	37.6%	→	★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	35.6%	36.9%	→	★★
30-Day Follow-Up—Total (6+ Years)	50.7%	54.5%	↑	★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	40.3%	43.6%	→	★★★
30-Day Follow-Up—Total (6+ Years)	50.2%	54.2%	→	★★★
Use of Opioids at High Dosage				
*18+ Years**	11.6%	10.9%	→	★
Initiation and Engagement of Substance Use Disorder (SUD) Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	51.0%	50.9%	→	★★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	19.8%	21.3%	↑	★★★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	55.2%	53.0%	→	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	79.4%	81.9%	↑	★★★
Care of Acute and Chronic Conditions				
Controlling High Blood Pressure				

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
18–85 Years	60.1%+	58.9%+	→	★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0%)—Total (18–75 Years)	63.0%+	67.6%+	→	★★★★★
*Poor HbA1c Control (>9.0%)—Total (18–75 Years)**	37.0%+	32.4%+	→	★★★
Pediatric Health				
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	48.4%	48.3%	→	★★★★
Childhood Immunization Status**				
Combination 3	61.8%+	59.6%+	→	★★
Combination 7	56.7%+	51.8%+	→	★★
Combination 10	30.9%+	22.9%+	↓	★★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	88.1%+	84.7%+	→	★★★
Combination 2 (Meningococcal, Tdap, HPV)	42.3%+	44.0%+	→	★★★★
Oral Evaluation, Dental Services				
Total (0–20 Years)[N]	35.3%	34.2%	↓	—
Well-Child Visits in the First 30 Months of Life				
First 15 Months—Six or More Well-Child Visits	58.1%	63.6%	↑	★★★
15 Months to 30 Months—Two or More Well-Child Visits	55.6%	59.9%	↑	★
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	39.6%	44.0%	↑	★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	51.0%	53.2%	↑	★★★
Cervical Cancer Screening				
21–64 Years	44.8%+	48.4%+	→	★
Appropriate Utilization of Services				
Ambulatory Care				
Emergency Department (ED) Visits —Total (0–85+ Years)[F]	445.8	440.6	—	—
Plan All-Cause Readmissions				
*Observed/Expected (O/E) Ratio—Total (18–64 Years)**	1.0705	1.0738	—	★

* A lower rate indicates better performance for this measure.
** Table A-2 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
+ Indicates the measure was reported using hybrid methodology.

Cells shaded green indicate that the rate met or exceeded the MY 2022 and/or MY 2023 national Medicaid mean.
— Indicates a 2022–2023 comparison is not presented in the CYE 2024 Annual Technical Report because either the CY 2022 rate was not presented in the CYE 2023 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
[1]Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.
[2] Performance Levels for CY 2023 were based on comparisons of the HEDIS MY 2023 measure rates to national Medicaid Quality Compass HEDIS MY 2023 benchmarks.
[D] DNR indicates the measure received a Do Not Report designation for CY 2023.
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.
[N] Measure has no NCQA Medicaid mean for comparison.
↑ Indicates statistically significant improvement of measure rates.
↓ Indicates statistically significant decline of measure rates.
→ Indicates no statistically significant change in measure rates.
Performance Levels for 2023 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

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

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

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group: • Nine of 13 BUFC ACC measure rates (69.23 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 **[Quality, Timeliness, Access]** – *Antidepressant Medication Management- Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total (18+ Years)* – *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)* and *30-Day Follow-Up—Total (13+ Years)* – *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* – *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* and *Engagement of SUD Treatment—Total—Total (13+ Years)* – *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (18–64 Years)*

Strengths, Opportunities for Improvement, and Recommendations
• BUFC ACC's performance measure rates for *Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* and *Engagement of SUD Treatment—Total—Total (13+ Years)* were at or between the 75th percentile and 89th percentile, indicating that most members diagnosed with SUD may have initiated SUD treatment and had two or more additional SUD services or MAT within 34 days of the initiation visit, which, in conjunction with counseling or other behavioral therapies, has been shown to reduce SUD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.[78] **[Quality, Timeliness, Access]**
In the Care of Acute and Chronic Conditions measure group: • BUFC ACC's performance measure rate for *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 %)—Total (18–75 Years)* was at or above the 90th percentile, indicating that most members diagnosed with diabetes are controlling their HbA1c levels. **[Quality]**
In the Pediatric Health measure group: • BUFC ACC's performance measure rates for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)* was at or between the 75th and 89th percentile, indicating that most children or adolescents with ongoing antipsychotic medication use had metabolic testing during the year. **[Quality]** • BUFC ACC's performance measure rates for *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* was at or between the 75th and 89th percentile, indicating most adolescents 13 years of age had one dose of meningococcal vaccine, one Tdap vaccine, and the complete HPV vaccine series by their 13th birthdays. **[Quality, Access]**
Opportunities for Improvement and Recommendations
While BUFC was successful in reporting valid rates for all AHCCCS-required performance measures for its ACC population, the audit identified some considerations and recommendations for future years' reporting. **[Quality]** Recommendation: HSAG recommends that BUFC ACC work to integrate race data that BUFC ACC noted it is receiving as of April 2024 for future stratification reporting to improve data completeness. In addition, The MRRV and case management medical record review validation (CMMRRV) processes found several criterial errors which impacted BUFC ACC's ability to report the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition* measure indicators using the hybrid methodology. In addition, the LTSS measures required several measures with second samples and revisions to the final medical record compliant case counts. HSAG recommends that BUFC ACC incorporate the feedback provided during this year's validation process into its abstraction process to mitigate these issues in future years.

[78] National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Substance Use (FUA). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-substance-use/. Accessed on: Feb 13, 2025.

Strengths, Opportunities for Improvement, and Recommendations
In the Maternal and Perinatal Care measure group, BUFC ACC's performance measure rate for *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, and the performance measure rate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* was at or between the 25th and 49th percentile, indicating an opportunity to increase access to timely prenatal and postpartum care. **[Quality, Timeliness, Access]** Recommendation: BUFC ACC has implemented multiple interventions to address the *Prenatal and Postpartum Care—Postpartum Care* rate, including a preventive care initiative for women, discharge outreach when a member delivers, and collaboration with behavioral health facilities. HSAG recommends that BUFC ACC monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Postpartum Care* measure indicators, measuring effectiveness of interventions when possible. HSAG recommends that BUFC ACC consider whether there are disparities/social determinants of health within BUFC ACC's population that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that BUFC ACC implement appropriate interventions to reduce barriers to care.
In the Behavioral Health measure group, BUFC ACC's performance measure rate for *Use of Opioids at High Dosage—18+ Years* was below the 25th percentile, indicating an opportunity to identify trends leading to higher opioid use. **[Quality]** Recommendation: In 2016, opioid-related overdoses accounted for more than 42,000 deaths in the United States. Of those, 40 percent involved prescription opioids. Literature suggests there is a correlation between high dosages of prescription opioids and the risk of both fatal and nonfatal overdose. HSAG recommends that BUFC ACC follow the CDC guidelines on opioid prescribing for chronic, nonmalignant pain, which recommend the use of "additional precautions" when prescribing dosages ≥50 morphine equivalent dose (MED) and that providers avoid or "carefully justify" increasing dosages ≥90 mg MED. In 2019, the authors of the 2016 guidelines published commentary that cautioned providers, systems, payers, and states from developing policies and practices that are "inconsistent with and go beyond" the guideline recommendations. The commentary included cautions regarding strict enforcement of dosage and duration thresholds, as well as abrupt tapering of opioids. The opioid dosage assessed in this measure is a reference point for health plans to identify members who may be at high risk for opioid overuse and misuse. HSAG recommends outreach to members who fall within this category to assess and schedule interventions as necessary.[79] HSAG also recommends that BUFC ACC identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts.
In the Pediatric Health measure group: • BUFC ACC's performance measure rate for *Child and Adolescent Well-Care Visits—Total (3–21 Years)* was below the 25th percentile, indicating that children and adolescents were not always receiving well-care visits at the recommended intervals. Assessing physical, emotional, and social development is important at

[79] National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/ Accessed on: Feb 13, 2025.

Strengths, Opportunities for Improvement, and Recommendations
every stage of life, particularly for children and adolescents. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[80] **[Quality, Access]** • BUFC ACC's performance measure rate for *Well-Child Visits in the First 30 Months of Life—15 Months to 30 Months—Two or More Well-Child Visits* fell below the 25th percentile, indicating opportunities for children who turned 30 months old during the measurement year to have at least two well-child visits with a PCP in the prior 15 months.[81] **[Quality, Access]** Recommendation: HSAG recommends that BUFC ACC continue implementing interventions as part of the *Back to Basics* PIP, which includes a root cause analysis and interventions to address both the *Child and Adolescent Well-Care Visits—Total (3–21 Years)* and the *Well-Child Visits in the First 30 Months of Life—15 Months to 30 Months—Two or More Well-Child Visits* measures. HSAG recommends that BUFC ACC draw as needed from other states' performance improvement initiatives. For instance, as part of a federal performance initiative to improve well-child care, California and Virginia have focused on delays in newborn enrollment data, and Missouri and Texas focused on beneficiary barriers and implemented interventions such as utilizing patient portals and phone outreach. HSAG recommends that BUFC ACC identify other barriers to care and conduct a focus group on identifying ways to address barriers.[82]
In the Preventive Screening measure group, BUFC ACC's performance measure rate for *Cervical Cancer Screening—21–64 Years* fell below the 25th percentile, indicating that women were not always receiving timely screening for cervical cancer. 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. Prolonged delays in screening may lead to delayed diagnoses, poor health consequences, and an increase in cancer disparities among women already experiencing health inequities.[83] **[Quality]** Recommendation: While BUFC ACC implemented interventions related to its MY 2022 *Cervical Cancer Screening—21–64 Years* rate, performance still fell below the 25th percentile for this measure during MY 2023. HSAG recommends that BUFC ACC expand on its most successful interventions related to improving female members' receipt of timely screening for cervical cancer. HSAG recommends that BUFC ACC consider utilizing one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve cervical cancer screening rates. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that BUFC ACC

[80] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Feb 13, 2025.
[81] 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: Feb 13, 2025.
[82] Centers for Medicare & Medicaid Services. Well-Child Care. Available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html. Accessed on: Feb 12, 2025.
[83] Centers for Disease Control and Prevention. Sharp Declines in Breast and Cervical Cancer Screening. Available at: https://www.cdc.gov/media/releases/2021/p0630-cancer-screenings.html. Accessed on: Feb 13, 2025.

Strengths, Opportunities for Improvement, and Recommendations
provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge.
In the Appropriate Utilization of Services measure group, BUFC ACC's performance measure rate for *Plan All-Cause Readmissions–Observed/Expected (O/E) Ratio—Total (18–64 Years)* fell below the 25th percentile, indicating that members who were admitted to an acute inpatient and observation stay might have been followed by an unplanned acute readmission for any diagnosis within 30 days.[84] Recommendations: HSAG recommends that BUFC ACC consider reviewing the Re-Engineered Discharge (RED), which has been shown to reduce readmissions and posthospital ED visits.[85] Other interventions that might be effective include technology platforms, including AI or machine learning, that can assist the plan in identifying members more at risk of re-admission. HSAG also recommends that BUFC ACC utilize case management strategies that focus on person-centered techniques, addressing barriers and/or social determinants of health as needed.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-23 presents performance measure recommendations made to BUFC ACC in the CYE 2023 Annual Technical Report[86] and BUFC ACC's follow-up to the recommendations, as well as an assessment of the degree to which BUFC ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-23—BUFC ACC Follow-Up to CYE 2023 Performance Measure Recommendations

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Recommendation 1:
While BUFC ACC implemented targeted interventions specific to the CY 2022 *Prenatal and Postpartum Care—Postpartum Care* rate, this rate remained low in CY 2022; therefore, HSAG recommended that BUFC ACC conduct a root cause analysis and continue to implement appropriate interventions based on the root cause analysis to improve performance relative to prenatal and postpartum care. HSAG also recommended that BUFC ACC monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Postpartum Care* measure indicator. **[Quality]**

[84] National Committee for Quality Assurance. Metabolic Monitoring for Children and Adolescents on Antipsychotics. Available at: https://www.ncqa.org/hedis/measures/plan-all-cause-readmissions/. Accessed on: Feb 12, 2025.
[85] Agency for Healthcare Research and Quality. Re-Engineered Discharge (RED) Toolkit. Available at: https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool1.html. Accessed on: Feb 12, 2025.
[86] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf Accessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
BUFC ACC's Response: BUFC ACC completed a fishbone diagram tool utilized for a root cause analysis for the *Postpartum Care* performance measure. Additionally, interventions that have been established or continued for implementation with enhancements are listed below: • Well-Women Preventive Care campaign initiated and includes education on the importance of prenatal and postpartum care as well as resources for engaging with providers. • Process established for the collection of non-standard supplemental data to be implemented upon onboarding of additional staff. • MCH team conducts discharge outreach calls to members after delivery, within 72 hours, to provide education on the importance of postpartum care and assistance with scheduling. • Collaboration with an outpatient behavioral health facility to encourage members who may be pregnant and facing mental health or substance abuse challenges to engage in prenatal and postpartum care. This has been established through distribution of postcards into multiple facilities that have a QR code for members to scan to obtain additional information on MCH services available to them. • MCH and QM teams collaborate to provide education to providers on measure specifications, best care practices, NOP reporting, family planning, and well women's care during Joint Operating Committees (JOCs), provider newsletters, and Banner University Health Plans (BUHP) Provider Forums.
HSAG's Assessment: HSAG determined that BUFC ACC satisfactorily addressed this prior year's recommendation.
Recommendation 2:
In 2016, opioid-related overdoses accounted for more than 42,000 deaths in the United States. Of those, 40 percent involved prescription opioids. Literature suggests there is a correlation between high dosages of prescription opioids and the risk of both fatal and nonfatal overdose. HSAG recommended that BUFC ACC follow the CDC guidelines on opioid prescribing for chronic, nonmalignant pain, which recommend the use of "additional precautions" when prescribing dosages ≥50 morphine equivalent dose (MED) and that providers avoid or "carefully justify" increasing dosages ≥90 mg MED. In 2019, the authors of the 2016 guidelines published commentary that cautioned providers, systems, payers, and states from developing policies and practices that are "inconsistent with and go beyond" the guideline recommendations. The commentary included cautions regarding strict enforcement of dosage and duration thresholds, as well as abrupt tapering of opioids. The opioid dosage assessed in this measure is a reference point for health plans to identify members who may be at high risk for opioid overuse and misuse. HSAG recommended outreach to members who fall within this category to assess and schedule interventions as necessary. [87]

[87] National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/ Accessed on: Feb 13, 2025.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures

BUFC ACC's Response:

Interventions that have been established or continued for implementation with enhancements are listed below:

- Established the Opioid Strategic Planning committee which meets, at minimum, quarterly.
- Pharmacy Controls: Prior authorization requirements for long- and short-acting opioids and restrictions on multiple short-acting prescriptions within 30 days.
- Provider Education: Opioid prescribing best practices, alternative pain management education, and Drug Enforcement Administration (DEA)-mandated education.
- Interdisciplinary Care Team: A collaborative team reviews high-dose opioid patients, monitors opioid use trends, and educates patients on Narcan.
- Embed the routine use of the opioid prescription database into the standard workflow.
- Mandated education sessions for providers involved in opioid prescribing, focusing on best practices, risk management, and alternative pain management options.
- Distributed "Narcan 101" materials to providers to support patient and family education on the importance and use of Narcan.
- Implemented tracking system to track Narcan prescription data, using it to assess the impact of provider education.
- Screening Tool Assessment: Identifying which validated opioid screening tools are currently available and being used within our organization and assessing their effectiveness.
- Provider Practice Evaluation: Identifying current provider practices to determine what types of screenings are being conducted and under what circumstances screenings are being overlooked.
- Continued pharmacy practices for Opioid-Specific Data Extensive Program for monitoring and intervention:
  - Members identified with high dose opioid use from pharmacy data are sent letters about the risks.
  - Providers of members identified with high dose opioid use from pharmacy data are sent letters about the risks.
  - These identified members are assigned a care manager.
  - Outcomes are reviewed by the Opioid Strategic Planning Committee.
  - Identified members with no change to the high rate of use are reviewed by the medical director to determine next steps.
    - Members may be enrolled in pharmacy restriction program.
    - Egregious cases may be sent to AHCCCS credentialing board.
- Ensure that opioid risk screening is a mandatory step for providers before prescribing opioids or managing chronic pain, ensuring consistency across the Banner systems.
- Establish protocols for joint care plans between physical health providers (PCPs and pain specialists) and behavioral health teams to ensure care coordination.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
• Form dedicated care coordination teams that include physical health, behavioral health, and pharmacy professionals to manage the care of at-risk individuals, ensuring communication and follow-up between departments. • A subpopulation analysis has been conducted to identify any areas of membership or subpopulations that are displaying a disparity. – This information will be reviewed with members of leadership and pharmacy to develop additional interventions to target these populations.
HSAG's Assessment: HSAG determined that BUFC ACC satisfactorily addressed this prior year's recommendation.
Recommendation 3:
HSAG recommended that BUFC ACC identify best practices to support children in receiving well-care visits according to recommended schedules. HSAG also recommended that BUFC ACC consider conducting a root cause analysis to identify barriers that members are experiencing in accessing care and services to implement appropriate interventions to improve performance related to timely well-care visits.
BUFC ACC's Response: BUF ACC completed a fishbone diagram tool utilized for a root cause analysis for the *Child and Adolescent Well-Care Visit* performance measure. Best practices have been reviewed and education has been shared with providers and are being assessed for potential implementation. Best practices that have been discussed include: • Expanding and encouraging providers to utilize virtual access such as telehealth visits, virtual messaging, and emails to increase flexibility and ease of accessibility to families and allow for timely reminders and monitoring. • Implementing a Cycle of Engagement system for use with providers to enhance the quality of well-care/well-child visits by engaging families prior to the visit allowing for a more tailored visit to the family's culture, concerns, and needs. • Incentive-based campaigns encouraging members to complete a well-care/well-child visit routinely. • Collaborations with Back-to-School community events such as school supply drives. • Collaborations with Reach Out and Read events where members receive books after well-care/well-child visits. Interventions that have been established or continued for implementation with enhancements are listed below: • Back-to-school incentive campaign was run from July 1, 2023–September 5, 2023, offering incentives to members who completed well-care visits during this time.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
• Fall incentive campaign was run from September 6, 2023–December 31, 2023, offering an additional incentive to any remaining eligible members. • Incentive campaign was redesigned for CY 24 to incorporate both the summer/back-to-school initiative and the fall incentive, running from July 1, 2024–November 1, 2024. – This incentive was targeted for members in identified areas of disparities, including 18–21-year-olds, those located in Gila, Graham, and La Paz Counties, and those in the American Indian/Alaska Native and Black/African American populations. • Targeted text message campaign was established in April 2024 for members in the 18–21-year-old age group upon identified disparity. • Targeted text message campaign was established in May 2024 for members in the American Indian/Alaska Native subpopulation upon identified disparity. • Additional incentive initiated on October 1, 2024, and scheduled to run through December 31, 2024, targeted to members eligible for the *Child and Adolescent Well-Care Visits* measure in populations with identified disparities. • Provider education on best practices, measure specifications, member barriers, and tips on overcoming barriers has been routinely shared through JOCs, BUHP Provider Forums, and provider newsletters.
HSAG's Assessment: HSAG determined that BUFC ACC satisfactorily addressed this prior year's recommendation.
Recommendation 4:
While BUFC ACC implemented interventions related to its CY 2021 *Cervical Cancer Screening—21–64 Years* rate, HSAG recommended that BUFC ACC expand on its most successful interventions related to improving female members' receipt of timely screening for cervical cancer. BUFC ACC should continue to consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended cancer screenings and make health decisions.
BUFC ACC's Response: Interventions that have been established or continued for implementation with enhancements are listed below: • Provider education on best practices, measure specifications, member barriers, and tips on overcoming barriers has been routinely shared through JOCs, BUHP Provider Forums, and provider newsletters. • Incentive campaign established to run from October 1, 2024, through December 31, 2024, targeted to members eligible for the *Cervical Cancer Screening* measure in populations with identified disparities. • Well-Women's Preventive Care text message campaign was initiated in July 2024 sending text messages or postcards to women providing education on the importance of routine wellness visits

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
and associated screenings, including cervical cancer screenings with resources for additional information. • Facilitate community-based Wellness Events that provide on-site screening.
HSAG's Assessment: HSAG determined that BUFC ACC satisfactorily addressed this prior year's recommendation.

Validation of Performance Improvement Projects

Back to Basics PIP

In CYE 2024, BUFC ACC continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 2, PIP validation activities focused on improvement from the baseline results. BUFC ACC submitted Remeasurement 2 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes to or discontinuation of the interventions.

HSAG conducted an annual validation of the second remeasurement year reflective of CY 2023 (January 1, 2023, through December 31, 2023) using AHCCCS-calculated and validated indicator rates. HSAG evaluated BUFC ACC's performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

Validation Results

Table 5-24 displays the overall confidence levels for the BUFC ACC *Back to Basics* PIP.

Table 5-24—BUFC ACC *Back to Basics* PIP Overall Confidence Levels

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]
BUFC ACC	*High Confidence*	100%	100%	*Low Confidence*	33%	100%

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

Measure Results

Table 5-25 and Table 5-26 provide the *Back to Basics* PIP baseline, Remeasurement Year 1, and Remeasurement Year 2 rates for each indicator for BUFC ACC.

Table 5-25—BUFC ACC *Back to Basics* PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: *W30 Rate 1*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
BUFC ACC	63.5%	58.1%	63.6%

HSAG rounded percentages to the first decimal place.

Table 5-26—BUFC ACC *Back to Basics* PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: *WCV*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
BUFC ACC	46.6%	39.6%	44.0%

HSAG rounded percentages to the first decimal place.

Interventions

Table 5-27 presents PIP interventions for BUFC ACC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-27—BUFC ACC *Back to Basics* PIP Interventions

Contractor	Interventions
BUFC ACC	• Promoted the Quality of Medicine (PQM) reports sent quarterly to providers to identify BUFC eligible members due and/or past due for a well-child/well-care visit. • The member outreach team contacted BUFC-eligible guardians of members/members identified as due and/or past due for a well-child/well-care visit, within the measurement period and assist to schedule an appointment.

Contractor	Interventions
	• EPSDT reminder postcards reminded guardians of members/members identified as due for a well-child/well-care visit, within the measurement period. • Second EPSDT reminder postcards reminded guardians of members/members identified as due for a well-child/well-care visit, within the measurement period, six months after their birth month. • Member newsletter. • Member handbook. • Online provider manual. • Health plan Facebook page included educational materials on well-child/well-care visits. • Provider site visits—Provider education on requirements and training is a component of EPSDT-related services, detailed information regarding all mailings, expectations, and minimum performance standards. • Health plan pediatric webpage educated members on immunizations, importance of routine care, benefits, and assistance available. • Participation in the Summer Back to School Campaign offered eligible members an incentive for completing a well-child visit during the campaign period. • Implemented a fall campaign that offered eligible members an incentive for completing a well-child visit during the campaign period. • Targeted text message campaign designed and implemented to outreach those young adult members ages 18–21 years old who were provided education and scheduling information for routine well-care visits.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-28 presents strengths, opportunities for improvement, and recommendations for BUFC ACC related to the *Back to Basics* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-28—BUFC ACC Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • BUFC ACC adhered to acceptable methodology through all phases of the PIP. **[Quality, Access]**

Strengths, Opportunities for Improvement, and Recommendations
• BUFC ACC developed and implemented interventions that led to non-statistically significant improvement in the *W30* performance indicator between the baseline and Remeasurement 2. **[Quality, Access]**
Opportunities for Improvement and Recommendations
For Indicator 2, BUFC ACC had a decline of 2.56 percentage points in the indicator rate between the baseline year and Remeasurement Year 2. **[Quality, Access]** Recommendations: As the PIP progresses, HSAG recommends that BUFC ACC: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. • Continue to implement identified interventions with clearly defined measures to assess the effectiveness of each intervention. Assure that all interventions are evaluated for effectiveness through a measure directly linked to the intervention.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-29 presents PIP recommendations made to BUFC ACC in the CYE 2023 Annual Technical Report[88] and BUFC ACC's follow-up to the recommendations, as well as an assessment of the degree to which BUFC ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-29—BUFC ACC Follow-Up to CYE 2023 PIP Recommendations

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG recommended that BUFC ACC: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. • Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.
BUFC ACC's Response: The *Back to Basics* PIP workgroup continues to meet, at minimum, quarterly. Workgroups are held with key leaders from the Maternal and Child Health team where data analysis, trends, and outcomes

[88] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf Accessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for PIPs
are reviewed and discussed. The workgroup has been focused on analysis of trends within different subpopulations to identify those that have disparities. Based on these findings, an emphasis on targeted interventions for these subpopulations has been developed. These interventions are focused on those subpopulations that hold a significant population size to impact the overall rates. Additionally, with concerns around the COVID-19 pandemic after the baseline year of this PIP, rates have continued to make steady improvements year over year for both indicators. Indicator 1 CY 23 rates have exceeded the baseline rate by 0.7 percent and Indicator 2 CY 23 rates are only 2.2 percent below the baseline rates. BUFC-ACC reviews and updates the fishbone diagram tool for the root cause analysis during each PIP workgroup meeting. Additionally, BUFC-ACC utilizes the PDSA cycle to monitor interventions implemented and their success and to ensure that progress is sustainable.
HSAG's Assessment: HSAG determined that BUFC ACC satisfactorily addressed this prior year's recommendation.

Prenatal and Postpartum Care PIP

Overview

AHCCCS initiated the implementation of the *Prenatal and Postpartum Care* PIP for the ACC population in CYE 2022. The objective of the *Prenatal and Postpartum Care* PIP is to improve health outcomes for members and infants. This PIP focuses on increasing the number and percentage of members with live birth deliveries that 1) received a prenatal care visit, and 2) received a postpartum visit. In CYE 2024, BUFC ACC continued to implement interventions to improve these outcomes and provided updates on the status of each intervention to AHCCCS.

Interventions

Table 5-30—BUFC ACC *Prenatal and Postpartum Care PIP* Interventions

Contractor	Interventions
BUFC ACC	Continued interventions with enhancements made to support the *Prenatal and Postpartum Care* PIP in CYE 2024 include:
	• Prenatal packets will be distributed to all pregnant members following MCH notification of the member's pregnancy and will be distributed every two weeks. • Development and implementation of a pilot program with an outpatient behavioral health/substance abuse facility to engage women who may be pregnant or postpartum and struggling with mental health and/or substance abuse challenges.
	Continued interventions to support the *Prenatal and Postpartum Care* PIP in CYE 2024 include:

Contractor	Interventions
	• Develop a PCP/practice-specific Value-Based Purchasing (VBP)/Pay-for-Performance program targeting timeliness of prenatal care within their assigned membership. • MCH to provide a minimum of two pregnancy submissions to each semiannual BUFC-ACC member newsletter, providing key maternity and family planning information to the membership. • MCH review of all OB referrals originating outside of the NOP process, within one business day of receipt. • Review weekly pregnancy indicator data to identify potential pregnancies, research and confirm pregnancies, education, and assist with initiation of prenatal care. • Conduct provider education on the health plan's coverage, requirements and resources related to family planning, prenatal and postpartum coverage, services, and care. • Members called within 72 hours post-discharge and educated on the importance of a postpartum visit, offered resources and additional assistance. • A customer care alert system that identifies members who have delivered or should have delivered puts an alert on the file to help connect with the member. • Webpage and social media posts to educate members on the importance of establishing prenatal care early and often, as well as providing education on postpartum care and postpartum depression (PPD). • Expand all utilization of technology platforms to improve accessibility to early and regular prenatal education, care, and health plan support.

Strengths, Opportunities for Improvement, and Recommendations

HSAG did not conduct validation on the *Prenatal and Postpartum Care* PIP in CYE 2024; therefore, strengths, opportunities for improvement, and recommendations are not provided.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-31 presents PIP recommendations made to BUFC ACC in the CYE 2023 Annual Technical Report[89] and BUFC ACC's follow-up to the recommendations, as well as an assessment of the degree to which BUFC ACC has effectively addressed the recommendations. Language in this section is

[89] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf Accessed on: Feb 23, 2025.

minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-31—BUFC ACC Follow-Up to CYE 2023 PIP Recommendations

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG recommended that BUFC ACC: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. • Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.
BUFC ACC's Response: The *Prenatal and Postpartum Care* PIP workgroup continues to meet, at minimum, quarterly. Workgroups are held with key leaders from the Maternal and Child Health team where data analysis, trends, and outcomes are reviewed and discussed. The workgroup has been focused on analysis of trends within different subpopulations to identify those that have disparities. Additionally, CY 23 rates for Indicator 1 have maintained from the baseline year, and CY 23 rates for Indicator 2 have increased by 1.0 percent since the baseline year. BUFC-ACC reviews and updates the fishbone diagram tool for the root cause analysis during each PIP workgroup meeting. Additionally, BUFC-ACC utilizes the PDSA cycle to monitor interventions implemented and their success and to ensure that progress is sustainable.
HSAG's Assessment: HSAG determined that BUFC ACC satisfactorily addressed this prior year's recommendation.

Compliance Reviews

Results

AHCCCS conducted a compliance review of BUFC ACC in CYE 2022. On May 30, 2024, AHCCCS accepted and closed the remaining two CAPs for BUFC ACC. Table 5-32 presents the updated CYE 2024 compliance review results for BUFC ACC.

Table 5-32—BUFC ACC Compliance Review Results

Compliance Focus Areas	CYE 2022 BUFC ACC Scores	CYE 2022 Program-Level Average	CYE 2023 BUFC ACC CAP Update	CYE 2024 BUFC ACC CAP Update
CC	100%	99%	NA	NA

Compliance Focus Areas	CYE 2022 BUFC ACC Scores	CYE 2022 Program-Level Average	CYE 2023 BUFC ACC CAP Update	CYE 2024 BUFC ACC CAP Update
CIS	97%	96%	NA	NA
DS	87%	91%	Partially Met	Met
GA	96%	92%	NA	NA
GS	99%	99%	NA	NA
MCH	70%	82%	Met	NA
MM	90%	94%	Met	NA
MI	100%	96%	NA	NA
QM	80%	77%	Partially Met	Met
QI	96%	92%	NA	NA
RI	100%	100%	NA	NA
TPL	100%	100%	NA	NA
ISOC	100%	96%	NA	NA

NA = Not applicable. A CAP was not required as the CYE 2022 score was 95% or above or the CAP was closed by AHCCCS in CYE 2023.
Partially Met = AHCCCS approved the Contractor's proposed CAP. The Contractor must submit evidence of compliance.
Met = AHCCCS accepted and closed the Contractor's CAP.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-33 presents strengths, opportunities for improvement, and recommendations for BUFC ACC based on compliance activities conducted in CYE 2024, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-33—BUFC ACC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
BUFC ACC has successfully closed out CAPs in the following focus areas: • Delivery Systems (DS) **[Timeliness, Access]** • Quality Management (QM) **[Quality]**
Opportunities for Improvement and Recommendations
As a result of its CAP interventions, BUFC ACC was found to be fully compliant within all focus areas and had no continuing corrective actions or recommendations.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-34 presents compliance recommendations made to BUFC ACC in the CYE 2023 Annual Technical Report[90] and BUFC ACC's follow-up to the recommendations, as well as an assessment of the degree to which BUFC ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-34—BUFC ACC Follow-Up to CYE 2023 Compliance Recommendations

Prior Year's Recommendation From the EQR Technical Report for Compliance
HSAG recommended that BUFC ACC continue to work on outstanding CAP items and submit to AHCCCS in the approved time frame.
BUFC ACC's Response: BUFC ACC has active CAPs in the following focus areas: • Delivery Systems (DS) [Timeliness, Access] • Quality Management (QM) [Quality] BUFC ACC will continue to correct any findings identified in its CAP to monitor compliance with the requirements in each of the AHCCCS focus areas listed above. BUFC ACC has successfully closed CAPs in the Adult, EPSDT, Maternal Child Health, and Medical Management focus areas. Additionally, in the AHCCCS Operational Review Updated Matrix from April 2024, the Delivery Systems (DS) CAPs were closed.
HSAG's Assessment: Based on the CAP closure for the DS and QM focus areas, and the response provided, HSAG determined that BUFC ACC has satisfactorily addressed the prior year's recommendations related to compliance.

Network Adequacy Validation

ISCA Results

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

[90] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf Accessed on: Feb 23, 2025.

Table 5-35 summarizes HSAG's validation ratings for BUFC ACC by indicator type.

Table 5-35—Summary of BUFC ACC's Validation Ratings by Indicator Type

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

Of the network adequacy indicators assessed, BUFC ACC received *High Confidence* for both appointment availability and time/distance indicators. However, there were identified areas for improvement; please refer to the Contractor-specific Strengths, Opportunities for Improvement, and Recommendations section below for more details.

NAV Results

HSAG evaluated BUFC ACC's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents CYE 2024 S1 validation findings specific to the ACC Program, with one results table for each of the following GSAs:

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

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

Table 5-36—Time/Distance Validation Results for BUFC ACC Central GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^	99.2^	100.0^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0^	99.3^	100.0^
BHRF	NA	98.5	NA
Cardiologist, Adult	100.0^	99.9^	100.0^
Cardiologist, Pediatric	100.0^	100.0^	100.0^
Dentist, Pediatric	99.6	99.4	100.0
Hospital	100.0	99.9	100.0
OB/GYN	100.0	100.0	100.0
Pharmacy	100.0	99.2	100.0

Minimum Network Requirement	Gila	Maricopa	Pinal
PCP, Adult	100.0^	99.8^	100.0^
PCP, Pediatric	100.0^	99.7^	100.0^

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

Table 5-37—Time/Distance Validation Results for BUFC ACC South GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Cochise	Graham	Greenlee	La Paz	Pima	Santa Cruz	Yuma
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^	100.0^	99.6^	100.0^	97.2^	100.0^	100.0^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0^	100.0^	99.4^	100.0^	97.2^	100.0^	100.0^
BHRF	NA	NA	NA	NA	92.1	NA	NA
Cardiologist, Adult	99.7^	100.0^	100.0	100.0^	99.4^	100.0^	100.0^
Cardiologist, Pediatric	100.0^	100.0^	100.0	100.0	99.7^	100.0^	100.0^
Dentist, Pediatric	99.7	96.6	61.0	49.5	98.6	100.0	99.8
Hospital	100.0	100.0	100.0	100.0	99.7	100.0	100.0
OB/GYN	100.0	100.0	100.0	100.0	99.7	100.0	100.0
Pharmacy	99.6	99.2	99.6	88.0	97.1	100.0	99.7
PCP, Adult	99.6^	99.7^	99.6^	99.7^	99.9^	100.0^	99.7^
PCP, Pediatric	99.8^	99.4^	99.5	100.0	99.7^	100.0^	99.8^

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

Strengths, Opportunities for Improvement, and Recommendations

Table 5-38 presents strengths, opportunities for improvement, and recommendations for BUFC ACC related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-38—BUFC ACC Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • BUFC ACC had processes in place to maintain current provider data, including utilizing the Arizona Association of Health Plans (AzAHP) forms to track provider data updates. Additionally, BUFC ACC performed a monthly reconciliation process of provider data between its systems to ensure accuracy and completeness. **[Access]** • BUFC ACC met all minimum network requirements for all assigned counties except Greenlee and La Paz counties. **[Access]** • BUFC ACC met all minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; BHRF; Cardiologist, Adult and Pediatric; Hospital; OB/GYN; and PCP, Adult and Pediatric. **[Access]** Note: BUFC ACC provides coverage in the following counties: Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Santa Cruz, and Yuma.
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: • In BUFC ACC's ISCAT responses and supporting documentation, BUFC ACC used multiple naming conventions for its database systems. **[Access]** Recommendation: HSAG recommends that BUFC ACC identify one consistent naming convention for each relevant database system as part of reporting to help ensure clarity in references and mitigate potential confusion. • BUFC ACC manually entered provider data updates from the AzAHP forms and provider rosters into the Provider Manager system. **[Access]** Recommendation: Although BUFC ACC had quality assurance checks and validations in place, HSAG recommends that BUFC ACC explore options to automate data transfer from electronic versions of the AzAHP forms and rosters into the Provider Manager system. • HSAG identified concerns with BUFC ACC's network adequacy indicator reporting processes regarding the lack of data checks conducted on the member data extracts used for network adequacy indicator calculation sent to Quest Analytics and the minimal data checks conducted on the provider data extracts used for network adequacy indicator calculation sent to Quest Analytics. **[Access]**

Strengths, Opportunities for Improvement, and Recommendations
Recommendation: HSAG recommends incorporating additional oversight through data reasonability checks and data quality checks. BUFC ACC may be able to mitigate the downstream impact of incorrect identification of member populations, provider classifications, and the results of network adequacy indicator calculation that would allow for better trending/comparison for additional oversight and monitoring activities. This would allow BUFC ACC to better identify gaps and monitor changes to members' access in its service areas. • BUFC ACC did not meet the minimum network requirements for Dentist, Pediatric and Pharmacy. **[Access]** Recommendation: HSAG recommends that BUFC ACC maintain current compliance with network standards and continue to address network gaps, as applicable.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-39 presents NAV recommendations made to BUFC ACC in the CYE 2023 Annual Technical Report[91] and BUFC ACC's follow-up to the recommendations, as well as an assessment of the degree to which BUFC ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-39—BUFC ACC Follow-Up to CYE 2023 NAV Recommendations

Prior Year's Recommendation From the EQR Technical Report for NAV
HSAG recommended that BUFC ACC maintain current compliance with network standards but continue to address network gaps, as applicable.
BUFC ACC's Response: BUFC-ACC analyzes the PAT file to determine if any noted variances are in line with natural network changes such as provider moves, adds, etc. If there are additional providers in the area to fill the gap, the providers are approached to join the network. If there are no providers in the area, BUFC-ACC is left with a gap, and an exception is submitted. Additionally, the following actions have been taken for Greenlee and La Paz counties: • Greenlee—Provider locations were identified within 50 miles of Morenci (Greenlee County). A deeper analysis is being conducted to pinpoint where exactly those members are located who are just over the 30-mile requirement accurately identify what offices to focus on to close the gap in this county. Additionally, according to the GEO from 9/25/24, there are 107 members in Greenlee

[91] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf Accessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for NAV
without access. Access standards in rural areas for BUFC are being reviewed. The GEO report shows 30 miles or 40 minutes for rural areas. While the 30-mile requirement is not being met, the GEO showed that members were within 39 miles, which would be equal to a 40-minute drive, therefore being within the range. • La Paz—Provider relations representative contacted the office in March and July of this year. Please note that there are not many provider options in La Paz due to how rural the county is, which is why there is an exception made by AHCCCS. Additionally, BUFC's dental benefits administrator has been contacting providers for recruitment attempts.
HSAG's Assessment: HSAG has determined that BUFC ACC has satisfactorily addressed the prior year's recommendations.

Care1st ACC-RBHA

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2024, HSAG evaluated Care1st ACC-RBHA's data system for processing of each data type used for reporting the Contractor's CY 2023 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that Care1st ACC-RBHA followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-40 displays HSAG's PMV findings for each data type reviewed during CYE 2024 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 5-40—CYE 2024 PMV Findings

Data Type	HSAG Findings
Medical Services Data	*No identified concerns*
Enrollment Data	*No identified concerns*
Provider Data	*No identified concerns*
Medical Record Review Process	*No identified concerns*
Supplemental Data	*No identified concerns*
Data Integration	*No identified concerns*

Results for Performance Measures

Table 5-41 presents the CY 2022 and CY 2023 Care1st ACC-RBHA performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and MY 2023. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and/or MY 2023. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 5-41—CY 2022 and CY 2023 Care1st ACC-RBHA Performance Measure Results

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	75.4%+	81.5%+	↑	★★
Postpartum Care	68.4%+	62.0%+	→	★
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	60.5%	61.6%	→	★★
Effective Continuation Phase Treatment—Total (18+ Years)	42.3%	44.7%	→	★★★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	31.8%	30.3%	→	★★★★
30-Day Follow-Up—Total (13+ Years)	44.2%	42.0%	→	★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	54.7%	48.8%	↓	★★★★
30-Day Follow-Up—Total (6+ Years)	69.8%	67.9%	→	★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	41.9%	52.1%	↑	★★★★
30-Day Follow-Up—Total (6+ Years)	54.8%	62.0%	→	★★★
Use of Opioids at High Dosage				
*18+ Years**	3.6%	5.9%	↓	★★
Initiation and Engagement of Substance Use Disorder (SUD) Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	41.8%	40.6%	→	★★
Engagement of SUD Treatment—Total—Total (13+ Years)	13.4%	15.4%	↑	★★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	40.7%	50.3%	→	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	78.5%	82.7%	→	★★★
Care of Acute and Chronic Conditions				
Controlling High Blood Pressure				
18–85 Years	43.1%+	63.3%+	↑	★★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0%)—Total (18–75 Years)	38.0%+	50.1%+	↑	★

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
*Poor HbA1c Control (>9.0%)—Total (18–75 Years)**	55.2%+	40.9%+	↑	★
Pediatric Health				
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	35.1%	46.0%	↑	★★★★
Childhood Immunization Status**				
Combination 3	47.2%+	48.9%+	→	★
Combination 7	42.3%+	42.3%+	→	★
Combination 10	20.7%+	16.5%+	→	★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	74.2%+	73.2%+	→	★
Combination 2 (Meningococcal, Tdap, HPV)	32.6%+	28.5%+	→	★
Oral Evaluation, Dental Services				
Total (0–20 Years)[N]	45.1%	39.9%	↓	—
Well-Child Visits in the First 30 Months of Life				
First 15 Months—Six or More Well-Child Visits	53.5%	54.8%	→	★★
15 Months to 30 Months—Two or More Well-Child Visits	53.5%	59.2%	↑	★
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	33.7%	41.8%	↑	★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	32.3%	36.4%	↑	★
Cervical Cancer Screening				
21–64 Years	39.2%+	36.0%+	→	★
Appropriate Utilization of Services				
Ambulatory Care				
Emergency Department (ED) Visits —Total (0–85+ Years)[F]	448.1	485.3	—	—
Plan All-Cause Readmissions				
*Observed/Expected (O/E) Ratio—Total (18–64 Years)**	0.9694	0.9087	—	★★★

* A lower rate indicates better performance for this measure.
** Table A-2 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
+ Indicates the measure was reported using hybrid methodology.
Cells shaded green indicate that the rate met or exceeded the MY 2022 and/or MY 2023 national Medicaid mean.

— Indicates a 2022–2023 comparison is not presented in the CYE 2024 Annual Technical Report because either the CY 2022 rate was not presented in the CYE 2023 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
[1]Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.
[2] Performance Levels for CY 2023 were based on comparisons of the HEDIS MY 2023 measure rates to national Medicaid Quality Compass HEDIS MY 2023 benchmarks.
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.
[N] Measure has no NCQA Medicaid mean for comparison.
↑ Indicates statistically significant improvement of measure rates.
↓ Indicates statistically significant decline of measure rates.
→ Indicates no statistically significant change in measure rates.
Performance Levels for 2023 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 5-42 presents strengths, opportunities for improvement, and recommendations for Care1st ACC-RBHA related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement. As of October 1, 2024, Care1st ACC-RBHA no longer holds an AHCCCS contract; therefore, the information in this section does not include recommendations.

Table 5-42—Care1st ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group: • Nine of 13 Care1st ACC-RBHA measure rates (69.23 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 **[Quality, Timeliness, Access]** – *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* – *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* – *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* – *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* – *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years*

Strengths, Opportunities for Improvement, and Recommendations
– *Use of Opioids at High Dosage—18+ Years* • Care1st ACC-RBHA's performance measure rates for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years), Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years),* and *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* were at or between the 75th and 89th percentile as well, indicating timely follow-up for members after going to the ED or being hospitalized for a mental illness **[Quality, Timeliness, Access]**
Opportunities for Improvement and Recommendations
In the Maternal and Perinatal Care measure group, Care1st ACC-RBHA's performance measure rate for *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, indicating an opportunity to increase access to timely postpartum care. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.[92] **[Quality, Timeliness, Access]**
In the Preventive Screening measure group, Care1st ACC-RBHA's performance measure rates for *Breast Cancer Screening (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* fell below the 25th percentile, indicating that some women were not receiving timely screening for breast and cervical cancers. Early detection reduces the risk of dying from these types of cancers and can lead to a greater range of treatment options and lower healthcare costs. **[Quality]**
In the Care of Acute and Chronic Conditions measure group, Care1st ACC-RBHA's performance measure rate for *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)—Total (18–75 Years)* and *HbA1c Poor Control (>9.0%)—Total (18–75 Years)* measure rates fell below the 25th percentile, indicating poor control over diabetes. **[Quality]**
In the Pediatric Health measure group: • Care1st ACC-RBHA's performance measure rates for *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10* and *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* fell below the 25th percentile, indicating that children and adolescents were not always getting their recommended immunizations. Vaccination coverage must be maintained in order to prevent a resurgence of vaccine-preventable diseases.[93] **[Quality, Access]** • Care1st ACC-RBHA's performance measure rates for *Well-Child Visits in the First 30 Months of Life—15 Months to 30 Months—Two or More Well-Child Visits* fell below the 25th percentile,

[92] National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/. Accessed on: Feb 13, 2025.
[93] National Committee for Quality Assurance. Childhood Immunization Status (CIS). Available at: https://www.ncqa.org/hedis/measures/childhood-immunization-status/. Accessed on: Feb 13, 2025.

Strengths, Opportunities for Improvement, and Recommendations
indicating opportunities for children who turned 30 months old during the measurement year to have at least two well-child visits with a PCP in the prior 15 months.[94] **[Quality, Access]** • Care1st ACC-RBHA's performance measure rates for *Child and Adolescent Well-Care Visits — Total (3–21 Years)* fell below the 25th percentile, indicating that children and adolescents were not always receiving well-care visits at the recommended intervals. Assessing physical, emotional, and social development is important at every stage of life, particularly for children and adolescents. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[95] **[Quality, Access]**

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-43 presents performance measure recommendations made to Care1st ACC-RBHA in the CYE 2023 Annual Technical Report[96] and Care1st ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Care1st ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-43—Care1st ACC-RBHA Follow-Up to CYE 2023 Performance Measure Recommendations

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Recommendation 1:
While Care1st ACC-RBHA conducted root cause analyses and implemented interventions specific to its CY 2021 *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Prenatal and Postpartum Care—Postpartum Care* rates, these rates remained low in CY 2022; therefore, HSAG recommended that Care1st ACC-RBHA continue to implement appropriate interventions to improve performance related to postpartum care. HSAG also recommended that Care1st ACC-RBHA monitor and expand on interventions currently in place to improve performance for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Prenatal and Postpartum Care—Postpartum Care* measure indicators.
Care1st ACC-RBHA's Response:
Care1st ACC-RBHA's performance measure rate for *Prenatal and Postpartum Care—Timeliness of*

[94] 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: Feb 13, 2025.
[95] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Feb 13, 2025.
[96] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf. Accessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Prenatal Care and *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, indicating an opportunity to increase access to timely prenatal and postpartum care. Root cause analysis focused on increasing access to prenatal and postpartum care by identifying those barriers, such as lack of opportunities for members to receive support, assistance, and encouragement throughout pregnancy and the postpartum period; lack of awareness of pregnancy or denial/indifference; difficulty in outreaching members due to correct contact information not always available; and lack of consistent positive performance from strategic partners and providers. The root cause analysis and identified barriers pertain to both the Medicaid and CHIP populations. In response to identified barriers, the following interventions were implemented or continued in CY 2023. These interventions were deployed for both the Medicaid and CHIP populations. Care1st ACC-RBHA also monitored and evaluated primary interventions in place for *Timeliness of Prenatal Care*: • Ongoing engagement and education of members about the importance of prenatal care as soon as the pregnancy is identified and specific to trimester through written material, text messages, and live phone outreach. Ongoing communication throughout pregnancy is important to healthy outcomes for mom and baby, but also because members may have gaps in enrollment and may qualify for the measure denominator later in pregnancy. In CY 2023, a total of 1,133 new pregnancies were identified, with staff able to engage 91.0 percent of pregnant members through outbound calls and mailing of prenatal packets. In addition, 2,185 text messages were delivered, encouraging ongoing prenatal care, with a very low opt-out rate of about 3.0 percent. • Offering a revamped member incentive program for completion of timely prenatal visits, with a change to using claims-based rewards, rather than member attestation. The revamped program was rolled out to members and providers in June 2023. Only 67 incentives were awarded in the second half of CY 2023, representing 5.9 percent of the indicator's eligible population (n=1,027). Incentives for postpartum visits totaled 888, representing 86.5 percent of the eligible population; however, the final rate for postpartum visits based on hybrid data collection declined in CY 2023. This intervention is considered ineffective in impacting rates for either indicator. The member incentive program will be realigned with AzCH-CCP for CY 2025, discontinuing the incentives for *PPC*. • Engaging high-volume providers around achieving goals for *Timeliness of Prenatal Care* with value-based agreements and incentives; discussing performance and improvement strategies in quarterly meetings. In CY 2023, large medical groups were engaged with incentives; none achieved the goal, with only one showing significant improvement over the previous year. • Sharing gaps in care for postpartum visits with all contracted providers on a monthly basis, along with the performance rate for their assigned members compared with all Care1st members. Since this measure is reliant on medical record review, monthly monitoring based primarily on administrative data did not yield reliable data to monitor effectiveness; however, the overall measure rate did not improve. • Offering education through the Provider Forum and other methods on a new NOP process to better capture data on members identified as pregnant.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
• Offering a Provider Portal, allowing on-demand access to view measure rates and member rosters, as well as NOP forms. Care1st showed a statistically significant improvement in the rate of *Timeliness of Prenatal Care*, from 75.4 percent in CY 2022 to 81.5 percent in CY 2023 ($p = 0.0415$). In response to identified barriers, the following interventions were implemented or continued in CY 2023 for the *Postpartum Care* submeasure. These interventions were deployed for both the Medicaid and CHIP populations. Care1st also monitored and evaluated interventions in place, including: • Engaging and educating members about the importance of a postpartum visit beginning in the second trimester through written material, texts, and live phone outreach. Members were also sent a packet/flyer in the third trimester reminding them of family planning options and the importance of a postpartum visit. Postpartum letters were sent to 813 members for whom the health plan had reliable contact information, and texts were delivered to 373 members. "Newborn calls," which included providing postpartum education and assistance with scheduling an appointment and transportation if needed, were made to 937 members, with a 68.4 percent reach rate. • Attempting to enroll pregnant members in a mobile application that provided push notifications to members' phones about important topics after delivery, including postpartum visits. The application also included a custom button that provided a direct connection to the Care1st MCH team, for help in making appointments and arranging for transportation. This intervention was not effective due to low enrollment numbers (only 112 enrollments after delivery in CY 2023) and was discontinued on 9/30/24. • Sending member gaps in care for postpartum visits to obstetrical providers on a monthly basis to engage members and attempt to schedule them for visits. Only a few showed significant improvement over the previous year. Despite these efforts, the Care1st rate of *Postpartum Care* was lower in CY 2023, at 62.0 percent, compared with 68.3 percent in CY 2022, although the change was not statistically significant ($p = 0.0671$). New or revised interventions for both *PPC* indicators in CY 2024, applicable to both the Medicaid and CHIP populations, include: • Distribution of a "Path to 5 Stars" reference guide for providers to educate on quality and performance measures, implemented in Q1 2024. The guide features best practices for closing quality care gaps and improving member experience, as well as common codes and exclusions to improve data capture. • Engaging providers through the Provider Quality Liaison (PQL) team to build stronger relationships with high-volume providers to increase performance, improve knowledge about measures, and provide technical assistance. This intervention was implemented in Q1. • Participation in the AzCH Provider Forum for OB/GYN providers, which supplies providers with material and engages them with education, technical assistance, and resources for performance improvement on the *PPC* measure.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
• Implementation of a care management program to increase member awareness and engagement in their prenatal and postpartum care, effective 10/1/24, which enhances current outreach efforts to engage newly identified pregnant members. Members are enrolled in the program from NOP through six weeks after delivery. The program educates and encourages members via text messaging and emails, as well as initial mailings, followed by "Guide to Pregnancy" booklets and "Life After Delivery" packets. • Implementation of a mobile application that provides a specialized care plan for members with tailored daily health check lists; provides alerts, care gaps, and progress tracking to CMS; and allows for two-way video/text communication with care management as of 10/1/24. • Implementation of an NCQA-accredited self-management tool on the member portal as of 10/1/24, to increase members' confidence and improvement in members' health. • Implementation of a new outreach program that provides member demographic data, care gap information, past seen provider information, and claims history all in one portal to improve the effectiveness of outreach.
HSAG's Assessment: HSAG determined that Care1st ACC-RBHA satisfactorily addressed these prior year's recommendations.
Recommendation 2:
While Care1st ACC-RBHA conducted root cause analyses and implemented interventions specific to its CY 2021 *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* rates, these rates remained low in CY 2022 and both declined from the prior year; therefore, HSAG recommended that Care1st ACC-RBHA continue to implement appropriate interventions to improve performance related to these rates. HSAG also recommends that Care1st ACC-RBHA monitor and expand on interventions currently in place to improve performance related to these screenings. In addition, HSAG recommended that Care1st ACC-RBHA conduct outreach to its members as well as educate them on the importance of these screenings.
Care1st ACC-RBHA's Response: HSAG stated that Care1st ACC-RBHA's performance measure rates for *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* fell below the 25th percentile, indicating that some women were not receiving timely screening for breast and cervical cancers. Of note, the measure rate for *Cervical Cancer Screening* experienced a significant decline from MY 2021. Root cause analysis focused on increasing the number of members receiving timely screenings and looking at those barriers affecting members, primarily a lack of information surrounding the process and the importance of annual screenings among members, as well as reluctance to obtain services due to anticipated discomfort of these procedures. These barriers are compounded by the inability to reach members due to outdated contact information and fewer radiology facilities in rural/isolated areas of the North GSA served by Care 1st. Moreover, members with complex and/or multiple chronic conditions are difficult to engage in preventive services. The root cause analysis also identified a need for increased collaboration with providers. The root cause analysis and identified barriers pertain to both the Medicaid and CHIP populations.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures

In addition, rates for both measures were likely affected by the multi-year look-back period, part of which (MY 2021) coincided with the COVID-19 PHE that limited accessibility of services and deterred members from seeking these services. It should also be noted that comparisons to CY 2021 rates should be interpreted with caution because of the significant change in the Care1st population between MY 2021 and MY 2022. The Care1st Central GSA membership was transferred to AzCH-CCP, leaving it with a different and historically difficult-to-engage population in the Frontier and Remote (FAR) areas of Northern Arizona.

In response to identified barriers, the following interventions were implemented or continued in CY 2023. These interventions were deployed for both the Medicaid and CHIP populations. Care1st ACC also monitored and evaluated interventions in place:

- Ongoing engagement and education of members about the importance of breast and cervical cancer screening through written material, text messages, and live phone outreach. A care engagement specialist reached out to members throughout the year but was only able to make attempts to 2,915 members (53.3 percent) due to disconnected/wrong numbers, not accepting calls, mailboxes full, busy signals, etc. Of those members, the specialist made contact with 727 members (24.9 percent) to educate them on the importance of screening, attempt to overcome objections to screening, and either schedule/refer or confirm that the member had already obtained a screening or was scheduled for one. Care1st also sent multiple text messages to members in the *BCS* denominator who were missing a screening, providing reasons to get a mammogram. A total of 3,550 *BCS* messages were delivered, with an opt-out rate of about 2.6 percent. The high contact rate through live phone outreach and low opt-out rate of text messages suggest the interventions were effective in supporting positive movement in the *BCS* rate.
- Delivering 20,031 well woman/cervical cancer screening messages to Care1st members, with an opt-out rate of about 3.0 percent.
- Offering a revamped *BCS* member incentive program for completion of timely prenatal visits, with a change to using claims-based rewards, rather than member attestation. The revamped program was rolled out to members and providers in June 2023. However, only 513 incentives were awarded (less than 10 percent of the measure denominator), indicating this intervention was not effective in supporting improvement. The member incentive program will be realigned with AzCH-CCP for CY 2025, discontinuing the incentive for *BCS*. However, an incentive will be offered in CY 2025 for completing a cervical cancer screening.
- Engaging high-volume providers around achieving goals for *Breast Cancer Screening* with value-based agreements and incentives; discussing performance and improvement strategies in quarterly meetings. In CY 2023, eight medical groups were engaged with incentives. None achieved the goal, although three groups showed significant improvement over the previous year.
- Sharing gaps in care for *Cervical Cancer Screening* with all contracted providers on a monthly basis, along with the performance rate for their assigned members compared with all Care1st members. Since this measure is reliant on medical record review, monthly monitoring based

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
primarily on administrative data did not yield reliable data to monitor effectiveness; however, the overall measure rate did not improve. • Collaboration with a large FQHC to schedule members with their mobile mammography events, which offered cervical cancer screenings at most events, utilizing a health plan care engagement specialist to make calls and schedule appointments or encourage members to attend the mobile events. However, members mostly expressed interest in obtaining mammograms from fixed sites. More than 60 mobile events were held in four northern counties in CY 2023. However, the health plan was not able to collect data for Care1st members attending these events. Care1st ACC showed a statistically significant improvement in the *BCS* rate, from 32.3 percent in CY 2022 to 36.4 percent in CY 2023 (p <0.0001). For *CCS*, the Care1st rate was lower in CY 2023, down from 39.2 percent in CY 2022, to 36.0 percent, although the change was not significant (p = 0.3875). New or revised interventions for both *BCS* and *CCS* in CY 2024, applicable to both the Medicaid and CHIP populations, include: • Distribution of a "Path to 5 Stars" reference guide for providers to educate on quality and performance measures, implemented in Q1 2024. The guide features best practices for closing quality care gaps and improving member experience, as well as common codes and exclusions to improve data capture. • Engaging providers through the PQL team to build stronger relationships with high-volume providers to increase performance, improve knowledge about measures, and provide technical assistance. This intervention was also implemented in Q1. • Participation in the AzCH Provider Forum for OB/GYN providers, which supplies providers with material and engages them with education, technical assistance, and resources for performance improvement on the *PPC* measure. The forum will also support improvement in cervical cancer screening. • Collaboration with the American Cancer Society Arizona chapter to offer motivational interviewing (MI) training to providers, enabling them to better engage patients in discussions of cancer screening. • Expansion of partnerships that incentivize rural radiology providers to reach out to members to attempt to schedule mammogram appointments, either through brick-and-mortar facilities or by mobile mammography. • Utilization of year-round hybrid data collection to improve reliability of monthly monitoring and effectiveness of targeted member and provider outreach. • Collaboration with a strategic partner that serves high-acuity and vulnerable members referred by Care Management. This initiative seeks to capitalize on existing outreach to engage members in care management of chronic conditions, as well in preventive services, including breast and cervical cancer screening. • Deployment of a personalized "member passport," for adult preventive screenings, including those for breast and cervical cancer. A letter lists the member's gaps in care and is accompanied by a

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
flyer detailing what each screening is, why it is important, and what to expect when obtaining the service.
HSAG's Assessment: HSAG determined that Care1st ACC-RBHA satisfactorily addressed these prior year's recommendations.
Recommendation 3:
HSAG recommended that Care1st ACC-RBHA conduct a root cause analysis to determine why some members are not managing their high blood pressure optimally. This could include conducting focus groups to identify barriers that members are experiencing in accessing care and services in order to implement appropriate interventions. Care1st ACC-RBHA should consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). Upon identification of a root cause, HSAG recommended that Care1st ACC-RBHA implement appropriate interventions to improve performance related to this chronic condition.
Care1st ACC-RBHA's Response: HSAG stated that Care1st ACC-RBHA's performance measure rate for *Controlling High Blood Pressure—18–85 Years* fell below the 25th percentile, indicating that not all members were receiving appropriate screenings and treatment for managing blood pressure. The root cause analysis focused on assisting members with hypertension in optimally managing their condition and looking at those barriers affecting members, such as minimal outreach to members and few member-focused interventions, compounded by the inability to reach members due to outdated contact information and lack of understanding about the importance of managing high blood pressure. The analysis also identified the need for provider-facing interventions focused on improving data capture for this hybrid measure, including increasing supplemental data feeds/EMR data from providers, in order to better monitor gap closure. The root cause analysis and identified barriers pertain to both the Medicaid and CHIP populations. In response to identified barriers, the following interventions were implemented or continued in CY 2023. These interventions were deployed for both the Medicaid and CHIP populations. Care1st also monitored and evaluated interventions in place: • Utilization of a member rewards program to incentivize adult members for completing ambulatory/preventive visits (*AAP*), thus providing opportunities to measure blood pressure and take actions to control hypertension (HTN). A total of 1,023 incentives were awarded in CY 2023, representing less than 3.0 percent of the population eligible for the incentive, indicating this intervention was not effective in supporting improvement. The member incentive program will be realigned with AzCH-CCP for CY 2025, discontinuing the incentive for *AAP*. • Utilization of a new medication adherence incentive program. Members with certain chronic conditions that have comorbid HTN can earn incentives for daily check-ins via a mobile application to show they are taking their medications and monitoring their blood pressure. Overall program engagement at the end of 2023 was 77.2 percent. Medication adherence for renin-

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
angiotensin system (RAS) agents to combat hypertension was >6 percent higher among members who participated in the program, compared with those who did not. • Sending text messages to members with no or noncompliant blood pressure readings on file and/or those in need of an annual well visit, with reminders to see their providers and a phone number to call for help in scheduling a visit. In CYE 2023, messages were successfully delivered to 4,545 members, with an opt-out rate of approximately 3.0 percent. • Sharing gaps in care for *Controlling Blood Pressure* with all contracted providers on a monthly basis, along with the performance rate for their assigned members compared with all Care1st members. Since this measure is reliant on medical record review, monthly monitoring based primarily on administrative data did not yield reliable data to monitor effectiveness; however, the overall measure rate did improve. New or revised interventions in CY 2024, applicable to both the Medicaid and CHIP populations, include: • Distribution of a "Path to 5 Stars" reference guide for providers to educate on quality and performance measures, implemented in Q1 2024. The guide features best practices for closing quality care gaps and improving member experience, as well as common codes and exclusions to improve data capture. • Engaging providers through the PQL team to build stronger relationships with high-volume providers to increase performance, improve knowledge about measures, and provide technical assistance. This intervention was implemented in Q1. • Deployment of a personalized "member passport" for adult preventive screenings, including blood pressure checks. A letter lists the member's gaps in care and is accompanied by a flyer detailing what each screening is, why it is important, and what to expect when obtaining the service. • Implementation of a new outreach program that provides member demographic data, care gap information, past seen provider information, and claims history all in one portal to improve the effectiveness of outreach. • Deployment of a member mailer specific to the importance of controlling blood pressure. • Utilization of year-round hybrid data collection to improve reliability of monthly monitoring and effectiveness of targeted member and provider outreach. • Engagement of providers around supplemental data feeds and EMR connectivity to improve data collection for this measure, so that the health plan does not continue to target members with gaps that are already closed.
HSAG's Assessment: HSAG determined that Care1st ACC-RBHA satisfactorily addressed these prior year's recommendations.
Recommendation 4:
HSAG recommended that Care1st ACC-RBHA conduct a root cause analysis to determine why some children are not getting their immunizations by their second birthday. This could include conducting focus groups to identify barriers that members are experiencing in accessing care and services in order

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
to implement appropriate interventions. Care1st ACC-RBHA should consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). Upon identification of a root cause, HSAG recommended that Care1st ACC-RBHA implement appropriate interventions to improve the performance related to childhood immunizations.

Care1st ACC-RBHA's Response:

HSAG stated that Care1st ACC-RBHA's performance measure rates for *Childhood Immunization Status—Combination 3, Combination 7,* and *Combination 10* fell below the 25th percentile, indicating that children were not always getting their immunizations by their second birthdays. The root cause analysis focused on overcoming recent decreases in childhood immunization rates and the reasons for that trend. The CDC has noted substantial declines in doses of long-recommended vaccines such as diphtheria, tetanus and acellular pertussis (DTaP) and measles, mumps and rubella (MMR) administered to children ages 0–23 months during mid-2020, compared with the same period in 2019 (Centers for Disease Control and Prevention, 2023).[97] As of 2022–2023, vaccination coverage levels had yet to rebound, according to several reports. Factors contributing to recent vaccination trends include shifts in public opinion and rising vaccine hesitancy since the pandemic began, likely fueled by vaccine misinformation.

For the Combination 10 series of vaccines, qualitative analysis showed low rates of completion of the influenza vaccine, resulting in a statistically significant difference between the rate for Combo 7 and the rate for Combo 10. When analyzing data for all the combinations, flu vaccination had the greatest effect on rates. Data from the NCQA underscores this observation: the national Medicaid mean for both Influenza vaccination and Combo 10 declined from 2020 (MY 2019) to 2022 (MY 2021), by 10.5 percent and 7.0 percent, respectively, while rates for other individual childhood vaccines had declines ranging from 2.8 percent to 4.8 percent (NCQA, 2023).[98]

Because Care1st utilizes intensive outreach to parents/healthcare decision makers to support completion of well visits and immunizations in the first 30 months of life, the health plan used feedback from these outreach calls to identify barriers that members are experiencing in accessing immunizations. Barriers identified were parental difficulty taking time off work to get their children vaccinated; lack of nearby providers in rural areas and traveling to a vaccination site; mistrust of government, the healthcare system, and vaccines; and parents/healthcare decision makers preferring to set their own schedule for immunizations, while choosing to forgo some vaccines. These issues have been echoed by network providers, and the health plan identified a need to increase collaboration with

[97] Childhood Vaccination Coverage Before and During the COVID-19 Pandemic among Children Born January 2017-May 2020, National Immunization Survey-Child (NIS-Child), 2018-2021. 2023. Available at: https://www.cdc.gov/vaccines/imz-managers/coverage/childvaxview/pubs-presentations/nis-child- pandemic-effects-2018-2021.html. Accessed on: Jan 13, 2025.

[98] National Committee for Quality Assurance. State of Healthcare Quality. Childhood Immunization Status (CIS). 2023. Available at https://www.ncqa.org/hedis/measures/childhood-immunization-status/. Accessed on: Feb 13, 2025.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
community organizations and providers to develop greater trust among parents/decision makers. The root cause analysis and identified barriers pertain to both the Medicaid and CHIP populations. In response to identified barriers, the following interventions were implemented or continued in CY 2023. These interventions were deployed for both the Medicaid and CHIP populations. Care1st also monitored and evaluated interventions in place: • Utilization of a member rewards program to incentivize members for completing well-child visits in the first 30 months of life, with a change to using claims-based rewards, rather than member attestation. This program incentivized completion of the first four visits and then two additional visits in the first 15 months of life, along with two visits from 15 to 30 months, offering opportunities for providers to discuss and administer vaccines. The revamped program was rolled out to members and providers in June 2023, with 308 rewards provided for visits in the first 15 months (representing about 30 percent of the denominator) and 1,095 rewards provided for visits 15–30 months (about 96.0 percent of the denominator). The member incentive program will be re-aligned with AzCH-CCP for CY 2025, adding incentives for some childhood immunizations and annual flu vaccination. • Ongoing outreach to educate on the importance of childhood immunizations and wellness visits and assisting members with scheduling appointments. Out of 6,549 outreach calls made to educate/assist with scheduling well-infant/child visits and immunizations in CY 2023, 869 (13.2 percent) were successful in reaching a live person and conducting the education. This is labor-intensive but lays the foundation for better understanding of the importance of preventive health screenings and immunizations among parents/healthcare decision makers. When making contact with parents/healthcare decision makers, care engagement specialists made a special point to discuss flu vaccination. • Sending text messages to parents/healthcare decision makers with education on developmental milestones tailored to the child's age and importance of immunizations, encouraging them to maintain all well visit appointments and talk with their child's PCP about any concerns or questions. In CY 2023, 5,777 messages were delivered, with an opt-out rate of about 2.0 percent. Most messages gave recipients the opportunity to click through the message to a Care1st landing page with more information. The click-through/engagement rate in CY 2023 was 12.0 percent. • Continue supporting and participating in community events that provide childhood immunizations and well-child checks. Care1st participated in six community events that offered immunizations and well-child checks. Direct data are not available for this intervention; however, it is considered a best practice in increasing trust by meeting parents/healthcare decision makers where they are and providing services in conjunction with CBOs. • Implementing a flu prevention program to promote annual flu vaccinations by postcards and interactive voice response (IVR) hold messages. Among members 0–4 years who received the intervention, 13.4 percent obtained a flu vaccination during the 2023–24 season. • Referring parents/healthcare decision makers in remote areas of Mohave County to a mobile services medical unit that provides primary care, including immunizations.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
• Deployment of "Practice Pointer" educational bulletins to providers, which include tips and resources for talking to parents/healthcare decision makers about the benefits and risks of vaccines during their children's visits. • Sharing gaps in care for *Childhood Immunization Status* measures with all contracted pediatric providers on a monthly basis, along with the performance rate for their assigned members compared with all Care1st members. Since this measure is somewhat reliant on medical record review, monthly monitoring based primarily on administrative data did not yield reliable data to monitor effectiveness. New or revised interventions in CY 2024, applicable to both the Medicaid and CHIP populations, include: • Distribution of a "Path to 5 Stars" reference guide for providers to educate on quality and performance measures, implemented in Q1 2024. The guide features best practices for closing quality care gaps and improving member experience, as well as common codes and exclusions to improve data capture. • Engaging providers through the PQL team to build stronger relationships with high-volume providers to increase performance, improve knowledge about measures, and provide technical assistance. This intervention was also implemented in Q1. • Deployment of an updated EPSDT Provider Quick Reference Guide to support collaboration with providers and the health plan, as well as providing educational material regarding how to reduce no-shows and missed appointments and scheduling follow-up appointments before the member leaves the office. • Deployment of a personalized "member passport" for children's preventive screenings, including immunizations. A letter lists the member's gaps in care and is accompanied by a flyer detailing what each screening/service is, why it is important, and what to expect when obtaining the service. • Implementation of a new outreach program that provides member demographic data, care gap information, past seen provider information, and claims history all in one portal to improve the effectiveness of outreach. • Utilization of year-round hybrid data collection to improve reliability of monthly monitoring and effectiveness of targeted member and provider outreach.
HSAG's Assessment: HSAG determined that Care1st ACC-RBHA satisfactorily addressed these prior year's recommendations.

Validation of Performance Improvement Projects

Back to Basics PIP

In CYE 2024, Care1st ACC-RBHA continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 2, PIP validation activities focused on improvement

from the baseline results. Care1st ACC-RBHA submitted Remeasurement 2 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes to or discontinuation of the interventions.

HSAG conducted an annual validation of the second remeasurement year reflective of CY 2023 (January 1, 2023, through December 31, 2023) using AHCCCS-calculated and validated indicator rates. HSAG evaluated Care1st ACC-RBHA's performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

Table 5-44 displays the overall confidence levels for the Care1st ACC-RBHA *Back to Basics* PIP.

Table 5-44—Care1st ACC-RBHA *Back to Basics* PIP Overall Confidence Levels

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]
Care1st ACC-RBHA	*High Confidence*	100%	100%	*No Confidence*	33%	100%

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

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

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

Measure Results

Table 5-45 and Table 5-46 provide the *Back to Basics* PIP baseline, Remeasurement Year 1, and Remeasurement Year 2 rates for each indicator for Care1st ACC-RBHA.

Table 5-45—Care1st ACC-RBHA *Back to Basics* PIP Rates for PIP Indicator 1

Contractor	PIP Measure Indicator 1: *W30 Rate 1*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
Care1st ACC-RBHA	70.5%	53.5%	54.8%

HSAG rounded percentages to the first decimal place.

Table 5-46—Care1st ACC-RBHA *Back to Basics* PIP Rates for PIP Indicator 2

Contractor	PIP Measure Indicator 2: *WCV*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
Care1st ACC-RBHA	51.4%	33.7%	41.8%

HSAG rounded percentages to the first decimal place.

Interventions

Table 5-47 presents PIP interventions for Care1st ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-47—Care1st ACC-RBHA *Back to Basics* PIP Interventions

Contractor	Interventions
Care1st ACC-RBHA	• Targeted outreach to members 18 to 20 years of age who were educated about the availability of health care and encouraged to use services before they age out of EPSDT coverage. This outreach took place via enhanced text messaging and mailers to members with messaging relevant to their unique needs and concerns. • Hosted in-person "Welcome Rooms" to connect with the community and educate on the importance of preventive/primary care and available covered benefits; identified members with gaps in care and referred to services. The Welcome Rooms were held in conjunction with local community organizations/events and provided other services that members could use (e.g., food distribution, health fairs, connection to community resources). • Launched interactive member portal, allowing the member to change PCP assignment, see personalized care gaps, search providers, and complete mini-health screener with one interaction at the member's convenience, 24/7. • Executed Teladoc contract, allowing members access to non-emergency telephone or video visits with licensed physical and behavioral health providers 24/7.

Contractor	Interventions
	• Revamped Member Incentive Program with new vendor, My Health Pays. The new incentive program allowed members to receive their reward with completion of a visit based on claims, and no longer required members to take additional action to complete an attestation. • Subcontracted with innovative healthcare providers and conducted outreach and engaged members via telehealth or in their homes to complete visits and educated/connected them to other needed care. Adobe Care and Wellness performed this work in Mohave and Yavapai counties. Care1st continued to explore options to better engage members in other counties. • Expanded Tribal Liaison Program with additional full-time employee who collaborated with tribal entities and CBOs to address barriers related to location, cultural factors, and SDOH that delayed screening among American Indian members. Planned interventions for CY 2024: • Engaged providers through the Arizona Complete Health Provider Engagement team and deployed new "Path to 5 Stars" provider resource guide for improving quality measures, including *W30* and *WCV*. The guide provided practitioners with Medicaid percentile targets, coding advice and best practices for performance improvement. The PQL team engaged high-volume Medicaid providers with a variety of data and resources. As of June 2024, Care1st members were added to the team's EPSDT Report for Non-compliance, a standardized template based on EPSDT form data received, that is shared quarterly with these providers. Additional reports and resources (care gap data, missed opportunities report, month-over-month and year-over-year performance and educational resources) were shared regularly. • Deployed new "Member Passport," with customized messaging to educate members on the importance of well-child visits and childhood immunizations. • Expanded sources of updated member contact information to utilize HIE and pharmacy data; updates are stored in Quality Outreach Tracker (QOT) tool. • Utilized EPSDT clinical forms from providers in processing HEDIS measures to determine when gaps are closed, allowing the health plan to more effectively target member- and provider-facing outreach with more current and complete data.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-48 presents strengths, opportunities for improvement, and recommendations for Care1st ACC-RBHA related to the *Back to Basics* PIP, as well as the related domains (Quality, Access, and/or

Timeliness) for each strength and opportunity for improvement. As of October 1, 2024, Care1st ACC-RBHA no longer holds an AHCCCS contract; therefore, the information in this section does not include recommendations.

Table 5-48—Care1st ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to the Back to Basics PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • Care1st ACC-RBHA performed accurate statistical testing between the baseline and Remeasurement 2 results. **[Quality**, **Access]** • Care1st ACC-RBHA developed and implemented measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 3. **[Quality**, **Access]**
Opportunities for Improvement and Recommendations
For Indicator 1, Care1st ACC-RBHA had a decline of 15.7 percentage points in the indicator rate between the baseline year and Remeasurement Year 2. Care1st ACC-RBHA had a decline of 9.6 percentage points in the indicator rate between the baseline year and Remeasurement Year 2 for Indicator 2. **[Quality, Access]**

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-49 presents PIP recommendations made to Care1st ACC-RBHA in the CYE 2023 Annual Technical Report[99] and Care1st ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Care1st ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-49—Care1st ACC-RBHA Follow-Up to CYE 2023 PIP Recommendations

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG recommended that Care1st ACC-RBHA: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.

[99] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf. Accessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for PIPs
• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.

Care1st ACC-RBHA's Response:

The Care1st QI team revisited the causal/barrier analysis in second quarter CY 2024, based on Remeasurement Year 2 (RY2) results. This analysis was applicable to both the Medicaid and CHIP populations, since combined population rates are reported.

Quantitative analysis showed that, for Indicator 1, Care1st had a decline of 13.0 percent between the Baseline Measurement Year (BMY) and RY2 (CY 2023). While the health plan did show some upward movement in the rate for Indicator 1 from Remeasurement Year 1 (RY1) to RY2, to 54.8 percent from 53.5 percent, the difference was not statistically significant (p =0.5787).

Care1st had a decline of 3.8 percent between Intervention Year 1 (IY1) and RY2 for Indicator 2. IY1 is being used in lieu of a baseline measurement, since the indicator changed after the BMY to the current HEDIS specifications for *Child and Adolescent Well-Care Visits*. This rate improved significantly in RY2, to 41.8 percent, from the RY1 rate of 34.0 percent (p< 0.0001).

Through quantitative analysis, Care1st continued to see a decline in compliance with completion of six visits after the fourth visit in the early well-child visit series (Indicator 1), providing opportunities to target members who may be able to complete two more visits by their 15-month birthdays, and move them to the "finish line."

For annual child/adolescent well visits (Indicator 2), the lowest rate by age stratification in CY 2023 was among 18- to 21-year-olds, at 17.6 percent compared with 41.8 percent overall.

Subpopulation analysis identified significant disparities among American Indian members compared with White members for both indicators in CY 2023. Analysis by county found that, for the *WCV* indicator, the rate in Mohave County increased from CY 2022, eliminating a disparity in that county, while significant disparities remained in Apache and Navajo counties.

Care1st also reviewed SDOH affecting members via Z code utilization and data from community health needs assessments (CHNAs) to inform factors and interventions that may further impact results for this PIP. This review showed the top SDOH factors affecting the membership (adults and children) were education and literacy, employment/unemployment, and housing and economic circumstances. Community-identified challenges and needs by county continued to reflect those SDOH, along with poverty, access/availability of health services, and transportation. A new issue that emerged in the most recent CHNAs was lack of affordable childcare.

The following member-facing barriers were identified through qualitative analysis in CYE 2024:

- Parents/healthcare decision makers in the North GSA, which comprises mostly FAR areas, continue to face unique geographic barriers in accessing services, compared with the rest of the

Prior Year's Recommendation From the EQR Technical Report for PIPs
State. The GSA is characterized by low population density, rugged terrain, longer distances and travel time to reach services as well as fewer services in the area, and fewer paved roads affecting seasonal access to services. The terrain and remoteness of some communities also impacts reliable cell and Internet service in certain areas. • The rural population in the North GSA has also been more difficult to engage in preventive services. Research has identified higher mistrust of government and institutions among rural communities of the United States since the COVID-19 PHE. An increase in rural community resistance/distrust of healthcare and public health interventions has been observed by health plan staff when reaching out to parents/healthcare decision makers in the last few years. • Parents/healthcare decision makers continue to be difficult to contact for education/assistance in scheduling appointments due to outdated information (address and/or phone number), members not answering their phones, voicemail full, etc. Out of 6,549 outreach calls made to educate/assist with scheduling well-infant/child visits and immunizations in CY 2023, 869 (13.2 percent) were successful in reaching a live person and conducting the education. • Competing priorities and SDOH continue to impede/delay access to care. These include access/availability of nearby health services, transportation, and childcare. • Feedback from parents/guardians and older adolescents indicated a continued lack of understanding that AHCCCS benefits for Medicaid members continue until the member turns 21 years of age. Many parents/guardians and older teen members have told health plan outreach staff that they thought their benefits ended at age 18. Care1st assessed the impact and effectiveness of interventions during the second remeasurement year and has implemented new or enhanced interventions to facilitate improvement. This assessment is applicable to both the Medicaid and CHIP populations. Clearly defined, objective measures are used to evaluate effectiveness. Some PIP interventions were discontinued due to the inability to evaluate effectiveness with clearly defined measures.

Interventions Assessment		
Interventions	**Timeline**	**Impact/Effectiveness**
Targeted outreach to members 18 to 20 years of age to educate about the availability of health care and dental benefits and encourage use of services before they age out of EPSDT coverage.	1/1/2020 – ongoing (monthly, based on member's birthdate and whether compliant or not)	Potential Impact: Engaging members with messaging relevant to their unique needs and concerns increases the likelihood that well/dental visits will be completed, thus improving member health outcomes. This intervention is likely to induce a permanent change when incorporated as a standard

Prior Year's Recommendation From the EQR Technical Report for PIPs		
		business practice, sustained over time. *Effectiveness: In CY 2023, 8,504 text messages were tailored to members ages 18 through 20 years, with an 86.5 percent reach rate (i.e., messages delivered). This intervention works in tandem with other member- and provider-facing outreach, which limits the ability to evaluate it independently. However, results for the WCV measure among members 18–20 years increased from the CY 2022 rate of 13.4 percent to 17.6 percent in CY 2023 (p<0.0001), indicating the intervention was moderately effective.*
Launch Provider Portal, allowing providers on-demand 24/7 access to care gap lists for outreach and health plan tools including EPSDT forms/clinical templates, clinical practice guidelines, and one-touch prior authorization request.	12/1/2022 – ongoing Incorporated as standard business practice for provider performance improvement resources	Potential Impact: Empowering providers with on-demand tools will help them more fully embrace ongoing collaboration with the health plan and support improved health outcomes. This intervention is likely to induce a permanent change because it involves sustained engagement of providers who serve the membership year after year. *Effectiveness: The Provider Portal went live for the ACC LOB on 12/1/22. Data for the efficacy of this intervention are not available; therefore, this activity is not considered a PIP intervention in CY 2024.*

Prior Year's Recommendation From the EQR Technical Report for PIPs		
Host in-person "Welcome Rooms" to connect with the community and educate on the importance of preventive/primary care and available covered benefits; identify members with gaps in care and refer to services. The Welcome Rooms are held in conjunction with local community organizations/events and provide other services that members can use (e.g., food distribution, health fairs, connection to community resources).	1/21/2023 – 11/30/2023 Discontinued	Potential Impact: Engaging and empowering members in their communities can improve enrollee health outcomes, especially with members who might otherwise delay or avoid screening, or who are difficult to contact. Meeting health plan staff in person increases the likelihood that members and communities will see Care1st as trustworthy and caring about them, creating long-term goodwill. *Effectiveness: Data for number of Care1st members reached are not available. However, it is considered a best practice for increasing trust by meeting members where they are and providing services in conjunction with CBOs, which can also help reduce SDOH barriers. Care1st partnered with several CBOs on six community events providing immunizations and well-child checks in 2023. This activity is not considered a PIP intervention in CY 2024, due to the inability to evaluate its effectiveness, but participation in and support of community initiatives, events, and activities remains a standard business practice for the health plan.*
Launch interactive Member Portal, allowing members to change PCP assignment, see personalized care gaps, search providers, and complete a mini-health screener with one	3/31/2023 – ongoing Incorporated as standard business practice for member communication with the health plan and self-management.	Potential Impact: By making services/tools more convenient, member satisfaction and engagement will likely increase, resulting in better health outcomes. This intervention is

Prior Year's Recommendation From the EQR Technical Report for PIPs		
interaction at the member's convenience, 24/7.		likely to induce a permanent change when incorporated as a standard business practice, since members/families stay with the health plan over time. *Effectiveness: The Member Portal went live on 3/31/23; however, usage was very low, as indicated by the number of times members used the portal to message the health plan (an average of 64 times per month). Data for the efficacy of this intervention are not available; therefore, this activity is not considered a PIP intervention in CY 2024.*
Execute telehealth contract, allowing members access to non-emergency telephone or video visits with licensed physical and behavioral health providers 24/7.	4/1/2023 – ongoing Incorporated as standard business practice to expand access to care, especially for members in rural communities.	Potential Impact: Making care more available and convenient can increase member satisfaction and engagement with the health care system, resulting in better health outcomes. This intervention is likely to induce a permanent change when incorporated as a standard business practice, since members/families often stay with one health plan over time. *Effectiveness: In CY 2023, 549 ACC members/unique users were engaged in the program, representing only 0.7 percent of the Care1st average monthly enrollment. It is not known if/how many users were parents/healthcare decision makers or members under 21. Data for the efficacy of this*

Prior Year's Recommendation From the EQR Technical Report for PIPs		
		intervention are not available; therefore, this activity is not considered a PIP intervention in CY 2024.
Revamp the member incentive program with a new vendor. The new incentive program allows members to receive their reward with completion of a visit based on claims and no longer requires members to take additional action to complete an attestation.	6/1/2023 – ongoing	Potential Impact: Encouraging completion of well/dental visits will positively impact member health outcomes. The incentive is likely to improve satisfaction among members or parents/healthcare decision makers. This intervention is likely to induce a permanent change when incorporated as a standard business practice, since members/families often stay with one health plan over time. *Effectiveness: The new incentive program was rolled out to members and providers in June 2023, with incentives paid beginning in July 2023. For completion of six well visits in the first 15 months, 308 incentives were distributed, representing approximately 40 percent of members in the measure denominator. Among members ages 3–20 years, 8,008 incentives were paid, representing about 30 percent of members in the measure denominator. Care1st cannot evaluate the effectiveness of this intervention because CY 2023 is the first year the new incentive was available; however, these results are encouraging and are being trended against CY 2024 data.*

Prior Year's Recommendation From the EQR Technical Report for PIPs		
Subcontract with innovative health care providers to conduct outreach and engage members via telehealth or in their homes to complete visits and educate/connect them to other needed care. One such provider performs this work in Mohave and Yavapai counties.	7/1/2023 – ongoing	Potential Impact: Reducing barriers to care/engagement through in-home access will improve outcomes of members who may be the most vulnerable. This intervention is likely to induce a permanent change when incorporated as a standard business practice, since members/families often stay with one health plan over time. *Effectiveness: This intervention was launched in July 2023 and was effective in supporting a significant increase in the WCV measure. The provider engaged directly with parents/healthcare decision makers of members in Mohave and Yavapai counties and completed wellness visits for 26.3 percent (2,869/10,881) from July–December 2023. This surpassed the 20 percent goal of gap closure during Q3 and Q4. The measure rate in Mohave County increased from 15.7 percent to 41.1 percent during that time, and the rate in Yavapai County increased from 19.1 percent to 49.4 percent. These two counties showed the largest increases in the measure rate over the second half of the year and contributed to the overall improvement in the WCV measure, as they represented 66.5 percent of the denominator. This intervention continues statewide under the AzCH-CCP contract with strategic partners.*

Prior Year's Recommendation From the EQR Technical Report for PIPs		
Expand the Tribal Liaison Program with additional full-time employee to collaborate with tribal entities and CBOs to address barriers related to location, cultural factors, and SDOH that may be delaying screening among American Indian members. This is a targeted intervention to address the significant disparity identified between AI and White members (30.8 percent vs. 42.1 percent) in CY 2023.	June 2022 – hired, program ongoing, monthly	Potential Impact: Culturally competent collaboration with tribes, CBOs, and members leverages the unique strengths of the membership, decreases resistance to partnership, and more effectively targets barriers to care, improving overall health outcomes. This intervention is likely to induce a permanent change as it has been incorporated as standard business practice and involves sustained engagement of tribes and CBOs, who often stay with one health plan over time. *Effectiveness: Data are not available for the effectiveness of this intervention in terms of the number of Care1st members reached; however, it is considered a best practice for increasing trust by meeting members where they are and providing services in conjunction with Tribal entities and CBOs, which can also help reduce SDOH barriers by connecting members to local services. This intervention resulted in the creation of formal agreements with Tribes in the North GSA in CYE 2023 that allow Care1st to provide services on-reservation, as well as several meetings to present information on health plan benefits and service and participation in other Tribal events, in order to gain better understanding between Tribal*

Prior Year's Recommendation From the EQR Technical Report for PIPs		
		members and the health plan. This system-level intervention continues as a PIP intervention and is being enhanced in 2024 with collaboration between the Tribal Liaison team and the health plan's Health Equity and Population Health staff to implement targeted activities to close care gaps.
(Enhanced) Engage providers through the Provider Engagement team and deploy new "Path to 5 Stars" provider resource guide for improving quality measures, including *W30* and *WCV*. The guide provides practitioners with Medicaid percentile targets, coding advice, and best practices for performance improvement. The PQL team engages high-volume Medicaid providers with a variety of data and resources. In June 2024, Care1st members were added to the team's EPSDT Report for Non-compliance, based on EPSDT form data, that is shared quarterly with providers. Additional reports and resources (care gap data, missed opportunities report, month-over-month and year-over-year performance) and educational resources are shared regularly.	1/1/2024 – ongoing	Potential Impact: Engaging providers with practice-specific member information and resources will support improved member outcomes. Ongoing engagement with an assigned PQL and enhanced tools will help them more fully embrace ongoing collaboration with the health plan. This intervention is likely to induce a permanent change because it involves sustained engagement of providers who will serve the health plan's membership year after year. *Effectiveness: This intervention will be assessed through the number of PQL engagements with providers in relation to indicator performance outcomes.*
(New) Deploy "member passport," with customized messaging to educate on the importance of well-child visits	6/1/2024 – ongoing	Potential Impact: Engaging members with messaging tailored to their needs increases the likelihood that well/dental visits

Prior Year's Recommendation From the EQR Technical Report for PIPs		
for all members with gaps in care. The passport explains why a service is important and what to expect during the visit.		will be completed, thus improving member health outcomes. This intervention is likely to induce a permanent change when incorporated as a standard business practice, as it empowers members/families, who often stay with Care1st over several years. *Effectiveness of this intervention will be assessed through the number of member passports successfully deployed in relation to indicator performance outcomes.*
(Enhanced) Expand sources of updated member contact information to utilize HIE and pharmacy data; updates are stored in a quality outreach tracker tool.	6/1/2024 – ongoing	Encouraging completion of well/dental visits will positively impact member health outcomes. This intervention is likely to induce a permanent change when incorporated as a standard business practice, facilitating more effective member outreach. *Effectiveness: This intervention will be assessed through the "reach rate" in contacting parents/health care decision makers and members.*
(New) Utilize EPSDT clinical forms from providers in processing HEDIS measures to determine when gaps are closed, allowing the health plan to more effectively target member- and provider-facing outreach with more current and complete data.	6/10/2024 – ongoing	Potential Impact: Engaging providers with practice-specific member information will support improved member outcomes, as well as provider satisfaction. More current and complete data will allow the health plan to more effectively target member-facing efforts to close care gaps and avoid member abrasion. This

Prior Year's Recommendation From the EQR Technical Report for PIPs		
		intervention is likely to induce a permanent change when incorporated as a standard business practice with providers who contract with the health plan year after year. *Effectiveness: This intervention will be assessed through the impact of this additional data source on indicator performance outcomes.*

The Care1st plan for sustaining improvement in indicator rates will be analyzed via the PDSA cycle to ensure ongoing improvement and appropriate corrections are made. Indicator rates along with identified interventions are evaluated via specific intervention PDSA cycles and during Performance Improvement Subcommittee monthly meetings and quarterly Quality Improvement Committee meetings. Additionally, indicator rates and interventions are monitored through the PMMR to ensure performance improvement during each quarter.

Ongoing interventions affect a large enough percentage of the eligible population to drive in improvement; specifically:

- The age group of 18–21-year-olds, which comprises about 17 percent of the *WCV* denominator, showed a rate that was 24 percent–32 percent below the other two age groups in CY 2023. An increase of 2.0 percent (approximately 71 more members compliant) in the rate for this age range would be significant and contribute to improving the overall rate.
- The member incentive program is open to all members on an annual basis. As noted, approximately 40 percent of members in the *W30*: Rate 1 denominator and 30 percent of members in the *WCV* denominator earned incentives.
- As noted, the strategic partnership with a provider in Mohave and Yavapai counties resulted in 26.3 percent of gaps closed, which represented approximately 43 percent of the total measure denominator. The relationship with strategic partners to close gaps in well-care visits has been expanded to more counties in 2024 under the AzCH-CCP contract.
- American Indian children and adolescents represent about 14 percent of the total measure denominator. Given the significant disparity in well visits between them and their White counterparts, greater collaboration with tribal entities and community organizations that serve American Indian members is an important intervention for this subpopulation.
- PQLs are tasked with engaging high-volume providers, who can significantly impact the overall indicator rates with tools and resources for performance improvement.

Prior Year's Recommendation From the EQR Technical Report for PIPs
• Member passports are deployed to all members with gaps in care for the indicators, although the reach rate is impacted by the proportion of undeliverable or unopened mail. This intervention is seen as working in concert with baseline interventions that include phone, mail, and text outreach to the PIP's population. • Utilizing EPSDT clinical forms received from providers to more effectively determine rates and remaining gaps in care allows the health plan to target member- and provider-facing outreach with more current and complete data, potentially impacting the indicator rates.
HSAG's Assessment: HSAG has determined that Care1st ACC-RBHA has satisfactorily addressed these prior year's recommendations.

Prenatal and Postpartum Care PIP

Overview

AHCCCS initiated the implementation of the *Prenatal and Postpartum Care* PIP for the ACC population in CYE 2022. The objective of the *Prenatal and Postpartum Care* PIP is to improve health outcomes for members and infants. This PIP focuses on increasing the number and percentage of members with live birth deliveries that 1) received a prenatal care visit, and 2) received a postpartum visit. In CYE 2024, Care1st ACC-RBHA continued to implement interventions to improve these outcomes and provided updates on the status of each intervention to AHCCCS.

Interventions

Table 5-50—Care1st ACC-RBHA *Prenatal and Postpartum Care* PIP Interventions

Contractor	Interventions
Care1st ACC-RBHA	New interventions to support the *Prenatal and Postpartum Care* PIP in CYE 2024 include:
	• Offer a member portal, allowing members 24/7 on-demand access to fill out a NOP form, view individual care gaps, complete a mini-health screener, search providers, and view authorization status. Members will also be able to access Krames, a self-management tool to provide postpartum resources and support, via the health plan member portal. • Utilize contract with Teladoc, allowing access to physical and behavioral health non-emergency on-demand care 24/7 through telephone call or video. • Send NOP reports to strategic partners and FQHCs to begin outreach and engage members timely for prenatal and postpartum care. The report has been automated to reduce manual requirements. NOP can also be accessed through the provider portal.

Contractor	Interventions
	• Utilize new Health Equity Dashboard to provide a method to assess HEDIS measures by race/ethnicity, age, gender, language, county and ZIP Code for specific measures.
	Continued interventions with enhancements made to support the *Prenatal and Postpartum Care* PIP in CYE 2024 include:
	• Offer My Health Pays Program to incentivize completion of timely prenatal visits, with revamp of program to include using a claims-based incentive payout. Members no longer need to take the extra step of filling out and submitting an attestation of a completed visit. • Offer My Health Pays Program to incentivize completion of postpartum visits, with revamp of program to include using a claims-based incentive payout. Members no longer need to take the extra step of filling out and submitting an attestation of a completed visit.
	Continued interventions to support the *Prenatal and Postpartum Care* PIP in CYE 2024 include:
	• Care engagement staff attempt to educate pregnant members about the importance of timely prenatal care through written material, text messages, and live phone outreach. Prenatal text messages focus of education tailored to the member's week of pregnancy to engage and provide information on self-care and content of prenatal visits specific to trimester. • Attempt to enroll pregnant members in the Pacify Program, which will provide push notifications to their phones about the importance of prenatal nutrition and visits. The application also includes a custom button that provides a direct connection to the Care1st MCH team, which can help in making appointments and arranging for transportation. • Educate pregnant members about family planning options and the importance of postpartum visits beginning in the 2nd trimester through written material, texts, and live phone outreach to help reinforce the value of a postpartum visit. Members are also sent a packet/flyer in the third trimester reminding them of family planning options and the importance of a postpartum visit. • Engage high-volume providers around achieving goals for timeliness of prenatal care with value-based agreements and incentives. Send monthly reports identifying members with gaps in care to value-based providers (VBPs) to review any open gaps and engage members or identify missed opportunities. Discuss performance and improvement strategies in quarterly meetings. • Attempt to enroll postpartum members in the Pacify Program, which will provide push notifications to their phones about the importance of postpartum visits. The application also includes a custom button that provides a direct connection to the Care1st MCH team, which can help in making a postpartum appointment and arranging for transportation.

Contractor	Interventions
	• Offer a provider portal, allows providers 24/7 on-demand access to view measure rates and member rosters, as well as submit prior authorization requests and access practice support tools, including NOP forms.

Strengths, Opportunities for Improvement, and Recommendations

HSAG did not conduct validation on the *Prenatal and Postpartum Care* PIP in CYE 2024; therefore, strengths, opportunities for improvement, and recommendations are not provided.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-51 presents PIP recommendations made to Care1st ACC-RBHA in the CYE 2023 Annual Technical Report[100] and Care1st ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Care1st ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-51—Care1st ACC-RBHA Follow-Up to CYE 2023 PIP Recommendations

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG recommended that Care1st ACC-RBHA: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. • Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.
Care1st ACC-RBHA's Response: The Care1st QI team revisited the causal/barrier analysis in Q2 CY 2024, based on IY1 results. This analysis is applicable to both the Medicaid and CHIP populations, since combined rates including both populations are reported.

[100] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for PIPs
Quantitative analysis found that, for Indicator 1, Care1st showed an increase of 6.1 percent between the BMY and IY1 (CY 2023), to 81.5 percent from 75.4 percent. The difference was statistically significant ($p = 0.0415$). Care1st showed a decline of 6.3 percent between the BMY and IY1, from 68.3 percent to 62.0 percent. The difference was not quite statistically significant ($p < 0.0671$). Subpopulation analysis identified a significant disparity among American Indian members compared with White members for Indicator 1, *Timeliness of Prenatal Care*, in CY 2023. There was no significant difference in the two subpopulations for Indicator 2, *Postpartum Visits*. Care1st also reviewed SDOH affecting members via Z code utilization and data from CHNAs to inform factors and interventions that may further impact results for this PIP. This review showed the top SDOH factors affecting the membership (adults and children) were education and literacy, employment/unemployment, and housing and economic circumstances. Community-identified challenges and needs by county continued to reflect those SDOH, along with poverty, access/availability of health services, and transportation. A new issue that emerged in the most recent CHNAs was lack of affordable childcare. The following member-facing barriers were identified through qualitative analysis in 2024: • Members in the North GSA, which comprised mostly FAR areas, continue to face unique geographic barriers in accessing services, compared with the rest of the State. The GSA is characterized by low population density, rugged terrain, longer distances and travel time to reach services as well as fewer services in the area, and fewer paved roads affecting seasonal access to services. The terrain and remoteness of some communities also impacts reliable cell and Internet service in certain areas. Research has shown that travel burden and inadequate digital access pose significant barriers to maternity care access for socioeconomically disadvantaged and rural communities (University of South Carolina Arnold School of Public Health, 2023).[101] • In addition, lack of transportation, lack of childcare, the practices and attitudes of some providers, and cultural differences between patients and providers have been cited in several studies as barriers to seeking prenatal care.

[101] University of South Carolina, Arnold School of Public Health. Low-income communities face dual barriers to maternity access. 2023. Available at: https://sc.edu/study/colleges_schools/public_health/about/news/2023/dual_barriers_maternity_care.php. Accessed on: Jan 13, 2025.

Prior Year's Recommendation From the EQR Technical Report for PIPs
• Individual-level factors, such as lack of awareness of pregnancy, denial of pregnancy, limited support, conflicting priorities, and indifference to pregnancy, also interfere with the timely use of prenatal and postpartum care, according to literature (Bellrose et al., 2022).[102] • Members continue to be difficult to contact for education/assistance in scheduling appointments due to outdated information (address and/or phone number), members not answering their phones, voicemail full, etc.

Care1st assessed the impact and effectiveness of interventions during the second remeasurement year and has implemented new or enhanced interventions to facilitate improvement. Clearly defined, objective measures are used to evaluate effectiveness. Some PIP interventions were discontinued due to the inability to evaluate effectiveness with clearly defined measures.

Interventions Assessment		
Interventions	**Timeline**	**Impact/Effectiveness**
Attempt to enroll pregnant members in a mobile application that provides push notifications to their phones about the importance of prenatal nutrition and visits, as well as postpartum visits. Video consultations with nutritionists are available 24/7. The application also includes a custom button that provides a direct connection to the Care1st MCH team, which can help in making appointments and arranging for transportation.	8/1/2017 – 9/30/2024	Potential Impact: Engaging and empowering members via telehealth 24/7 can improve enrollee health outcomes and satisfaction. *Effectiveness: This intervention is considered not effective due to low enrollment numbers (only 112 enrollments after delivery in CY 2023) and no apparent effect on the rate of postpartum visits. The program was discontinued on 9/30/2024.*
Host in-person "Welcome Rooms" to connect with the community and educate on the importance of preventive/primary care and available covered benefits;	1/21/2023 – 11/30/2023 Discontinued	Potential Impact: Engaging members in their communities can improve enrollee health outcomes. Meeting health plan staff in person increases the likelihood that members and

[102] Bellrose M, Rodriguez M, Vivier PM. A systematic review of the qualitative literature on barriers to high-quality prenatal and postpartum care among low-income women. *Health Services Research*. 2022.;57(4): 775-785. Available at: https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.14008. Accessed on: Jan 13, 2025.

Prior Year's Recommendation From the EQR Technical Report for PIPs		
identify members with gaps in care and refer to services. The Welcome Rooms are held in conjunction with local community organizations/events and provide other services that members can use (e.g., food distribution, health fairs, connection to community resources).		communities will see Care1st as trustworthy and caring about them, creating long-term goodwill. *Effectiveness: Data for the number of Care1st members reached are not available. However, it is considered a best practice for increasing trust by meeting members where they are and providing services in conjunction with CBOs, which can also help reduce SDOH barriers. Care1st partnered with several CBOs on community events in 2023. This activity is not considered a PIP intervention in CY 2024, due to the inability to evaluate its effectiveness, but participation in and support of community events, initiatives, and activities remains a standard business practice.*
Launch Provider Portal, allowing providers on-demand 24/7 access to care gap lists for outreach and health plan tools including NOP forms, clinical practice guidelines, and one-touch prior authorization request.	12/1/2022 – ongoing Incorporated as standard business practice for provider performance improvement resources.	Potential Impact: Empowering providers with on-demand tools will help them more fully embrace ongoing collaboration with the health plan and support improved health outcomes. This intervention is likely to induce a permanent change because it involves sustained engagement of providers who serve the membership year after year. *Effectiveness: The Provider Portal went live for the ACC LOB on 12/1/22. Data for the efficacy of this intervention are not available; therefore, this activity*

Prior Year's Recommendation From the EQR Technical Report for PIPs		
		is not considered a PIP intervention in CY 2024.
Launch interactive Member Portal, allowing members to change PCP assignment, see personalized care gaps, search providers, and complete a mini-health screener with one interaction at the member's convenience, 24/7.	3/31/2023 – ongoing Incorporated as standard business practice for member communication with the health plan and self-management.	Potential Impact: By making services/tools more convenient, member satisfaction and engagement will likely increase, resulting in better health outcomes. This intervention is likely to induce a permanent change when incorporated as a standard business practice, since members/families stay with the health plan over time. *Effectiveness: The Member Portal went live on 3/31/23; however, usage was very low, as indicated by the number of times members used the portal to message the health plan (an average of 64 times per month). Data for the efficacy of this intervention are not available; therefore, this activity is not considered a PIP intervention in CY 2024.*
Revamp the member incentive program with a new vendor. The new incentive program allows members to receive their reward with completion of a visit based on claims and no longer requires members to take additional action to complete an attestation.	6/1/2023 – 12/31/2024	Potential Impact: Encouraging completion of well/dental visits will positively impact member health outcomes. The incentive is likely to improve satisfaction among members. This intervention is likely to induce a permanent change when incorporated as a standard business practice, since members often stay with one health plan over time.

Prior Year's Recommendation From the EQR Technical Report for PIPs		
		Effectiveness: The program was rolled out to members and providers in June 2023, with only 87 members receiving the incentive for prenatal care visits, representing 8.6 percent of the eligible population (n=1,027), in CY 2023. Incentives for postpartum visits totaled 888, representing 86.5 percent of the eligible population; however, the final rate for postpartum visits based on hybrid data declined in CY 2023. This intervention is considered ineffective in impacting rates for either indicator. The member incentive program will be realigned with AzCH-CCP for CY 2025, discontinuing the incentives for PPC.
Subcontract with innovative health care providers to conduct outreach and engage members via telehealth or in their homes to complete visits and educate/connect them to other needed care. One such provider performs this work in Mohave and Yavapai counties.	7/1/2023 – ongoing	Potential Impact: Reducing barriers to care/engagement through in-home access will improve outcomes of members who may be the most vulnerable. This intervention is likely to induce a permanent change when incorporated as a standard business practice, since members/families often stay with one health plan over time. *Effectiveness: This intervention was launched in July 2023; however, a decision was made to focus on supporting the W30 and WCV measures for members in Mohave and Yavapai counties. This intervention continues statewide under the AzCH-CCP*

Prior Year's Recommendation From the EQR Technical Report for PIPs		
		contract with strategic partners and includes a gap closure for PPC in CY 2024.
Expand the Tribal Liaison Program with an additional full-time employee to collaborate with tribal entities and CBOs to address barriers related to location, cultural factors, and SDOH that may be delaying screening among American Indian members. This is a targeted intervention to address the significant disparity identified between American Indian and White members (30.8 percent vs. 42.1 percent) in CY 2023.	June 2022 – hired, program ongoing	Potential Impact: Culturally competent collaboration with tribes, CBOs, and members leverages the unique strengths of the membership, decreases resistance to partnership, and more effectively targets barriers to care, improving overall health outcomes. This intervention is likely to induce a permanent change as it has been incorporated as standard business practice and involves sustained engagement of tribes and CBOs. *Effectiveness: Data are not available for the effectiveness of this intervention in terms of the number of Care1st members reached; however, it is considered a best practice for increasing trust by providing services in conjunction with tribal entities and CBOs, which can also help reduce SDOH barriers. This intervention resulted in the creation of formal agreements with tribes in the North GSA in CYE 2023 that allow Care1st to provide services on-reservation, as well as several meetings to present information on health plan benefits and service and participation in other tribal events, in order to gain better understanding between tribal members and the health plan. This system-level intervention*

Prior Year's Recommendation From the EQR Technical Report for PIPs		
		continues as a PIP intervention, and is being enhanced in 2024 with collaboration between the Tribal Liaison team and the health plan's Health Equity and Population Health staff to implement targeted activities to close care gaps.
(Enhanced) Send NOP reports to strategic partners and FQHCs to begin outreach and engage members in a timely manner for prenatal and postpartum care. The report has been automated to reduce manual requirements. NOP can also be accessed through the Provider Portal.	1/1/2024 – ongoing	Potential Impact: Engaging strategic partners, FQHCs, and other providers with actionable information will support improved member outcomes by leveraging their ability to engage members in care earlier. This intervention is likely to induce a permanent change because it involves sustained engagement of providers who serve the health plan's membership year after year. *Effectiveness: Given that NOP reports are available to all contracted providers, including FQHCs, plus Strategic Partners, this intervention will be assessed through the Indicator 1 rate trend.*
(Enhanced) Engage providers through the PQLs and deploy the new provider resource guide for improving quality measures, including *W30* and *WCV*. The guide provides practitioners with Medicaid percentile targets, coding advice, and best practices for performance improvement. The PQL team engages high-	1/1/2024 – ongoing	Potential Impact: Engaging providers with practice-specific member information and resources will support improved member outcomes. Ongoing engagement with an assigned PQL and enhanced tools will help them more fully embrace ongoing collaboration with the health plan. This intervention is likely to induce a permanent change

Prior Year's Recommendation From the EQR Technical Report for PIPs		
volume Medicaid providers with a variety of data and resources. In June 2024, Care1st members were added to the team's EPSDT Report for Non-compliance, based on EPSDT form data, that is shared quarterly with providers. Additional reports and resources (care gap data, missed opportunities report, month-over-month and year-over-year performance) and educational resources are shared regularly.		because it involves sustained engagement of providers who will serve the health plan's membership year after year. *Effectiveness: This intervention will be assessed through the number of PQL engagements with providers in relation to indicator performance outcomes.*
(New) Implement an enhanced care management program, which consists of identifying pregnant members, stratifying them by risk level and impact ability, and providing case management and care interventions through six weeks after delivery. The program also offers advice and resources for all enrolled pregnant members and new parents. Members can fill put a NOP form through the member portal or call Member Services to get connected with this program.	10/1/2024 – ongoing	Potential Impact: Educating members on the importance of prenatal and postpartum care even if they are feeling well and providing enhanced case management/care coordination allows for additional opportunities for members to receive assistance, encouragement, and support. This should result in improved member health outcomes. This intervention is likely to induce a permanent change when incorporated as a standard business practice because it involves sustained engagement of providers and strategic partners who serve the membership year after year. *Effectiveness: This intervention will be assessed through the percentage of members identified as having high-risk pregnancies enrolled in case management and*

Prior Year's Recommendation From the EQR Technical Report for PIPs		
		the number of members referred to care coordination.
(New) Utilize a mobile application that provides a specialized daily health check list to pregnant and postpartum members, along with provider alerts and care gaps, as well as progress tracking to care managers. The application also allows for two-way video/text communication with care managers.	6/1/2024 – ongoing	Potential Impact: Providing enhanced case management/care coordination allows for additional opportunities for members to receive assistance, encouragement, and support. This should result in improved member health outcomes. This intervention is likely to induce a permanent change when incorporated as a standard business practice because it involves sustained engagement of members. *Effectiveness: This intervention will be assessed through the percentage of members identified as having high-risk pregnancies enrolled in case management and the number of members referred to care coordination.*
(New) Hold Care Management Provider Forums for OB/GYNs to outreach and provide education on the use of CPT II codes, the necessity of postpartum visits, and family planning policies.	5/1/2024 – ongoing	Potential Impact: Providing education and technical assistance to maternity care providers is likely to increase their engagement with members, as well as the ability of the health plan to collect more information through claims, leading to more effective monitoring and targeting of interventions. *Effectiveness: This intervention will be assessed through the rate trends for both indicators.*
(Enhanced) Implement year-round hybrid data collection for	6/1/2024 – ongoing	Potential Impact: Utilization of year-round hybrid data collection

Prior Year's Recommendation From the EQR Technical Report for PIPs		
PPC by the health plan's HEDIS Team.		will improve reliability of monthly monitoring and effectiveness of targeted member and provider outreach. This may also increase member and provider satisfaction by reducing abrasion from outreach after a gap has been closed. *Effectiveness: This intervention will be assessed through the rate trends for both indicators.*

The Care1st plan for sustaining improvement in indicator rates will be analyzed via the PDSA cycle to ensure ongoing improvement and appropriate corrections are made. Indicator rates along with identified interventions are evaluated via specific intervention PDSA cycles and during Performance Improvement Subcommittees' monthly meetings and quarterly Quality Improvement Committees. Additionally, indicator rates and interventions are monitored through the PMMR to ensure performance improvement during each quarter.

Ongoing interventions affect a large enough percentage of the eligible population to drive in improvement; specifically:

- American Indian women represent about 9 percent of the eligible population. Given the significant disparity in the rate of *Timeliness of Prenatal Care* between them and their White counterparts, greater collaboration with tribal entities and community organizations that serve American Indian members is an important intervention for this subpopulation.
- Care1st is attempting to collect NOP forms on all newly identified pregnant members to facilitate/coordinate care and engagement by providers and the health plan.
- PQLs are tasked with engaging high-volume providers, who can significantly impact the overall indicator rates with tools and resources for performance improvement.
- The enhanced Care Management program is available to all newly identified pregnant members, with those at higher risk receiving more intensive case management, but activities are aimed at improving birth outcomes for the entire population.
- The new mobile application is focused on members in case management. It is expected that up to 60 percent of pregnant members may be enrolled in high-risk case management.
- The Provider Forum is aimed at educating and providing technical assistance to all maternity care providers. Because of the potential for low provider attendance at forums, the health plan is currently seeking to engage more providers through individual outreach.

Prior Year's Recommendation From the EQR Technical Report for PIPs
• Utilizing year-round hybrid data collection for both indicators allows the health plan to more effectively determine rates and remaining gaps in care, thus targeting member- and provider-facing outreach with more current and complete data, potentially impacting the indicator rates.
HSAG's Assessment: HSAG has determined that Care1st ACC-RBHA has satisfactorily addressed these prior year's recommendations.

Compliance Reviews

Results

AHCCCS conducted a compliance review of Care1st ACC-RBHA from December 11, 2023, through December 15, 2023. On March 8, 2024, AHCCCS finalized the report findings, provided Care1st ACC-RBHA with a CAP submission matrix, and required a CAP for any standard with a total score of less than 95 percent. On April 19, 2024, AHCCCS accepted Care1st ACC-RBHA's proposed CAPs and required the Contractor to submit updated policies, manuals, desktop procedures, and other vital documents to provide evidence of CAP completion. On June 4, 2024, AHCCCS reviewed Care1st ACC-RBHA's status and determined that all CAPs had been completed and approved for closure.

Table 5-52—Care1st ACC-RBHA Compliance Review Results

Compliance Focus Areas	CYE 2024 Care1st ACC-RBHA Scores	CYE 2024 Program-Level Average	CYE 2024 Care1st ACC-RBHA CAP Update
CC	93%	95%	Met
CIS	99%	99%	NA
DS	97%	97%	NA
GA	98%	97%	NA
GM	100%	100%	NA
GS	100%	100%	NA
MCH	97%	96%	NA
MM	93%	95%	Met
MI	96%	94%	NA
QM	89%	89%	Met
QI	100%	100%	NA
RI	100%	100%	NA
TPL	100%	100%	NA

Compliance Focus Areas	CYE 2024 Care1st ACC-RBHA Scores	CYE 2024 Program-Level Average	CYE 2024 Care1st ACC-RBHA CAP Update
ISOC	99%	99%	NA

NA = Not applicable. A CAP was not required as the CYE 2024 score was 95% or above.
Met = AHCCCS accepted and closed the Contractor's CAP.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-53 presents strengths, opportunities for improvement, and recommendations for Care1st ACC-RBHA based on compliance activities conducted in CYE 2024, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement. As of October 1, 2024, Care1st ACC-RBHA no longer holds an AHCCCS contract; therefore, the information in this section does not include recommendations.

Table 5-53—Care1st ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
Care1st ACC-RBHA scored at or above 95 percent in the following focus areas: • Claims and Information Standards (CIS) **[Access]** • Delivery Systems (DS) **[Timeliness, Access]** • General Administration (GA) **[Timeliness, Access]** • Grants Management (GM) **[Quality, Access]** • Grievance Systems (GS) **[Timeliness, Access]** • Adult, EPSDT and Maternal Child Health (MCH) **[Quality, Timeliness, Access]** • Member Information (MI) **[Quality]** • Quality Improvement (QI) **[Quality, Access]** • Reinsurance (RI) **[Quality]** • Third-Party Liability (TPL) **[Quality, Timeliness, Access]** • Integrated Systems of Care (ISOC) **[Quality, Access]**
Opportunities for Improvement and Recommendations
Care1st ACC-RBHA scored below 95 percent in the following focus areas: • Corporate Compliance (CC) **[Quality, Access]** • Medical Management (MM) **[Timeliness, Access]** • Quality Management (QM) **[Quality]**

Strengths, Opportunities for Improvement, and Recommendations
As a result of its CAP interventions implemented in CYE 2024, Care1st ACC-RBHA was found to be fully compliant within all focus areas and had no continuing corrective actions or recommendations.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Compliance review recommendations were not included in the CYE 2023 EQR technical report as compliance review activities were not conducted in CYE 2023; therefore, no follow-up was required by Care1st ACC-RBHA.

Network Adequacy Validation

ISCA Results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Care1st ACC-RBHA's interpretation of data was accurate.

Table 5-54 summarizes HSAG's validation ratings for Care1st ACC-RBHA by indicator type.

Table 5-54—Summary of Care1st ACC-RBHA's Validation Ratings by Indicator Type

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

Of the network adequacy indicators assessed, Care1st ACC-RBHA received *High Confidence* for both appointment availability and time/distance indicators. However, there were identified areas for improvement; please refer to the Contractor-specific Strengths, Opportunities for Improvement, and Recommendations section below for more details.

NAV Results

HSAG evaluated Care1st ACC-RBHA's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents CYE 2024 S1 validation findings specific to the ACC Program, with one results table for the following GSA:

- North GSA: Apache, Coconino, Mohave, Navajo, and Yavapai counties

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

Table 5-55—Time/Distance Validation Results for Care1st ACC-RBHA North GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Apache	Coconino	Mohave	Navajo	Yavapai
Behavioral Health Outpatient and Integrated Clinic, Adult	80.0^	99.1^	99.9^	95.1^	100.0^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	75.4^	98.5^	99.9^	92.7^	100.0^
BHRF	NA	NA	NA	NA	NA
Cardiologist, Adult	91.4^	99.3^	99.9^	96.2^	100.0^
Cardiologist, Pediatric	98.7^	100.0^	100.0^	100.0^	100.0^
Dentist, Pediatric	86.0	87.5	99.0	90.7	98.4
Hospital	97.0	100.0	99.9	99.9	100.0
OB/GYN	95.9	99.9	100.0	99.9	100.0
Pharmacy	99.1	94.1	99.1	99.4	99.0
PCP, Adult	91.3^	98.9^	98.9^	99.8^	100.0^
PCP, Pediatric	89.2^	98.2^	99.1^	97.2^	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.
^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-56 presents strengths, opportunities for improvement, and recommendations for Care1st ACC-RBHA related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement. As of October 1, 2024, Care1st ACC-RBHA no longer holds an AHCCCS contract; therefore, the information in this section does not include recommendations.

Table 5-56—Care1st ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to NAV

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

Strengths, Opportunities for Improvement, and Recommendations
• Care1st ACC-RBHA had established processes to research daily and monthly missing or incomplete data from the 834 files that included a Queued Error report that captured any critical data elements determined to be missing. **[Access]** • Care1st ACC-RBHA had established a robust process to maintain data accuracy and completeness by utilizing a reference file and multiple internal reports to compare the provider data loaded into Portico weekly. **[Access]** • Care1st ACC-RBHA met all minimum network requirements for all assigned counties except Apache and Coconino counties. **[Access]** • Care1st ACC-RBHA met all minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult and Pediatric; Hospital; OB/GYN; PCP, Adult and Pediatric; and Pharmacy. **[Access]** Note: Care1st ACC-RBHA provides coverage in the following counties: Apache, Coconino, Mohave, Navajo, and Yavapai.
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: • Care1st ACC-RBHA did not meet the minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Pediatric and Dentist, Pediatric. **[Access]**

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-57 presents NAV recommendations made to Care1st ACC-RBHA in the CYE 2023 Annual Technical Report[103] and Care1st ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Care1st ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-57—Care1st ACC-RBHA Follow-Up to CYE 2023 NAV Recommendations

Prior Year's Recommendation From the EQR Technical Report for NAV
HSAG recommended that Care1st ACC-RBHA maintain current compliance with network standards but continue to address network gaps, as applicable.
Care1st ACC-RBHA's Response: In CY 2023, Care1st took the following actions, applicable to both the Medicaid and CHIP populations, to close gaps in its network:

[103] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf Accessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for NAV

- Dental Services—Care1st worked with its dental benefit administrator to review the AHCCCS Saturation Analysis report and identify 32 providers at approximately 15 locations to reach out to for contract discussions. The health plan also requested an exception and continued to search for dentists in the northeast Apache and Greenlee County areas to add to the network.
- Outpatient and Integrated Clinics—Care1st used the AHCCCS Saturation Analysis report and identified two potential recruitment opportunities, executing a contract with a treatment center, which went into effect 11/1/23. The health plan continued to monitor any changes to the network and identify potential recruitment opportunities.
- Pharmacy—Care1st increased network compliance for pharmacy from 78.3 percent in 2022 to 89.9 percent in 2023. This increase was the result of adding pharmacies to the Care1st network. The health plan continued to review network adequacy results to determine if there was an opportunity to close the remaining gaps.
- Care1st did not show a network gap for hospitals in 2023 or 2024.

As of October 2024, there were two gaps in the Northern GSA. Outlined below are the Care1st strategies, efforts, and exception requests, applicable to both the Medicaid and CHIP populations, to address the identified areas of noncompliance:

- *Dentist—Pediatric—Coconino:* Currently, 87.6 percent of Care1st pediatric members have access to a dental provider within the defined time and distance standards. On July 17, 2024, AHCCCS approved a Care1st Network Exception for Dentist—Pediatric—Coconino County. Care1st partners with its contracted dental benefits administrator to administer the dental program. Care1st will continue to closely monitor any changes to the network and identify potential recruitment opportunities to close this gap.
- *Outpatient and Integrated Clinic—Pediatric—Apache County:* The current results show that 76.6 percent of Care1st members have access to behavioral health services within the defined time and distance requirements. On September 19, 2024, AHCCCS approved a Care1st Network Exception for Outpatient and Integrated Clinic—Pediatric—Apache County. Care1st will continue to closely monitor any changes to the network and identify potential recruitment opportunities to close this gap.

For Outpatient and Integrated Clinic—Adult—Apache County, this provider type qualifies for a telehealth standard modification. Therefore, with the availability of telehealth in Apache County for this provider type and the fact that 80.2 percent of Care1st members have availability within the defined time and distance standards, this category is now considered to be passing. Care1st will continue to closely monitor any changes to the network and identify potential recruitment opportunities.

Counties where Telehealth Services are available:

Provider Types	Apache	Coconino	Mohave	Navajo	Yavapai	Maricopa
Behavioral Health Outpatient Clinic & Integrated	X	X	X	X	X	X

Prior Year's Recommendation From the EQR Technical Report for NAV						
Clinic, Adult						
Behavioral Health Outpatient Clinic & Integrated Clinic, Pediatric	X	X	X	X	X	X
Cardiologist, Adult	X	X	X	X	X	X
Cardiologist, Pediatric		X			X	X
PCP, Adult	X	X	X	X	X	X
PCP, Pediatric	X	X	X	X	X	X

HSAG's Assessment:

HSAG has determined that Care1st ACC-RBHA has satisfactorily addressed this prior year's recommendation.

HCA ACC

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2024, HSAG evaluated HCA ACC's data system for processing of each data type used for reporting the Contractor's CY 2023 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that HCA ACC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-58 displays HSAG's PMV findings for each data type reviewed during CYE 2024 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 5-58—CYE 2024 PMV Findings

Data Type	HSAG Findings
Medical Services Data	*No identified concerns*
Enrollment Data	*No identified concerns*
Provider Data	*No identified concerns*
Medical Record Review Process	*No identified concerns*
Supplemental Data	*No identified concerns*
Data Integration	*No identified concerns*

Results for Performance Measures

Table 5-59 presents the CY 2022 and CY 2023 HCA ACC performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and MY 2023. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and/or MY 2023. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 5-59—CY 2022 and CY 2023 HCA ACC Performance Measure Results

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	86.8%+	87.4%+	→	★★★
Postpartum Care	65.3%+	79.2%+	↑	★★
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	60.2%	62.0%	→	★★
Effective Continuation Phase Treatment—Total (18+ Years)	43.1%	43.7%	→	★★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	32.7%	33.0%	→	★★★★
30-Day Follow-Up—Total (13+ Years)	42.9%	48.3%	↑	★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	54.4%	57.9%	↑	★★★★★
30-Day Follow-Up—Total (6+ Years)	71.7%	74.2%	→	★★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	43.6%	35.5%	↓	★★
30-Day Follow-Up—Total (6+ Years)	52.0%	49.9%	↓	★★
Use of Opioids at High Dosage				
*18+ Years**	4.4%	4.9%	→	★★
Initiation and Engagement of Substance Use Disorder (SUD) Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	48.3%	48.7%	→	★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	18.3%	18.4%	→	★★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	51.6%	47.9%	→	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	77.2%	80.7%	↑	★★
Care of Acute and Chronic Conditions				
Controlling High Blood Pressure				
18–85 Years	62.0%+	64.3%+	→	★★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0%)—Total (18–75 Years)	50.1%+	55.5%+	→	★★

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
*Poor HbA1c Control (>9.0%)—Total (18–75 Years)**	38.9%+	31.6%+	↑	★★★
Pediatric Health				
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	38.9%	49.6%	↑	★★★★
Childhood Immunization Status*				
Combination 3	52.8%+	53.0%+	→	★
Combination 7	46.5%+	44.8%+	→	★
Combination 10	20.2%+	17.8%+	→	★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	82.7%	83.5%+	→	★★★
Combination 2 (Meningococcal, Tdap, HPV)	31.9%	35.5%+	→	★★★
Oral Evaluation, Dental Services				
Total (0–20 Years)[N]	46.6%	50.6%	↑	—
Well-Child Visits in the First 30 Months of Life				
First 15 Months—Six or More Well-Child Visits	56.1%	63.3%	↑	★★★
15 Months to 30 Months—Two or More Well-Child Visits	54.7%	59.4%	↑	★
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	39.8%	43.2%	↑	★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	40.9%	45.8%	↑	★
Cervical Cancer Screening				
21–64 Years	47.4%	47.9%+	→	★
Appropriate Utilization of Services				
Ambulatory Care				
Emergency Department (ED) Visits —Total (0–85+ Years)[F]	514.8	507.3	—	—
Plan All-Cause Readmissions				
*Observed/Expected (O/E) Ratio—Total (18–64 Years)**	0.9296	0.9941	—	★★

* A lower rate indicates better performance for this measure.
** Table A-2 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
+ Indicates the measure was reported using hybrid methodology.
Cells shaded green indicate that the rate met or exceeded the MY 2022 and/or MY 2023 national Medicaid mean.

— Indicates a 2022–2023 comparison is not presented in the CYE 2024 Annual Technical Report because either the CY 2022 rate was not presented in the CYE 2023 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
[1]Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.
[2] Performance Levels for CY 2023 were based on comparisons of the HEDIS MY 2023 measure rates to national Medicaid Quality Compass HEDIS MY 2023 benchmarks.
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.
[N] Measure has no NCQA Medicaid mean for comparison.
↑ Indicates statistically significant improvement of measure rates.
↓ Indicates statistically significant decline of measure rates.
→ Indicates no statistically significant change in measure rates.
Performance Levels for 2023 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 5-60 presents strengths, opportunities for improvement, and recommendations for HCA ACC related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-60—HCA ACC Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
Within the Behavioral Health measure group, seven of 13 HCA ACC measure rates (53.85 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. **[Quality, Timeliness, Access]** • *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)* and *30-Day Follow-Up—Total (13+ Years)* • *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* • *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* and *Engagement of SUD Treatment—Total—Total (13+ Years)* • *Use of Opioids at High Dosage—18+ Years* HCA ACC's performance measure rates for *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)* and *30-Day Follow-Up—Total(13+ Years)* and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total (6+ Years)* were at or above the 75th

Strengths, Opportunities for Improvement, and Recommendations
percentile, and *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* was at or above the 90th percentile, indicating that most members are getting adequate follow-up and coordinated care following an ED visit or hospitalization for mental illness or substance use. **[Quality, Timeliness, Access]**
Within the Care of Acute and Chronic Conditions measure group: • HCA ACC's performance measure rate for *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 %)—Total (18–75 Years)* met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. **[Quality]**
Within the Pediatric Health measure group: • HCA ACC's performance measure rate for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)* met or exceeded the 75th percentile. **[Quality]**
Opportunities for Improvement and Recommendations
While HCA ACC was successful in reporting valid rates for all AHCCCS-required performance measures for its ACC populations, the PMV audit identified some considerations and recommendations for future years' reporting. **[Quality]** Recommendation: HSAG recommends that HCA ACC continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES. Also, HSAG recommends that HCA ACC continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes AHCCCS requirements for MCO-enrolled members who switch product lines or MCOs and members for whom HCA ACC does not hold the primary insurance contract.
In the Behavioral Health measure group, HCA ACC's performance measure rate for *Adherence to Antipsychotic Medications for Individuals with Schizophrenia—18+ Years* fell below the 25th percentile, indicating adults 18 years of age and older who have schizophrenia or schizoaffective disorder who were dispensed an antipsychotic medication did not remain on the medication for at least 80 percent of their treatment period. **[Quality]** Recommendation: Schizophrenia is a chronic and disabling psychiatric disorder that requires ongoing treatment and monitoring. Symptoms include hallucinations, illogical thinking, memory impairment, and incoherent speech. Medication nonadherence is common and a major concern in the treatment of schizophrenia. Using antipsychotic medications as prescribed reduces the risk of relapse or hospitalization.[104] In a systematic review of medication adherence studies, several

[104] National Committee for Quality Assurance. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA). Available at: https://www.ncqa.org/hedis/measures/adherence-to-antipsychotic-medications-for-individuals-with-schizophrenia/. Accessed on: Feb 13, 2025.

Strengths, Opportunities for Improvement, and Recommendations
interventions that worked in studies were motivational interviewing, daily texts to individuals with schizophrenia, and other medication reminders. Other effective studies utilized Meds-Help, a pharmacy-based intervention, environmental support through home visits and reminders to adhere to medication, a psychoeducational program (FSPP), an intervention called STOPS that focuses on the importance of the supervisor's role for patients during treatment, and an IOT program.[105] HSAG recommends that HCA ACC consider implementing one or more of these interventions that have been associated with increased medication adherence for members with schizophrenia. In addition, HSAG recommends that HCA ACC consider utilizing financial incentives offered to patients with severe mental illness to improve treatment adherence.
In the Pediatric Health measure group: • HCA ACC's performance measure rates for *Child and Adolescent Well-Care Visits—Total (3–21 Years)* and *Well-Child Visits in the First 30 Months of Life—15 Months to 30 Months—Two or More Well-Child Visits* fell below the 25th percentile, indicating that children and adolescents were not always receiving their well-care visits. Assessing physical, emotional, and social development is important at every stage of life, particularly for children and adolescents. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[106] **[Quality, Access]** Recommendation: While HCA ACC conducted a root cause analysis and implemented interventions specific to the MY 2022 *Well-Child Visits in the First 30 Months of Life—15 Months to 30 Months—Two or More Well-Child Visits* and *Child and Adolescent Well-Care Visits—Total (3–21 Years)* rates, these rates remained low in MY 2023; therefore, HSAG recommends that HCA ACC monitor and expand on interventions currently in place to improve the performance related to well-care visits. Notably, HCA ACC is implementing interventions as part of the *Back to Basics* PIP, which includes a root cause analysis and interventions to address well-child care. HSAG recommends that HCA ACC draw as needed from other states' performance improvement initiatives. For instance, as part of a federal performance initiative to improve well-child care, California and Virginia have focused on delays in newborn enrollment data, and Missouri and Texas focused on beneficiary barriers and implemented interventions such as utilizing patient portals and phone outreach. HSAG recommends that HCA ACC identify other barriers to care and conduct a focus group on identifying ways to address barriers.[107]

[105] Cahaya N, Kristina SA, Widayanti AW, et al. Interventions to Improve Medication Adherence in People with Schizophrenia: A Systematic Review. Patient preference and adherence vol. 16 2431-2449. 1 Sep. 2022, doi:10.2147/PPA.S378951. Available at: https://pubmed.ncbi.nlm.nih.gov/36072918/. Accessed on: Feb 13, 2025.
[106] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Feb 13, 2025.
[107] Centers for Medicare & Medicaid Services. Well-Child Care. Available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html. Accessed on: Feb 12, 2025.

Strengths, Opportunities for Improvement, and Recommendations
• HCA ACC's performance measure rates for *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10* fell below the 25th percentile, indicating that children were not always getting their immunizations by their second birthday. Vaccination coverage must be maintained in order to prevent a resurgence of vaccine-preventable diseases.[108] **[Quality, Access]** Recommendation: HSAG recommends that HCA ACC provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.
In the Preventive Screening measure group, HCA ACC's performance measure rates for *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* fell below the 25th percentile, indicating that some women were not receiving timely screening for breast and cervical cancers. Early detection reduces the risk of dying from these types of cancers and can lead to a greater range of treatment options and lower healthcare costs. **[Quality]** Recommendation: While HCA ACC implemented interventions specific to the MY 2022 *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* rates, these rates remained low in MY 2023; therefore, HSAG recommends that HCA ACC identify additional interventions to improve performance on these screening measures. HSAG recommends that HCA ACC consider utilizing one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve screening rates. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-61 presents performance measure recommendations made to HCA ACC in the CYE 2023 Annual Technical Report[109] and HCA ACC's follow-up to the recommendations, as well as an assessment of the degree to which HCA ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

[108] National Committee for Quality Assurance. Childhood Immunization Status (CIS). Available at: https://www.ncqa.org/hedis/measures/childhood-immunization-status/. Accessed on: Feb 13, 2025.

[109] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf. Accessed on: Feb 23, 2025.

Table 5-61—HCA ACC Follow-Up to CYE 2023 Performance Measure Recommendations

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Recommendation 1:
While HCA ACC conducted a root cause analysis and implemented interventions specific to its *Prenatal and Postpartum Care—Postpartum Care* measure indicator, this rate remained low in CY 2022; therefore, HSAG recommended that HCA ACC continue to implement appropriate interventions to improve performance related to postpartum care. HSAG also recommended that HCA ACC monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Postpartum Care* measure.
HCA ACC's Response: Health Choice initiated a *Prenatal and Postpartum Care* PIP. CY 2022 was the baseline measurement year for this PIP and CY 2023 was the intervention year. As part of this plan, Health Choice conducted a root cause analysis in the form of an Ishikawa diagram. Health Choice conducted the following interventions to address these root causes. • Provider Education—The MCH Leadership team will participate in education sessions with providers to augment prenatal visits. This will be a joint effort with the provider network. • Stork Newsletter—Develop a pregnancy newsletter (Stork Newsletter) targeted to newly identified pregnant members. • Community Collaboration—Collaborate with Community Outreach to implement initiatives that promote culturally sensitive education on preconception health, maternal health, and barriers to prenatal care in the community. • Provider Partnership—Work with OB providers to facilitate members' timely prenatal appointment compliance rates. • Targeted Outreach—Outreach pregnant members with two or more missed appointments to assist with rescheduling. • Member Outreach—Outreach all newly identified pregnant women within their first trimester or within 42 days of enrollment. • VBP Contracting—Health Choice has *Prenatal and Postpartum Care (PPC)* measures included in appropriate provider contracts to promote the success of the *PPC* measures. The result of these interventions, as well as improving our data collection process to ensure that all completed appointments are included in the data, was that Health Choice met the identified minimum performance standard (MPS) for both the prenatal and postpartum measures in the intervention year, CY 2023.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures

Indicator	Baseline Year 2022				Intervention Year 2023			
	N	D	%	Goal	N	D	%	Goal
Prenatal	348	403	86.4%	83.5%	331	380	87.1%	83%
Postpartum	262	403	65.0%	76.2%	298	380	78.4%	77%

HSAG's Assessment:

HCA ACC identified interventions that were implemented for CY 2023 as a result of conducting a root cause analysis; therefore, HSAG determined that HCA ACC satisfactorily addressed the prior year's recommendation.

Recommendation 2:

Schizophrenia is a chronic and disabling psychiatric disorder that requires ongoing treatment and monitoring. Symptoms include hallucinations, illogical thinking, memory impairment, and incoherent speech. Medication nonadherence is common and a major concern in the treatment of schizophrenia. Using antipsychotic medications as prescribed reduces the risk of relapse or hospitalization.[110] HSAG recommended that HCA ACC conduct a root cause analysis to determine why members with a diagnosis of schizophrenia were not always receiving continuous medication treatment. Upon identification of a root cause, HCA ACC should continue to implement appropriate interventions to improve performance related to its *Adherence to Antipsychotic Medications for Individuals with Schizophrenia—18+ Years* measure rate. HSAG also recommended that HCA ACC monitor and expand on interventions currently in place to improve performance related to continuous medication treatment for members with a diagnosis of schizophrenia.

HCA ACC's Response:

Health Choice has conducted a root cause analysis to determine the causes of low performance on this measure. The Health Choice pharmacy team and clinical care management team work closely to ensure that members and providers have the support needed in order for the members to remain adherent to their medications. Health Choice conducted this root cause analysis in the form of an Ishikawa diagram.

Health Choice conducted the following interventions to target these root causes.

- The Health Choice Pharmacy Team runs a report of pharmacy fills and identifies members who have received antipsychotic medications in the past and have not refilled them.

[110] National Committee for Quality Assurance. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA). Available at: https://www.ncqa.org/hedis/measures/adherence-to-antipsychotic-medications-for-individuals-with-schizophrenia/ Accessed on: Feb 13, 2025.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
• The pharmacy team then conducts outreach to the member and/or the treatment team in order to alleviate barriers to the member picking up their medications. • Barriers the pharmacy team can assist with include: – Out of refills. – Transportation issues. – Medication synchronization and conversion to 90–100 day fills to reduce trips to the pharmacy. – Reminders and check-ins reinforce the importance of taking the medication every day. – Pharmacy supply or customer service issues. – Facilitate the prior authorization when needed. – Adverse reactions to medications. – Clinical questions from members about their medications. – Pharmacy billing errors result in false assumptions about whether a member is adherent or not. • The Clinical Care Management Department can also assist members with these issues if they have been referred to care management or disease management.
HSAG's Assessment: HCA ACC identified interventions that were implemented as a result of conducting a root cause analysis; therefore, HSAG determined that HCA ACC satisfactorily addressed these prior year's recommendations.
Recommendation 3:
While HCA ACC conducted a root cause analysis and implemented interventions specific to the CY 2021 *Child and Adolescent Well-Care Visits—Total (3–21 Years)* rate, this rate remained low in CY 2022; therefore, HSAG recommended that HCA ACC identify best practices to support children in receiving well-care visits according to recommended schedules. Additionally, HSAG recommended that HCA ACC monitor and expand on interventions currently in place to improve the performance related to well-care visits.
HCA ACC's Response: Health Choice initiated a CAP in CY 2023 in order to target this measure. As part of this plan, Health Choice conducted a root cause analysis in the form of an Ishikawa diagram. Health Choice conducted the following interventions to target these root causes. • Back-to-School (BTS) campaign targeting school-aged members to increase well-child visits and immunizations prior to the start of the school year, including flyers, social media campaign, and partnering with large primary care groups. • Text messaging and IVR calls campaign targeting noncompliant members to educate and remind them to schedule a wellness appointment. • Engage with school-based telehealth providers for K-12 for fast access to physical health care.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
• Develop new educational flyers targeting adolescents and young adults. • Use social media to reach families and youth with information about the importance, timing, and content of preventive care visits. • Educate the member/parents/guardians on the importance of EPSDT/well visits through monthly member newsletters, birthday cards, reminder letters, and phone communication. • Increase member awareness of telehealth as an alternative to in-person visits, when applicable. • Collaborate with the Community Relations Department to organize health fairs and assist with calls to schedule appointments. • EPSDT staff will utilize the gap in care list to conduct outreach calls to noncompliant members and providers. • Through value-based purchasing (VBP), Health Choice is leveraging Arizona's successful managed care model to address inadequacies of the current health care delivery system. This program includes alternative payment models, differential adjusted payments, direct payments, and performance based payments. The incentive of higher payment for higher performance will ensure these providers focus on targeted measures. This measure has been included in the CY 2023 VBP contracting. • MCOs are encouraging enrolled members ages 3–19 to complete well-care visits between June 5 and September 6. Those members will be eligible to receive an incentive for attending their well-care appointments. The MCOs are coordinating a statewide outreach, advertising, and educational campaign with live events, to complete as many well-care visits as possible during this time frame. In 2023, the *Child and Adolescent Well-Care Visits* rate increased by 1.2 percent over 2022. This represented a slightly larger increase as compared to the change between 2021 and 2022. Analyzing this change using a Chi-squared test with Yates' correction reveals a two-tailed *p* value of less than 0.0001. This means that the change is considered to be statistically significant. While the analysis of this PDSA cycle indicates that statistically significant improvement took place over the past two years, Health Choice will continue another PDSA cycle in 2024.
HSAG's Assessment: HCA ACC identified interventions that were implemented for CY 2023 as a result of conducting a root cause analysis; therefore, HSAG determined that HCA ACC satisfactorily addressed these prior year's recommendations.
Recommendation 4:
HSAG recommended that HCA ACC conduct a root cause analysis to determine why some children are not always getting their immunizations by their second birthday. This could include conducting focus groups to identify barriers that members are experiencing in accessing care and services in order to implement appropriate interventions. HCA ACC should consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, a lack of service providers, or the need for

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
community outreach and education). Upon identification of a root cause, HSAG recommended that HCA ACC implement appropriate interventions to improve performance related to childhood immunizations.
HCA ACC's Response: Health Choice initiated a CAP in CY 2023 in order to target this measure. As part of this plan, Health Choice conducted a root cause analysis in the form of an Ishikawa diagram. Health Choice conducted the following interventions to target these root causes. • MCOs are encouraging enrolled members ages 3–19 to complete well-care visits between June 5 and September 6. Those members will be eligible to receive an incentive for attending their well-care appointments. The MCOs are coordinating a statewide outreach, advertising, and educational campaign with live events, to complete as many well-care visits as possible during this time frame. • The Health Choice EPSDT team completes regular member outreach including calls to members, parents, guardians, and their PCPs to ensure care is received and correct billing codes are used. The team can assist directly with scheduling appointments for well- care visits, immunizations, and other services. They are also able to review immunization records and schedules and encourage the opportunity to catch up on missed immunizations. They can also provide education on the importance of completing each vaccine series. • Health Choice has resumed holding and participating in live health events for members. These had been on hold during the COVID-19 global pandemic. At these events, members can receive or schedule needed well-care visits and services. Vaccinations are frequently provided during these events. In 2023, Health Choice is excited to have partnered with two more large practices to hold health events. • Health Choice has worked to improve alignment with Arizona State Immunization Information System (ASIIS) data to accurately capture immunizations given to our members. We have seen an increase in the completeness of these data but have recently realized that for our rural members who border other states—they are often closest to a provider in the neighboring state and the immunization information is not available in ASIIS. Health Choice is working to add in Utah Statewide Immunization Information System data for 2024.
HSAG's Assessment: HSAG determined that HCA ACC satisfactorily addressed these prior year's recommendations.
Recommendation 5:
While HCA ACC implemented interventions specific to the CY 2021 *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* rates, these rates remained low in CY 2022; therefore, HSAG recommended that HCA ACC conduct a root cause analysis for these measures and continue to implement appropriate interventions to improve performance related to these rates. HSAG also recommended that HCA ACC monitor and expand on interventions currently in place to improve performance related to these screenings.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures

HCA ACC's Response:

With regard to the *Breast Cancer Screening* measure: Health Choice initiated a CAP in CY 2023 in order to target this measure. As part of this plan, Health Choice conducted a root cause analysis in the form of an Ishikawa diagram.

Health Choice conducted the following interventions to target these root causes.

- Identify members with gaps, outreach to members to coordinate scheduling, possible events.
- Provide practices with updated mammogram gaps and rosters; working with providers on orders; follow through.
- MRR to identify potential opportunities to close gaps, assist with provider education, review noncompliant records.
- Teams will track gap closure and assess intervention required to ensure practices are tracking to meet year-end gap closure target, CareRadius alerts, potential for provider portal reporting, provider scorecard.
- Continue to coordinate activities with vendor partners.
- Member education and website communication.
- Member reward and incentive program—a gift card for completion of visits.
- Through VBP, Health Choice is leveraging Arizona's successful managed care model to address inadequacies of the current health care delivery system. This program includes alternative payment models, differential adjusted payments, direct payments, and performance based payments. The incentive of higher payment for higher performance will ensure these providers focus on targeted measures. This measure has been included in the CY 2023 VBP contracting.

With regard to the *Cervical Cancer Screening* measure: Health Choice initiated a CAP in CY 2023 in order to target this measure. As part of this plan, Health Choice conducted a root cause analysis in the form of an Ishikawa diagram.

Health Choice conducted the following interventions to target these root causes.

- Identify members with gaps, outreach to members to coordinate scheduling.
- Provide practices with updated rosters; working with providers on orders; follow through.
- MRR to identify potential opportunities to close gaps, assist with provider education, review noncompliant records.
- Teams will track gap closure and assess intervention required to ensure practices are tracking to meet year-end gap closure target, CareRadius alerts, potential for provider portal reporting, provider scorecard.
- The Health Choice quality improvement specialists complete regular outreach and coordination with our providers. They send lists of member gaps for many measures, educate providers on proper billing to meet identified measures, conduct regular phone and in-person meetings to

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
troubleshoot issues, and provide technical assistance. They provide each provider with a toolkit containing information on how to bill and coordinate on assigned measures. • Quality improvement specialists continue manual data mining as well as providing gap reports to providers. Education on cervical cancer screenings provided to provider groups. • Through VBP, Health Choice is leveraging Arizona's successful managed care model to address inadequacies of the current health care delivery system. This program includes alternative payment models, differential adjusted payments, direct payments, and performance based payments. The incentive of higher payment for higher performance will ensure these providers focus on targeted measures. This measure has been included in the CY 2023 VBP contracting.
HSAG's Assessment: HSAG determined that HCA ACC satisfactorily addressed these prior year's recommendations.

Validation of Performance Improvement Projects

Back to Basics PIP

In CYE 2024, HCA ACC continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 2, PIP validation activities focused on improvement from the baseline results. HCA ACC submitted Remeasurement 2 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes to or discontinuation of the interventions.

HSAG conducted an annual validation of the second remeasurement year reflective of CY 2023 (January 1, 2023, through December 31, 2023) using AHCCCS-calculated and validated indicator rates. HSAG evaluated HCA ACC's performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

Validation Results

Table 5-62 displays the overall confidence levels for the HCA ACC *Back to Basics* PIP.

Table 5-62—HCA ACC *Back to Basics* PIP Overall Confidence Levels

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]
HCA ACC	*High Confidence*	100%	100%	*Moderate Confidence*	33%	100%

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

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

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

Measure Results

Table 5-63 and Table 5-64 provide the *Back to Basics* PIP baseline, Remeasurement Year 1, and Remeasurement Year 2 rates for each indicator for HCA ACC.

Table 5-63—HCA ACC *Back to Basics* PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: *W30 Rate 1*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
HCA ACC	59.4%	56.1%	63.3%

HSAG rounded percentages to the first decimal place.

Table 5-64—HCA ACC *Back to Basics* PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: *WCV*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
HCA ACC	43.6%	39.8%	43.2%

HSAG rounded percentages to the first decimal place.

Interventions

Table 5-65 presents PIP interventions for HCA ACC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-65—HCA ACC *Back to Basics* PIP Interventions

Contractor	Interventions
HCA ACC	• EPSDT staff conducted outreach calls to member with gaps in care. During the calls, the staff educated members on the benefits of the well-child visit, questioned the parents to determine what barriers have hindered them from scheduling, assisted with scheduling appointments, and arranged transportation. • HCA ACC also conducted regular outreach via other methods to ensure providers and members were aware of the need for these services and that these measures remain a focus for pediatric providers. Health Choice Communications Team sent fax blasts, spoke about these measures at the provider forum, discussed value-based contracts with providers, and sent reminder letters to members. • Missed Appointment Logs—HCA ACC Care Management Team received missed appointment logs from a number of our larger providers. The Health Choice care managers then made follow-up calls to assist the member in rescheduling the missed appointment. This also provided an opportunity to assist the member in overcoming any barriers that prevented the member from being able to attend the appointment. • The AHCCCS Back to School Campaign is a multi-plan, coordinated effort that improved the rates of well-child and annual dental visits for Medicaid enrolled children across the State. It involved coordinated outreach and education with standardized messaging across all AHCCCS plans and providers. Per AHCCCS instructions, the campaign included identifying target members, conducting outreach to PCP and OB/GYN providers, established provider participation agreements as needed, and purchased backpacks and supplies. Alternatively, funding/supplementing existing back-to-school drive supplies through potential partner organizations and sending/launching member and provider communication materials. • HCA ACC initiated a project to ensure that all CRS members had adequate coordination of care. An audit took place to review CRS members. The purpose was to ensure that care management had been offered to all CRS qualifying members, that there were no issues with missing paperwork that may have led to delays in care, and to complete outreach specific to the *W30* and *WCV* measures.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-66 presents strengths, opportunities for improvement, and recommendations for HCA ACC related to the *Back to Basics* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-66—HCA ACC Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • HCA ACC adhered to acceptable methodology through all phases of the PIP. **[Quality**, **Access]** • HCA ACC developed and implemented interventions that led to statistically significant improvement in the *WCV* performance indicator between the baseline year and Remeasurement Year 2. **[Quality**, **Access]**
Opportunities for Improvement and Recommendations
For Indicator 2, HCA ACC had a decline of 0.4 percentage points in the indicator rate between the baseline year and Remeasurement Year 2. **[Quality**, **Access]** Recommendations: As the PIP progresses, HSAG recommends that HCA ACC: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. • Continue to implement identified interventions with clearly defined measures to assess the effectiveness of each intervention. Assure that all interventions are evaluated for effectiveness through a measure directly linked to the intervention.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-67 presents PIP recommendations made to HCA ACC in the CYE 2023 Annual Technical Report[111] and HCA ACC's follow-up to the recommendations, as well as an assessment of the degree to which HCA ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

[111] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf. Accessed on: Feb 23, 2025.

Table 5-67—HCA ACC Follow-Up to CYE 2023 PIP Recommendations

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG recommended that HCA ACC: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. • Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.
HCA ACC's Response: *Back to Basics* PIP 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 critically important in disease prevention, early detection, and treatment. It is equally important in evaluating a child's developmental milestones, addressing parental concerns, and assessing a child or adolescent's psychological and social development. 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. Health Choice is working diligently to improve the measures associated with the *Back to Basics* PIP. These, as HSAG has noted in the EQR, have been negatively impacted by the COVID-19 PHE. This was one of the primary reasons that Health Choice chose to initiate the Back-to-School program in 2022 rather than in 2023 with the other AHCCCS Health Plans. Interventions included in the *Back to Basics* PIP submission are: • W30 - Ensure all guardians receive outreach regarding gaps in care via the EPSDT team or the Quality Improvement Specialist (QIS) team. • W30 - Ensure all clinics can access gaps in care reports on the provider portal. • W30 - Retrieve medical records for all noncompliant members who appear to be overdue. Load compliance as supplemental data on a monthly basis; cascade to performance improvement coordination (PIC) trackers. • W30 - Provide reports to practices that track members who are due within the open schedule time frame, members who are overdue, members who need to be rescheduled, and a summary of completed members versus target. • W30 - Provider outreach to ensure that correct billing codes are utilized and submitted within claim data. • W30 - Ensure monthly refresh of gaps in care notifications for CareRadius users.

Prior Year's Recommendation From the EQR Technical Report for PIPs
• W30 - Continued EPSDT efforts; EPSDT mailer to families; extended clinic hours for two large primary care groups. • WCV - Educate the member/parents/guardians on the importance of EPSDT well visits through monthly member newsletters, birthday cards, reminder letters, and phone communication. • WCV - Outreach to the member/parents/guardians of members with missed appointments to educate and assist in rescheduling. • WCV - Member incentive for obtaining an EPSDT/well visit. • WCV - Collaborate with the Community Relations Department to organize health fairs and assist with calls to schedule appointments. • WCV - EPSDT staff will utilize the gap in care list to conduct outreach calls to noncompliant members and providers. • WCV - To bridge the gaps in care for EPSDT members ages 3–21 and reduce barriers, we engaged with Matrix Medical Network to offer in-home well-child visits. • WCV - Blast fax to provider offices about the updated periodicity schedule, best practices to improve wellness visits rate, and access to care was sent in March. Additional education about the EPSDT visits was provided during the Q1 provider forum. Health Choice continued to partner with value-based providers by sharing performance data related to well-child visits and identifying priority target populations for outreach to ensure that members are receiving all preventive services. In CY 2023, Health Choice reviewed trends in these results and made changes to interventions accordingly. Updates are listed below. • The QIS team distributed open gap rosters of members missing primary care visits to providers and completed data mining for members aging out of the measure to ensure necessary services were received prior to them aging out. • Efforts to increase engagement with a Back-to-School campaign helped increase rates from 2022 to 2023. Health Choice recognizes additional efforts will be needed to continue to see an increase in services as well as to collect data related to Health Choice children with other primary insurance. Health Choice is actively pursuing automated data sources to help us better reflect our true rates of care. • A fax blast was sent out on 06/26/2023 with information related to well-child visits and all the necessary and associated services that may be provided at those appointments, including vaccinations and screenings. • The Healthy Rewards Program was updated and discussed in the spring and summer member newsletters. This relates to the *W30*, *WCV*, *OEV*, *PPC*, and *BCS* measures. • Direct member support and provider education was provided throughout CY 2023. • Health Choice organized/hosted eight dental health fairs and six mobile dentistry events in 2023. Health Choice called 6,521 members to invite them to these events, 678 appointments were made, and 441 members attended these events and received preventive dental services.

Prior Year's Recommendation From the EQR Technical Report for PIPs
• The dental management team, including the dental director, conducted 121 visits to dental providers/groups in seven counties in central and northern AZ and UT and shared valuable information aimed to improve the preventive visits rate and reduce no-shows. • Health Choice mailed 126,838 first dental reminders, 66,428 second reminder letters, and 64,365 missed dental appointment postcards. • Health Choice mailed the dental home notification letter to 101,541 EPSDT members in August 2023. • Health Choice processed 792 dental referrals. • Health Choice faxed 68 gaps in care rosters containing 24,145 members noncompliant with the dental measure. • Health Choice released the new dental prior authorization submission through the provider portal feature. Continued changes in measures and methodology make year-over-year comparisons of results difficult. CY 2023 was the second year in a row where the *WCV* measure was the only measure to not meet the identified MPS. However, the rate from CY 2022 to CY 2023 increased from 38.3 percent to 42.4 percent. When this change is evaluated using a Chi-squared test with Yates' correction, the Chi-squared equals 307.492 with 1 degree of freedom. The two-tailed *p* value equals 0.0001, meaning that this improvement is considered to be extremely statistically significant. In conclusion, Health Choice met the identified target for two of the three indicators and saw a statistically significant increase in the third.
HSAG's Assessment: HSAG determined that HCA ACC satisfactorily addressed these prior year's recommendations.

Prenatal and Postpartum Care PIP

Overview

AHCCCS initiated the implementation of the *Prenatal and Postpartum Care* PIP for the ACC population in CYE 2022. The objective of the *Prenatal and Postpartum Care* PIP is to improve health outcomes for members and infants. This PIP focuses on increasing the number and percentage of members with live birth deliveries that 1) received a prenatal care visit, and 2) received a postpartum visit. In CYE 2024, HCA ACC continued to implement interventions to improve these outcomes and provided updates on the status of each intervention to AHCCCS.

Interventions

Table 5-68—HCA ACC *Prenatal and Postpartum Care* PIP Interventions

Contractor	Interventions
HCA ACC	Continued interventions to support the *Prenatal and Postpartum Care* PIP in CYE 2024 include:
	• Direct member outreach • Targeted member outreach • Provider outreach • Pyx Health • Stork Newsletter • Further subpopulation analysis

Strengths, Opportunities for Improvement, and Recommendations

HSAG did not conduct validation on the *Prenatal and Postpartum Care* PIP in CYE 2024; therefore, strengths, opportunities for improvement, and recommendations are not provided.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-69 presents PIP recommendations made to HCA ACC in the CYE 2023 Annual Technical Report[112] and HCA ACC's follow-up to the recommendations, as well as an assessment of the degree to which HCA ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-69—HCA ACC's Follow-Up to CYE 2023 PIP Recommendations

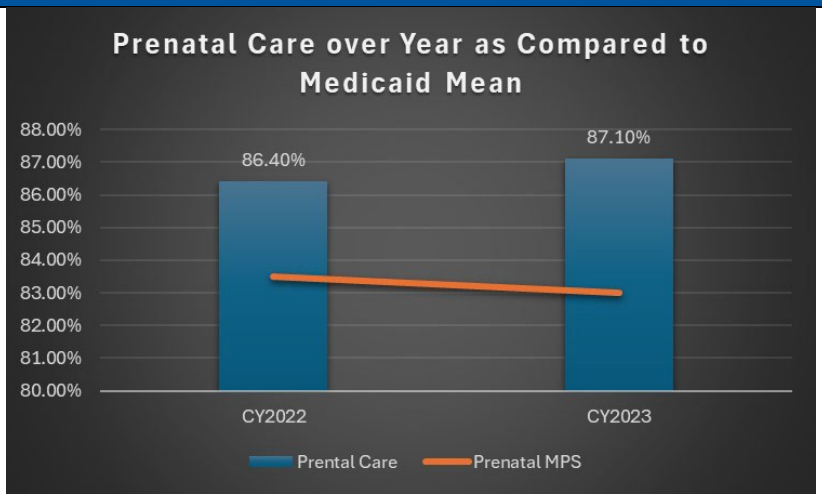
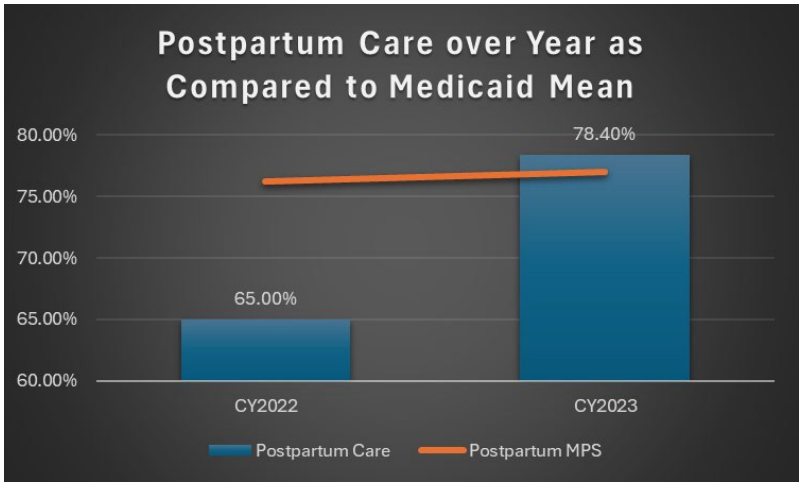
Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG recommended that HCA ACC: • Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary. • Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available. • Develop and document a plan for sustaining the improvement for any demonstrated improvement in indicator rates.

[112] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf. Accessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for PIPs
HCA ACC's Response: According to the CDC, at least 50,000 women in the United States are affected by severe morbidity due to unexpected pregnancy-related health problems. In addition, more than 700 women die each year from pregnancy-related problems or delivery complications. Racial disparities exist among pregnancy-related deaths, as the CDC reports "American Indian, Alaska Native, and Black women are two to three times more likely to die of pregnancy-related causes than White women."[113] Every death related to pregnancy is a tragedy, especially considering the CDC found that four in five of the deaths are preventable.[114] According to Healthy People 2030, "Women's health before, during, and after pregnancy can have a major impact on infants' health and well-being."[115] Strategies, such as maintaining a healthy lifestyle, receiving proper health care, and adopting healthy habits before and during pregnancy helps prevent pregnancy complications and improve health outcomes for women and their babies. In addition, these strategies may assist in promoting infant health, development, and overall well-being. The goal of the *Prenatal and Postpartum Care* PIP is to demonstrate a statistically significant increase in the number and percentage of members with live birth deliveries that 1) received a prenatal care visit, and 2) received a postpartum visit, followed by sustained improvement for one consecutive year. Initial root cause analysis uncovered data issues preventing accurate identification of prenatal and postpartum appointments. These are identified manually requiring a great amount of labor to include them. Health Choice is working to automate these processes. Health Choice also identified needs for member and provider education, member incentives, and outreach and coordination of care. Baseline interventions for this project include: • Provider Education - MCH Leadership team will participate in education sessions with providers to augment prenatal visits. This will be a joint effort with provider network. • Stork Newsletter - Develop pregnancy newsletter (Stork Newsletter) targeted to newly identified pregnant members. • Community Collaboration - Collaborate with Community Outreach to implement initiatives that promote culturally sensitive education on preconception health, maternal health, and barriers to prenatal care in the community.

[113] Centers for Disease Control and Prevention. Hear Her Campaign. Pregnancy-Related Deaths in the United States. Available at: https://www.cdc.gov/hearher/pregnancy-related-deaths/index.html. Accessed on: Feb 13, 2025.
[114] Ibid.
[115] U.S. Department of Health and Human Services. Healthy People 2030. Pregnancy and Childbirth. Available at: https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth#:~:text=Women's%20health%20before%2C%20during%2C%20and%20after%20pregnancy%20can%20have%20a,and%20to%20have%20healthy%20babies. Accessed on: Feb 13, 2025.

Prior Year's Recommendation From the EQR Technical Report for PIPs
• Provider Partnership - Work with OB providers to facilitate member timely prenatal appointment compliance rates. • Targeted Outreach - Outreach pregnant members with two or more missed appointments to assist with rescheduling. • Member Outreach - Outreach all newly identified pregnant women within their first trimester or within 42 days of enrollment. • VBP Contracting - Health Choice has *PPC* measures included in appropriate provider contracts to promote the success of the *PPC* measures. Since the inception of the project, Health Choice has modified our member outreach for better success and has implemented a program to incentivize members to attend their needed visits. Health Choice met both the prenatal and postpartum measures in CY 2023. In hybrid reporting for both indicators, *Timeliness of Prenatal Care* and *Postpartum Care*, Health Choice exceeded the identified targets. For the *Timeliness of Prenatal Care Measure*, the rate increased by only 0.7 percent which, when analyzed for statistical significance using a Chi-squared test with Yates' correction, the two-tailed *p* value was .08376. This means that the increase was not statistically significant. However, this rate continues to exceed the identified MPS, and further increases are likely to be small and not statistically significant. However, for the *Postpartum Care* measure, the rate increased by 13.4 percent. This brought the measure above the identified target. When this change was analyzed for statistical significance using a Chi-squared test with Yates' correction, the two-tailed *p* value was less than 0.0001. That means that this increase is considered to be extremely statistically significant. Please see the below results comparing the prenatal and postpartum care rates to their respective targets in the baseline and intervention years.

Prior Year's Recommendation From the EQR Technical Report for PIPs


HSAG's Assessment: HSAG determined that HCA ACC satisfactorily addressed these prior year's recommendations.

Compliance Reviews

Results

AHCCCS conducted a compliance review of HCA ACC in CYE 2022. On December 20, 2024, AHCCCS accepted and closed the remaining four CAPs for HCA ACC. Table 5-70 presents the compliance review results for HCA ACC.

Table 5-70—HCA ACC Compliance Review Results

Focus Areas	CYE 2022 HCA ACC Scores	CYE 2022 Program-Level Average	CYE 2023 HCA ACC CAP Update	CYE 2024 HCA ACC CAP Update
CC	100%	99%	NA	NA
CIS	99%	96%	NA	NA
DS	98%	91%	NA	NA
GA	78%	92%	Partially Met	Met
GS	99%	99%	NA	NA
MCH	98%	82%	NA	NA
MM	97%	94%	NA	NA
MI	94%	96%	Partially Met	Met
QM	75%	77%	Partially Met	Met
QI	83%	92%	Partially Met	Met
RI	100%	100%	NA	NA
TPL	100%	100%	NA	NA
ISOC	98%	96%	NA	NA

NA = Not applicable. A CAP was not required as the CYE 2022 score was 95% or above or the CAP was closed by AHCCCS in CYE 2023.
Partially Met = AHCCCS approved the Contractor's proposed CAP. The Contractor must submit evidence of compliance.
Met = AHCCCS accepted and closed the Contractor's CAP.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-71 presents strengths, opportunities for improvement, and recommendations for HCA ACC based on compliance activities conducted in CYE 2024, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-71—HCA ACC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HCA ACC has successfully closed out CAPs in the following focus areas: • General Administration (GA) **[Timeliness, Access]** • Member Information (MI) **[Quality]** • Quality Management (QM) **[Quality]**

Strengths, Opportunities for Improvement, and Recommendations
• Quality Improvement (QI) **[Quality, Access]**
Opportunities for Improvement and Recommendations
As a result of its CAP interventions, HCA ACC was found to be fully compliant within all focus areas and had no continuing corrective actions or recommendations.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-72 presents compliance recommendations made to HCA ACC in the CYE 2023 Annual Technical Report[116] and HCA ACC's follow-up to the recommendations, as well as an assessment of the degree to which HCA ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-72—HCA ACC Follow-Up to CYE 2023 Compliance Recommendations

Prior Year's Recommendation From the EQR Technical Report for Compliance
HSAG recommended that HCA ACC continue to work on outstanding CAP items and submit to AHCCCS in the approved time frame.
HCA ACC's Response: Health Choice received a number of CAPs based on the results of the CY 2022 AHCCCS Operational Review. Per the CYE 2023 External Quality Review Annual Technical Report, Health Choice successfully initiated all the required CAPs, and the following strength was noted. "AHCCCS approved Health Choice ACC's proposed CAPs for all focus areas with scores less than 95 percent. Health Choice ACC will provide evidence of CAP completion in CYE 2024." As for our submission to AHCCCS in July 2024, Health Choice has submitted all the required items to close the remaining CAPs and is awaiting the final notification of CAP closure. Please see the below summary of remaining CAP items demonstrating that each CAP has either been closed or that final deliverables have been submitted and are awaiting closure.

Health Choice CY 2022 AHCCCS Operational Review CAPs Status		
Domain	**Status**	**Date of Last Action**
CIS 5	**Accepted and Closed**	**6/22/2023**
DS 16	**Accepted and Closed**	**2/3/2023**

[116] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf. Accessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for Compliance			
	GA 1	Accepted and Closed	2/3/2023
	GA 4	Accepted and Closed	2/3/2023
	GS 8	Accepted and Closed	2/3/2023
	MCH 6	Accepted and Closed	6/22/2023
	MM 3	Accepted and Closed	2/3/2023
	MM 4	Accepted and Closed	6/22/2023
	MM 19	Submitted Awaiting Closure	7/15/2024
	MI 9	Accepted and Closed	2/3/2023
	QM 1	Submitted Awaiting Closure	7/16/2024
	QM 4	Accepted and Closed	6/24/2024
	QM 6	Submitted Awaiting Closure	7/15/2024
	QM 7	Accepted and Closed	6/24/2024
	QM 8	Submitted Awaiting Closure	7/15/2024
	QM 9	Accepted and Closed	6/22/2023
	QM 10	Accepted and Closed	6/24/2024
	QM 11	Submitted Awaiting Closure	7/15/2024
	QM 13	Submitted Awaiting Closure	7/15/2024
	QM 14	Submitted Awaiting Closure	7/15/2024
	QM 15	Accepted and Closed	6/24/2024
	QM 16	Accepted and Closed	6/22/2023
	QI 2	Accepted and Closed	6/24/2024
	QI 4	Accepted and Closed	6/24/2024
	QI 6	Accepted and Closed	6/24/2024
	ISOC 17	Accepted and Closed	2/3/2024

HSAG's Assessment:

Based on the CAP closure for the GA, MI, QM, and QI focus areas, and the response provided, HSAG determined that HCA ACC has satisfactorily addressed the prior year's recommendations related to compliance.

Network Adequacy Validation

ISCA Results

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

Table 5-73 summarizes HSAG's validation ratings for HCA ACC by indicator type.

Table 5-73—Summary of HCA ACC's Validation Ratings by Indicator Type

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

Of the network adequacy indicators assessed, HCA ACC received *High Confidence* for both appointment availability and time/distance indicators.

NAV Results

HSAG evaluated HCA ACC's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents CYE 2024 S1 validation findings specific to the ACC Program, with one results table for each of the following GSAs:

- Central GSA: Gila, Maricopa, and Pinal counties
- North GSA: Apache, Coconino, Mohave, Navajo, and Yavapai counties

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

Table 5-74—Time/Distance Validation Results for HCA ACC Central GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^[1]	98.9^[1]	100.0^[1]
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0^[1]	99.0^[1]	100.0^[1]
BHRF	NA	98.2[1]	NA
Cardiologist, Adult	100.0^	99.9^	100.0^
Cardiologist, Pediatric	100.0^	100.0^	100.0^
Dentist, Pediatric	100.0	99.3	100.0
Hospital	100.0[1]	99.9[1]	100.0[1]
OB/GYN	100.0	100.0	100.0
Pharmacy	100.0	99.1	100.0
PCP, Adult	100.0^	99.8^	100.0^
PCP, Pediatric	100.0^	99.8^	100.0^

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

^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

[1] In CYE 2024 S1, HCA ACC's data included decreased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; Behavioral Health Residential Facility; and Hospital. When contacted, HCA ACC indicated its query parameters for including these providers in its reporting were too narrow, resulting in the exclusion of some providers who should have been included in its reporting. HCA ACC has taken steps to revise the query to correct it for the next submission. The decreased number of providers potentially influenced the validated compliance for these provider categories.

Table 5-75—Time/Distance Validation Results for HCA ACC North GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Apache	Coconino	Mohave	Navajo	Yavapai
Behavioral Health Outpatient and Integrated Clinic, Adult	88.1^[1]	97.6^[1]	99.9^[1]	96.0^[1]	99.3^[1]
Behavioral Health Outpatient and Integrated Clinic, Pediatric	88.8^[1]	96.0^[1]	100.0^[1]	95.1^[1]	99.5^[1]
BHRF	NA	NA	NA	NA	NA
Cardiologist, Adult	95.7^	99.2^	100.0^	97.0^	100.0^
Cardiologist, Pediatric	99.2^	100.0^	100.0^	100.0^	100.0^
Dentist, Pediatric	87.9	97.3	99.3	97.7	99.2
Hospital	90.3[1]	100.0[1]	100.0[1]	99.9[1]	100.0[1]
OB/GYN	98.2	100.0	100.0	100.0	100.0
Pharmacy	91.7	91.7	99.0	98.3	98.0
PCP, Adult	90.1^	98.2^	98.8^	98.3^	99.6^
PCP, Pediatric	92.2^	97.4^	99.4^	97.7^	99.2^

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

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

^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

[1] In CYE 2024 S1, HCA's data included decreased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; Behavioral Health Residential Facility; and Hospital. When contacted, HCA indicated its query parameters for including these providers in its reporting were too narrow, resulting in the exclusion of some providers who should have been included in its reporting. HCA has taken steps to revise the query to correct it for the next submission. The decreased number of providers potentially influenced the validated compliance for these provider categories.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-76 presents strengths, opportunities for improvement, and recommendations for HCA ACC related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-76—HCA ACC Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • HCA ACC had processes in place to maintain provider data including utilizing AzAHP forms to track provider data requests and weekly quality control processes to audit provider updates. **[Access]** • HCA ACC met all minimum network requirements for all assigned counties except Apache County. **[Access]** • HCA ACC met all minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; BHRF; Cardiologist, Adult and Pediatric; Hospital; OB/GYN; PCP, Adult and Pediatric; and Pharmacy. **[Access]** Note: HCA ACC provides coverage in the following counties: Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal, and Yavapai
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: • Isolated data issues may have contributed to specific instances affecting HCA ACC's compliance with time/distance standards. **[Access]** Recommendation: HSAG recommends that AHCCCS support HCA ACC in continuing to monitor the Contractor's processes for creating the PAT file and review this file for accuracy prior to submitting to AHCCCS. • HCA ACC did not meet the minimum network requirements for Dentist, Pediatric. **[Access]** Recommendation: HSAG recommends that HCA ACC maintain current compliance with network standards and continue to address network gaps, as applicable.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-77 presents NAV recommendations made to HCA ACC in the CYE 2023 Annual Technical Report[117] and HCA ACC's follow-up to the recommendations, as well as an assessment of the degree to which HCA ACC has effectively addressed the recommendations. Language in this section is minimally

[117] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf. Accessed on: Feb 23, 2025.

edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-77—HCA ACC Follow-Up to CYE 2023 NAV Recommendations

Prior Year's Recommendation From the EQR Technical Report for NAV
HSAG recommended that HCA ACC maintain current compliance with network standards but continue to address network gaps, as applicable.

HCA ACC's Response:

Health Choice acknowledges the opportunities for improvement and recommendations and has taken steps to address network gaps. The chart below recognizes improvements in network adequacy from Q2 CYE 2023 to Q4 CYE 2023.

County	Provider Category	Q2 2023	Q4 2023
Apache	Dentist, Pediatric	85.2	86.3
Coconino	Dentist, Pediatric	85.5	95.5
Coconino	Behavioral Health OP and IC, Adult	76.8	98.0
Coconino	Behavioral Health OP and IC, Pediatric	68.1	96.7

At the end of Q4 CYE 2023, Health Choice was deficient in only one specialty, Pediatric Dentistry, in Apache County. We are working to recruit providers to address the shortages in this medically underserved county and monitoring network changes. To support access to care, Health Choice has partnered with dentists who conduct healthcare events using mobile dental vehicles in underserved areas such as Apache County.

As acknowledged in HSAG's identified opportunities for improvement, there was an isolated data issue contributing to specific instances affecting our compliance with time/distance standards in Q2 for Behavioral Health Outpatient and Integrated Clinic—Adult and Pediatric. As illustrated by the adequacy results in Q4, the issue has been corrected and we are in compliance with time/distance standards. In Provider Categories where Health Choice reported results that differ from HSAG's results (Mismatch), it was determined that the overall Average Difference Mismatch was less than 1 percent. This analysis considers the results for Q2 CYE 2023 and Q4 CYE 2023.

The greatest mismatch noted was in pharmacy, where Health Choice reported a higher percentage of members meeting the standard than HSAG. Our pharmacy benefit manager handles recruiting and managing our pharmacy network, including major chains and independent pharmacies. At the same time, Health Choice also uses geo-mapping software to ensure compliance with access standards and monitors for accuracy in data reporting.

Prior Year's Recommendation From the EQR Technical Report for NAV		
A. Time Period	**Average Difference Mismatch**	
	Q2 2023	**Q4 2023**
D. Provider Category: Pharmacy	2.24%	2.60%

The greatest mismatch noted was in PCP—Pediatric for Q2 CYE 2023, where HSAG reported a higher percentage of members meeting the standard than Health Choice. Using geo-mapping software and the AHCCCS Saturation data to monitor for reporting accuracy, we significantly diminished the average mismatch in the following reporting period Q4 CYE 2023.

A. Time Period	Average Difference Mismatch	
	Q2 2023	Q4 2023
D. Provider Category: PCP, Pediatric	-3.20%	-0.10%

Upon receiving HSAG data, Health Choice conducts a thorough analysis, as illustrated in this response, to identify and correct any discrepancies as necessary.

Health Choice has processes, policies, and procedures in place to continually assess and evaluate the adequacy of our provider network. We understand that network adequacy is a multifaceted measure of performance that enables health plans to attract and retain members, enhance member satisfaction and experience, ensure compliance with regulatory bodies, support cost-effective provider agreements, expand our geographical footprint, and ultimately meet and satisfy the health care needs of our membership. Our strategies and innovative approach to the development and accessibility of our provider network is not limited to the following:

- Continued investment and training in data analytics: The use of advanced analytics and investment with our internal/external partners allows us to collect and analyze data on provider performance, member utilization, member demographics, and outcomes. These key indicators allow us to identify trends and make decisions supported by data-driven results to improve the continued development of our provider network.
- Expand geographic coverage: Continued provider network expansion ensures the geographical mix and diversity of our network which ultimately expands coverage to our members and ensures member choice, where applicable. We engage and collaborate with community partners, internal departments, regulatory bodies, and members to improve access to healthcare services following the identification of potential service gaps. The Health Choice provider network also includes providers capable of delivering care through alternative methods such as telehealth, virtual clinics, field clinics, and mobile services to improve accessibility in underserved areas.
- Member engagement: Our dedicated staff makes every effort to enhance member education to raise awareness for services available to members such as telehealth, member incentives, etc. Our goal is to obtain members' feedback to facilitate members' engagement as they make informed decisions in their own healthcare journey for the improvement of healthier outcomes.

Prior Year's Recommendation From the EQR Technical Report for NAV
HSAG's Assessment: HSAG determined that HCA ACC satisfactorily addressed these prior year's recommendations.

Mercy Care ACC-RBHA

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2024, HSAG evaluated Mercy Care ACC-RBHA's data system for processing of each data type used for reporting the Contractor's CY 2023 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that Mercy Care ACC-RBHA followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-78 displays HSAG's PMV findings for each data type reviewed during CYE 2024 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 5-78—CYE 2024 PMV Findings

Data Type	HSAG Findings
Medical Services Data	*No identified concerns*
Enrollment Data	*No identified concerns*
Provider Data	*No identified concerns*
Medical Record Review Process	*No identified concerns*
Supplemental Data	*No identified concerns*
Data Integration	*No identified concerns*

Results for Performance Measures

Table 5-79 presents the CY 2022 and CY 2023 Mercy Care ACC-RBHA performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and MY 2023. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and/or MY 2023. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 5-79—CY 2022 and CY 2023 Mercy Care ACC-RBHA Performance Measure Results

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	84.9%+	89.8%#	—	★★★★

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Postpartum Care	78.1%+	79.3%#	—	★★
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	53.8%	51.3%	↓	★
Effective Continuation Phase Treatment—Total (18+ Years)	35.2%	35.7%	→	★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	33.1%	31.3%	→	★★★★
30-Day Follow-Up—Total (13+ Years)	42.9%	41.3%	→	★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	48.2%	52.3%	↑	★★★★
30-Day Follow-Up—Total (6+ Years)	65.5%	69.6%	↑	★★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	52.1%	51.1%	→	★★★★
30-Day Follow-Up—Total (6+ Years)	63.0%	60.2%	→	★★★
Use of Opioids at High Dosage				
*18+ Years**	9.1%	8.6%	→	★
Initiation and Engagement of Substance Use Disorder (SUD) Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	54.5%	52.4%	↓	★★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	20.7%	20.0%	→	★★★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	57.7%	41.6%	↓	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	81.1%	83.2%	↑	★★★
Care of Acute and Chronic Conditions				
Controlling High Blood Pressure				
18–85 Years	59.9%+	67.6%+	↑	★★★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0%)—Total (18–75 Years)	58.4%+	64.0%+	→	★★★★★
*Poor HbA1c Control (>9.0%)—Total (18–75 Years)**	34.8%+	28.2%+	↑	★★★★
Pediatric Health				
Metabolic Monitoring for Children and Adolescents on Antipsychotics				

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	52.9%	52.5%	→	★★★★
Childhood Immunization Status*				
Combination 3	56.9%+	62.5%+	→	★★
Combination 7	52.8%+	51.3%+	→	★★
Combination 10	23.1%+	24.3%+	→	★★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	89.1%+	87.1%+	→	★★★★
Combination 2 (Meningococcal, Tdap, HPV)	40.1%+	41.4%+	→	★★★
Oral Evaluation, Dental Services				
Total (0–20 Years)[N]	52.2%	71.9%	↑	—
Well-Child Visits in the First 30 Months of Life				
First 15 Months—Six or More Well-Child Visits	65.1%	67.9%	↑	★★★★
15 Months to 30 Months—Two or More Well-Child Visits	63.1%	66.3%	↑	★★
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	49.6%	53.6%	↑	★★★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	54.3%	55.3%	↑	★★★
Cervical Cancer Screening				
21–64 Years	60.1%+	60.8%+	→	★★★
Appropriate Utilization of Services				
Ambulatory Care				
Emergency Department (ED) Visits —Total (0–85+ Years)[F]	519.6	510.9	—	—
Plan All-Cause Readmissions				
*Observed/Expected (O/E) Ratio—Total (18–64 Years)**	1.0103	0.9682	—	★★

* A lower rate indicates better performance for this measure.
** Table A-2 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
+ Indicates the measure was reported using hybrid methodology.
# Rate is as reported by the MCO in the NCQA HEDIS IDSS, which may influence comparability to the MCO rates reported through PMV.
Cells shaded green indicate that the rate met or exceeded the MY 2022 and/or MY 2023 national Medicaid mean.
— Indicates a 2022–2023 comparison is not presented in the CYE 2024 Annual Technical Report because either the CY 2022 rate was not presented in the CYE 2023 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
[1]Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a p value of <0.01 due to large denominators.

[2] Performance Levels for CY 2023 were based on comparisons of the HEDIS MY 2023 measure rates to national Medicaid Quality Compass HEDIS MY 2023 benchmarks.
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.
[N] Measure has no NCQA Medicaid mean for comparison.
↑ Indicates statistically significant improvement of measure rates.
↓ Indicates statistically significant decline of measure rates.
→ Indicates no statistically significant change in measure rates.
Performance Levels for 2023 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 5-80 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-80—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Maternal and Perinatal Care measure group, both of Mercy Care ACC-RBHA's measure rates (100.0 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. **[Quality]**
In the Behavioral Health measure group: • Nine of 13 Mercy Care ACC-RBHA measure rates (69.23 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023: **[Quality, Timeliness, Access]** – *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)* and *30-Day Follow-Up—Total (13+ Years)* – *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* – *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* – *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* and *Engagement of SUD Treatment—Total—Total (13+ Years)* – *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (18–64 Years)*

Strengths, Opportunities for Improvement, and Recommendations
• Mercy Care ACC-RBHA's performance measure rates for *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years), Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years), Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years),* and *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years*) and *Engagement of SUD Treatment—Total—Total (13+ Years*) were at or between the 75th and 89th percentile, indicating good follow-up and/or coordinated care following ED, inpatient, or SUD treatment. **[Quality, Timeliness, Access]**
In the Care of Acute and Chronic Conditions measure group, Mercy Care ACC-RBHA measure rates for *Controlling High Blood Pressure—18–85 Years, Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 %)—Total (18–75 Years)* and *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)* met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. In addition, the Mercy Care ACC-RBHA measure rate for *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 %)—Total (18–75 Years)* met or exceeded the 90th percentile. **[Quality]**
In the Pediatric Health measure group: • Five of 11 Mercy Care ACC-RBHA measure rates (45.45 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. **[Quality, Timeliness, Access]** • Mercy Care ACC-RBHA's performance measure rate for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)* was at or between the 75th and 89th percentile, indicating that most children and adolescents with ongoing antipsychotic medication use had metabolic testing performed. Metabolic monitoring (blood glucose and cholesterol testing) is an important component of ensuring appropriate management of children and adolescents on antipsychotic medications.[118] **[Quality]** • Mercy Care ACC-RBHA's performance measure rate for *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* was at or between the 75th and 89th percentile, indicating many adolescent members are receiving the recommended vaccinations. **[Quality]** • Mercy Care ACC-RBHA's performance measure rate for *Well-Child Visits in the First 30 Months of Life—First 15 Months—Six or More Well-Child Visits* was at or between the 75th and 89th percentile, indicating most child members had six or more well-child visits with a PCP during their first 15 months of life. **[Quality, Access]**
In the Preventive Screening measure group, all of Mercy Care ACC-RBHA's measure rates (100.0 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. **[Quality]**

[118] National Committee for Quality Assurance. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM). Available at: https://www.ncqa.org/hedis/measures/metabolic-monitoring-for-children-and-adolescents-on-antipsychotics/. Accessed on: Feb 13, 2025.

Strengths, Opportunities for Improvement, and Recommendations
Opportunities for Improvement and Recommendations
While Mercy Care ACC-RBHA was successful in reporting valid rates for all AHCCCS-required performance measures for its ACC population, the audit identified recommendations for future years' reporting. **[Quality]** Recommendation: HSAG recommends that Mercy Care ACC-RBHA continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes AHCCCS' requirements for MCO-enrolled members who switch product lines or MCOs and members for whom Mercy Care ACC-RBHA does not hold the primary insurance contract. In addition, HSAG recommends that Mercy Care ACC-RBHA continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES.
In the Behavioral Health measure group, Mercy Care ACC-RBHA's performance measure rate for *Use of Opioids at High Dosage—18+ Years* fell below the 25th percentile indicating an opportunity to identify trends leading to opioid use. **[Quality]** Recommendation: In 2016, opioid-related overdoses accounted for more than 42,000 deaths in the United States. Of those, 40 percent involved prescription opioids. Literature suggests there is a correlation between high dosages of prescription opioids and the risk of both fatal and nonfatal overdose. HSAG recommends that Mercy Care ACC-RBHA follow the CDC guidelines on opioid prescribing for chronic, nonmalignant pain, which recommend the use of "additional precautions" when prescribing dosages ≥50 MED and that providers avoid or "carefully justify" increasing dosages ≥90 mg MED. In 2019, the authors of the 2016 guidelines published commentary that cautioned providers, systems, payers and states from developing policies and practices that are "inconsistent with and go beyond" the guideline recommendations. The commentary included cautions regarding strict enforcement of dosage and duration thresholds, as well as abrupt tapering of opioids. The opioid dosage assessed in this measure is a reference point for health plans to identify members who may be at high risk for opioid overuse and misuse. HSAG recommends outreach to members who fall within this category to assess and schedule interventions as necessary.[119] While Mercy Care ACC-RBHA implemented interventions to improve performance related to opioid use, performance still remained under the 25th percentile in MY 2023. HSAG also recommends that Mercy Care ACC-RBHA identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts.
In the Behavioral Health measure group, Mercy Care ACC-RBHA's performance measure rates for *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total (18+ Years)* fell below the 25th percentile, indicating an opportunity to identify trends leading to antidepressant medication mismanagement. **[Quality]**

[119] National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/ Accessed on: Feb 20, 2025.

Strengths, Opportunities for Improvement, and Recommendations
Recommendation: Suicide is the 10th leading cause of death in the United States. Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy and self-esteem, and can lead to suicide. Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness, and identifying and managing side effects.[120] HSAG recommends that Mercy Care ACC-RBHA consider clinical recommendations shown to improve adherence to antidepressants, such as assessing depressive symptoms at baseline and each follow-up, as well as providing psychoeducation to the member and family.[121]

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-81 presents performance measure recommendations made to Mercy Care ACC-RBHA in the CYE 2023 Annual Technical Report[122] and Mercy Care ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-81—Mercy Care ACC-RBHA Follow-Up to CYE 2023 Performance Measure Recommendations

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Recommendation 1:
In 2016, opioid-related overdoses accounted for more than 42,000 deaths in the United States. Of those, 40 percent involved prescription opioids. Literature suggests there is a correlation between high dosages of prescription opioids and the risk of both fatal and nonfatal overdose. HSAG recommended that Mercy Care ACC-RBHA follow the CDC guidelines on opioid prescribing for chronic, nonmalignant pain, which recommend the use of "additional precautions" when prescribing dosages ≥50 MED and that providers avoid or "carefully justify" increasing dosages ≥90 mg MED. In 2019, the authors of the 2016 guidelines published commentary that cautioned providers, systems, payers and states from developing policies and practices that are "inconsistent with and go beyond" the guideline recommendations. The commentary included cautions regarding strict enforcement of dosage and duration thresholds, as well as abrupt tapering of opioids. The opioid dosage assessed in this measure is a reference point for health plans to identify members who may be at high risk for

[120] National Committee for Quality Assurance. Antidepressant Medication Management. Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management. Accessed on: Feb 13, 2025.
[121] Solmi M, Miola A, Croatto G, et al. How can we improve antidepressant adherence in the management of depression? A targeted review and 10 clinical recommendations. *Brazilian Journal of Psychiatry*. 2021;43(2):189–202.
[122] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Repor*t. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf. Accessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
opioid overuse and misuse. HSAG recommended outreach to members who fall within this category to assess and schedule interventions as necessary.[123]
Mercy Care ACC-RBHA's Response: Mercy Care is following the CDC guideline. As a result of this analysis, Mercy Care developed the following interventions aimed at reducing the number and percentage of members who are prescribed high dose opioids: • Pharmacy Risk Prevention Report including members at risk for adherence noncompliance and gap in care data (measures: *AMM*, *HDO*, *SAA*, *SPD*, *SPC*, *SSD,* and *UOP*). • Opioid/SUD best practices presentation to Mercy Care Value-Based Service (VBS) providers by the MC associate chief medical officer. • Educational Outreach Program (EOP) with provider fax including targeted member information for providers identified as having members on > 90MME. This also includes an opioid prescriber report card. • Telephonic one-on-one provider outreach to the top 10 high morphine milligram equivalents (MME) prescribers. • SMS (PBM program): This program targets high-risk drug classes, focusing on controlled substances, and inappropriate use and misuse related indicators such as poly-pharmacy, provider shopping, and high-total controlled substance claims volume. On a quarterly basis, clinical pharmacists will evaluate controlled substance claims and any available supporting medical data to identify potential medication misuse and inappropriate claims for appropriate intervention. During subsequent quarters, pharmacists conduct follow-up activities utilizing physician responses and current claim activity. Situations identified as being potentially inappropriate may be referred to the client (plan) for further action. • Creation and distribution of a report of members who are utilizing 50–89 MME for provider awareness and intervention prior to the member reaching 90 MME. • Mercy Care's associate chief medical officer outreach to prescribing providers of members who are in the *HDO* measure numerator. • Mercy Care case managers will outreach members in the *HDO* measure for care coordination. Mercy Care will continue to monitor the plan's performance with this measure through the additional phases of the PDSA cycle and modify existing interventions or implement additional interventions as necessary.
HSAG's Assessment: Mercy Care ACC-RBHA identified interventions that were implemented for CY 2023 as a result of conducting a root cause analysis; therefore, HSAG determined that Mercy Care ACC-RBHA satisfactorily addressed the prior year's recommendation.

[123] National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/ Accessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Recommendation 2:
Suicide is the 10th leading cause of death in the United States. Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy and self-esteem, and can lead to suicide. Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness and identifying and managing side effects.[124] HSAG recommended that Mercy Care ACC-RBHA conduct a root cause analysis or focus study to determine why some members with a diagnosis of major depression were not receiving continuous medication treatment. 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 ACC-RBHA should implement appropriate interventions to improve performance related to antidepressant medication management. Educating staff and patients continuously to ensure consistent communication of the importance of medication adherence is highly suggested.
Mercy Care ACC-RBHA's Response: Mercy Care conducted a root cause analysis utilizing a fishbone diagram. Factors which may impact member compliance with medication adherence, including adherence to antidepressant medications include: • Provider office staff may not understand the importance of sharing information or may think that they are prohibited from sharing information due to Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. • PCPs may be unaware of members who are nonadherent to their antidepressant medications. • Limited staffing resources at the provider offices to research and identify members who are nonadherent to their antidepressant medications. • Stigma related to the diagnosis of depression. • Side effects, such as weight gain, or adverse drug reactions. Interventions include: • Pharmacy advisor support adherence • Additional retrospective drug utilization review to identify any potential major drug interactions which include antidepressant medication • Monitoring parameters for Behavioral Health Medications Guide (MC Provider Website) • PMMT Program/Care Manager referral program • Data review and best practice identification

[124] National Committee for Quality Assurance. Antidepressant Medication Management. Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management. Accessed on: Feb 13, 2025.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
• Mercy Care Health Assistant Application—member Web portal to provide educational information regarding gaps in care along with digital and written member outreach • Addition of the *AMM* measure to Mercy Care's VBS provider incentive program • Pharmacy Risk Prevention Report including members at risk for adherence noncompliance and gap in care data (measures: *AMM*, *HDO*, *SAA*, *SPD*, *SPC*, *SSD,* and *UOP*) Mercy Care will continue to monitor the plan's performance with this measure through the additional phases of the PDSA cycle and modify existing interventions or implement additional interventions as necessary.
HSAG's Assessment: Mercy Care ACC-RBHA identified interventions that were implemented for CY 2023 as a result of conducting a root cause analysis; therefore, HSAG determined that Mercy Care ACC-RBHA satisfactorily addressed the prior year's recommendation.
Recommendation 3:
HSAG recommended that Mercy Care ACC-RBHA conduct a root cause analysis to determine why some children are not getting their immunizations by their second birthday. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services to implement appropriate interventions. Mercy Care ACC-RBHA should consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). Upon identification of a root cause, HSAG recommended that Mercy Care ACC-RBHA implement appropriate interventions to improve performance related to childhood immunizations.
Mercy Care ACC-RBHA's Response: Mercy Care conducted a root cause analysis utilizing a fishbone diagram. The PHE has been shown to have an influence on both members and providers. As providers were following CDC guidelines by closing offices and dealing with staffing shortages, immunizations visits may have been postponed until they could go back to in-person visits. Routine immunizations were substantially disrupted worldwide. (Greater than 80 million children). Many parents had reservations about the COVID-19 vaccine, which resulted in an impact in traditional vaccines overall. HEDIS audit factors demonstrated areas of opportunity for educating the parents/guardians on the effects of vaccines. Parents do receive a list of no-cost immunization/vaccine clinics in the member handbook. As a result of this analysis, Mercy Care developed the following interventions: • ASIIS Data feeds • WCV outreach calls (6 months, 9 months, 11 months, 18 months, and 3–6 years). Calls emphasize the importance of well-child visits, assessments, vaccines, and preventive care. • EPSDT member mailing—letter is sent to the parents/guardians of members between 0–22 months old, if the outreach staff is unable to get a hold of them via phone call. They also receive a thank you letter if the outreach staff is able to reschedule their appointment.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
• WCV missed visit calls—reminds the members' parents/guardian of a missed well visit, assists with rescheduling needs, and emphasizes the importance of well-child visits to include the importance of assessments, vaccines, and preventive care. • EPSDT member mailing—WCV missed visit letter is sent to the members' parents/guardian if they missed a well visit emphasizing the importance of well-child visits and vaccines. • EPSDT member outreach is sent to the parents/guardians of 1-month old members which includes a WCV and immunization information booklet, an immunization magnet, and a growth chart. All include WCV and vaccines schedules per the periodicity schedule. • EPSDT member mailing—letters, flyers, and postcards are sent to the parents/guardians of members to remind them of their EPSDT well visit and any vaccines needed at that time. These notices are sent at 6 months old, 15 months old, 30 months old, and then every year between 1–20 years old. • Written provider "gaps in care" outreach letter sent to PCPs listing members in need of an EPSDT well visit, immunizations and dental visits for members ages 0–15 months, 18–24 months, and 3–20 years old. The letter also includes a list of adolescent members ages 11 and 12 in need of immunizations. The letter includes details on EPSDT visit requirements such as WCV dates from the EPSDT periodicity schedule, dates for dental visits, and specific vaccines needed listed by age. • EPSDT coordinators meet with the providers either in-person or virtually to discuss the immunization and EPSDT periodicity schedules and advise the provider of members who are not up to date. • EPSDT provider required screening mailing is sent as a reminder on EPSDT visit requirements including information on vaccines. • Distribution of the latest AHCCCS periodicity schedule to MC care managers to remind caregivers of the required visit intervals. • Partnership and collaboration with Phoenix Children's Care Network (PCCN) and Employers Health Network (EHN) to promote EPSDT "awareness." • Mercy Care Health Assistant Application—member Web portal to provide educational information regarding gaps in care along with digital and written member outreach. • Member incentives to complete well-child visits • Health Matters Fall/Winter 2023 Member Newsletter provides the member with information on EPSDT visits and age-appropriate vaccines. • Staying Healthy Fall/Winter 2024 Member Newsletter provides the member with information on EPSDT visits and age-appropriate vaccines. Mercy Care will continue to monitor the plan's performance with this measure through the additional phases of the PDSA cycle and modify existing interventions or implement additional interventions as necessary.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
HSAG's Assessment: Mercy Care ACC-RBHA identified interventions that were implemented for CY 2023 as a result of conducting a root cause analysis; therefore, HSAG determined that Mercy Care ACC-RBHA satisfactorily addressed the prior year's recommendation.

Validation of Performance Improvement Projects

Back to Basics PIP

In CYE 2024, Mercy Care ACC-RBHA continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 2, PIP validation activities focused on improvement from the baseline results. Mercy Care ACC-RBHA submitted Remeasurement 2 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes to or discontinuation of the interventions.

HSAG conducted an annual validation of the second remeasurement year reflective of CY 2023 (January 1, 2023, through December 31, 2023) using AHCCCS-calculated and validated indicator rates. HSAG evaluated Mercy Care ACC-RBHA's performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

Validation Results

Table 5-82 displays the overall confidence levels for the Mercy Care ACC-RBHA *Back to Basics* PIP.

Table 5-82—Mercy Care ACC-RBHA *Back to Basics* PIP Overall Confidence Levels

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]
Mercy Care ACC-RBHA	*Low Confidence*	80%	89%	*High Confidence*	100%	100%

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

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

Measure Results

Table 5-83 and Table 5-84 provide the *Back to Basics* PIP baseline, Remeasurement Year 1, and Remeasurement Year 2 rates for each indicator for Mercy Care ACC-RBHA.

Table 5-83—Mercy Care ACC-RBHA *Back to Basics* PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: *W30 Rate 1*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
Mercy Care ACC-RBHA	65.0%	65.1%	67.9%

HSAG rounded percentages to the first decimal place.

Table 5-84—Mercy Care ACC-RBHA *Back to Basics* PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: *WCV*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
Mercy Care ACC-RBHA	52.9%	49.6%	53.6%

HSAG rounded percentages to the first decimal place.

Interventions

Table 5-85 presents PIP interventions for Mercy Care ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-85—Mercy Care ACC-RBHA *Back to Basics* PIP Interventions

Contractor	Interventions
Mercy Care ACC-RBHA	• Enhanced provider education on the AHCCCS periodicity schedule which requires eight well-visits by age 15 months and annual well-visits after 24 months of age. • Enhanced provider education on well-child visit codes. • Enhanced provider awareness of sick and well-visit combination and coding (modifier 25).

Contractor	Interventions
	• Enhanced provider awareness of Mercy Care's "unlimited" well-child visit policy. • Partnership and collaboration with PCCN and EHN to promote EPSDT "awareness." • Referred new members to PCCN providers for comprehensive EPSDT services and care. • Revised member outreach schedule for members ages 3–6 from a "summer schedule" with calls beginning in April and ending in August, to a monthly schedule to increase well-child visit rates for this age group. • Collaborated with Native Health and the Phoenix Indian Medical Center. • Multi-modal member outreach to members who had gaps in care with well-child visits and/or immunizations. Mercy Care Health Assistant member portal, text messaging, emails, and incentives. • Launched HEDIS and EPSDT Health Equity Provider Training. • Leveraged faith-based organizations to disseminate information on the identified disparities.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-86 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA related to the *Back to Basics* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-86—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
Mercy Care ACC-RBHA developed and implemented interventions that led to statistically significant improvement in both indicator outcomes between baseline and Remeasurement 2. **[Quality, Access]**
Opportunities for Improvement and Recommendations
Mercy Care ACC-RBHA did not update its resubmission narrative summary to reflect the revised statistical testing and did not provide CY 2023 intervention effectiveness data for two interventions. **[Quality, Access]** Recommendations: As the PIP progresses, HSAG recommends that Mercy Care ACC-RBHA: • Seek technical assistance from HSAG to understand the requirements for statistical testing.

Strengths, Opportunities for Improvement, and Recommendations
• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. • Assure that all interventions are evaluated for effectiveness through a measure directly linked to the intervention.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-87 presents PIP recommendations made to Mercy Care ACC-RBHA in the CYE 2023 Annual Technical Report[125] and Mercy Care ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-87—Mercy Care ACC-RBHA Follow-Up to CYE 2023 PIP Recommendations

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG recommended that Mercy Care ACC-RBHA: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. • Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.
Mercy Care ACC-RBHA's Response: Mercy Care continues to review the PIP rates at least quarterly, with an annual final measurement year evaluation once the data are finalized. When the health plan identifies declines in performance, or that the rates are not on track to reach the defined goal, we initiate or follow to the next step in the PDSA cycle. Interventions are assessed for effectiveness and best practices are identified, documented, and incorporated into the health plan's standard operating procedures.
HSAG's Assessment: HSAG determined that Mercy Care ACC-RBHA satisfactorily addressed these prior year's recommendations.

[125] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf. Accessed on: Feb 23, 2025.

Prenatal and Postpartum Care PIP

Overview

AHCCCS initiated the implementation of the *Prenatal and Postpartum Care* PIP for the ACC population in CYE 2022. The objective of the *Prenatal and Postpartum Care* PIP is to improve health outcomes for members and infants. This PIP focuses on increasing the number and percentage of members with live birth deliveries that 1) received a prenatal care visit, and 2) received a postpartum visit. In CYE 2024, Mercy Care ACC-RBHA continued to implement interventions to improve these outcomes and provided updates on the status of each intervention to AHCCCS.

Interventions

Table 5-88—Mercy Care ACC-RBHA *Prenatal and Postpartum Care* PIP Interventions

Contractor	Interventions
Mercy Care ACC-RBHA	Continued interventions to support the *Prenatal and Postpartum Care* PIP in CYE 2024 include: • Leveraging the ACOG data submitted to the perinatal Integrated Care Management (ICM) team for low-risk pregnancy identification, in addition to use by perinatal CM team. • Leveraging newborn notifications for identification of postpartum members. • Implementing a process to identify pregnant members through positive pregnancy tests in the HIE. • Revising the outreach process so that the postpartum mailing is sent to the member regardless of whether or not the member's PCP or baby's PCP information is available (revised letter template and process). • Written educational information: member handbook, member newsletters, maternity booklets, letters and flyers that focus on the components of prenatal and postpartum visits. • Provider letter is mailed to PCPs and OB/GYNs letting them know they have a newly pregnant member that requires prenatal/postpartum care. • Virtual or face-to-face contacts between the Mercy Care coordinators, PCPs, and OB/GYNs to provide education on the components of prenatal/postpartum visits. • MCH outreach call staff assist with setting appointments and provide information on community resources during their outreach calls. • MCH outreach call staff submit referrals to the perinatal ICM team for care management identification discovered during the outreach call. • MCH coordinators assist the care management department by providing outreach to members to verify the need for care management during their

Contractor	Interventions
	pregnancy. During these calls the coordinators also assist with setting appointments and providing information on community resources. • Improving medical record retrieval processes to ensure requested records for all sample members are received. • Prenatal and postpartum member incentives for all LOBs. • Healthmine application—member Web portal. • Add the prenatal care measure to Mercy Care's VBS contracts. • Sharing of gap in care data, which includes identified race and ethnicity, with Mercy Care VBS providers for outreach and care coordination. • Collecting available SDOH data from sources including but not limited to claims, SocialScape, and Pyx.

Strengths, Opportunities for Improvement, and Recommendations

HSAG did not conduct validation on the *Prenatal and Postpartum Care* PIP in CYE 2024; therefore, strengths, opportunities for improvement, and recommendations are not provided.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-89 presents PIP recommendations made to Mercy Care ACC-RBHA in the CYE 2023 Annual Technical Report[126] and Mercy Care ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-89—Mercy Care ACC-RBHA Follow-Up to CYE 2023 PIP Recommendations

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG recommended that Mercy Care ACC-RBHA: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. • Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.

[126] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf. Accessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for PIPs
Mercy Care ACC-RBHA's Response: Mercy Care continues to review the PIP rates at least quarterly, with an annual final measurement year evaluation once the data are finalized. When the health plan identifies declines in performance, or that the rates are not on track to reach the defined goal, we initiate or follow to the next step in the PDSA cycle. Interventions are assessed for effectiveness and best practices are identified, documented, and incorporated into the health plan's standard operating procedures.
HSAG's Assessment: HSAG determined that Mercy Care ACC-RBHA satisfactorily addressed these prior year's recommendations.

Compliance Reviews

Results

AHCCCS conducted a compliance review of Mercy Care ACC-RBHA from February 12, 2024, through February 15, 2024. On May 2, 2024, AHCCCS finalized the report findings, provided Mercy Care ACC-RBHA with a CAP submission matrix, and required a CAP for any standard with a total score of less than 95 percent. On June 7, 2024, AHCCCS accepted Mercy Care ACC-RBHA's proposed CAPs and required the Contractor to submit updated policies, manuals, desktop procedures, and other vital documents to provide evidence of CAP completion. CAP items were under review by AHCCCS at the time this report was being written. Results of the CAP update will be included in the CYE 2025 annual technical report.

Table 5-90—Mercy Care ACC-RBHA Compliance Review Results

Compliance Focus Areas	CYE 2024 Mercy Care ACC-RBHA Scores	CYE 2024 Program-Level Average
CC	100%	95%
CIS	99%	99%
DS	97%	97%
GA	96%	97%
GM	100%	100%
GS	100%	100%
MCH	96%	96%
MM	97%	95%
MI	90%	94%
QM	95%	89%
QI	100%	100%

Compliance Focus Areas	CYE 2024 Mercy Care ACC-RBHA Scores	CYE 2024 Program-Level Average
RI	100%	100%
TPL	100%	100%
ISOC	99%	99%

Strengths, Opportunities for Improvement, and Recommendations

Table 5-91 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA based on compliance activities conducted in CYE 2024, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-91—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
Mercy Care ACC-RBHA scored at or above 95 percent in the following focus areas: • Claims and Information Standards (CIS) **[Access]** • Delivery Systems (DS) **[Timeliness, Access]** • General Administration (GA) **[Timeliness, Access]** • Grants Management (GM) **[Quality, Access]** • Grievance Systems (GS) **[Timeliness, Access]** • Adult, EPSDT and Maternal Child Health (MCH) **[Quality, Timeliness, Access]** • Medical Management (MM) **[Timeliness, Access]** • Quality Management (QM) **[Quality]** • Quality Improvement (QI) **[Quality, Access]** • Reinsurance (RI) **[Quality]** • Third-Party Liability (TPL) **[Quality, Timeliness, Access]** • Integrated Systems of Care (ISOC) **[Quality, Access]** AHCCCS approved Mercy Care ACC-RBHA's proposed CAPs for all focus areas with scores less than 95 percent. Mercy Care ACC-RBHA provided evidence of CAP completion at the end of CYE 2024.
Opportunities for Improvement and Recommendations
Mercy Care ACC RBHA scored below 95 percent in the following focus area: • Member Information (MI) **[Quality]**

Strengths, Opportunities for Improvement, and Recommendations
Recommendation: HSAG recommends that Mercy Care ACC-RBHA continue to work with AHCCCS on closing remaining CAPs.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Compliance review recommendations were not included in the CYE 2023 EQR technical report as compliance review activities were not conducted in CYE 2023; therefore, no follow-up was required by Mercy Care ACC-RBHA.

Network Adequacy Validation

ISCA Results

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

Table 5-92 summarizes HSAG's validation ratings for Mercy Care ACC-RBHA by indicator type.

Table 5-92—Summary of Mercy Care ACC-RBHA's Validation Ratings by Indicator Type

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

Of the network adequacy indicators assessed, Mercy Care ACC-RBHA received *High Confidence* for both appointment availability and time/distance indicators. However, there were identified areas for improvement; please refer to the Contractor-specific Strengths, Opportunities for Improvement, and Recommendations section below for more details.

NAV Results

HSAG evaluated Mercy Care ACC-RBHA's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents CYE 2024 S1 validation findings specific to the ACC Program, with one results table for the following GSA:

- Central GSA: Gila, Maricopa, and Pinal counties

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

Table 5-93—Time/Distance Validation Results for Mercy Care ACC-RBHA Central GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^[1]	99.1^[1]	100.0^[1]
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0^[1]	99.2^[1]	100.0^[1]
BHRF	NA	99.5	NA
Cardiologist, Adult	100.0^	100.0^	100.0^
Cardiologist, Pediatric	100.0^	100.0^	100.0^
Dentist, Pediatric	98.9	99.6	100.0
Hospital	100.0[1]	99.9[1]	100.0[1]
OB/GYN	100.0	99.9	100.0
Pharmacy	100.0	99.1	100.0
PCP, Adult	100.0^	99.8^	100.0^
PCP, Pediatric	100.0^	99.7^	100.0^

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

^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

[1] In CYE 2024 S1, Mercy Care ACC-RBHA's data included substantially increased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; and Hospital. When contacted, Mercy Care ACC-RBHA indicated that it inadvertently included home office addresses in its report of service addresses, raising the number of providers in the count. The increased number of providers potentially influenced the validated compliance for these provider categories.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-94 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-94—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to NAV

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

Strengths, Opportunities for Improvement, and Recommendations
• Mercy Care ACC-RBHA demonstrated its capability for ensuring the accuracy and completeness of its provider network by conducting rigorous quality assurance processes, including monthly provider data reconciliations, maintaining regular provider outreach and communication, and conducting annual audits of provider data. **[Access]** • Mercy Care ACC-RBHA met all minimum network requirements for all assigned counties. **[Access]** Note: Mercy Care ACC-RBHA provides coverage in the following counties: Gila, Maricopa, and Pinal.
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: • Isolated data issues may have contributed to specific instances affecting Mercy Care ACC-RBHA's compliance with time/distance standards. **[Access]** Recommendation: HSAG recommends that AHCCCS support Mercy Care ACC-RBHA in continuing to monitor the Contractor's processes for creating the PAT file and review this file for accuracy prior to submitting to AHCCCS. • HSAG identified an opportunity for Mercy Care ACC-RBHA to improve the results to calculate time/distance indicators. **[Access]** Recommendation: HSAG recommends that Mercy Care ACC-RBHA incorporate additional oversight and monitoring when transferring Quest-generated output to the ACOM Policy 436 template to ensure the most accurate results are being submitted to AHCCCS**.**

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-95 presents NAV recommendations made to Mercy Care ACC-RBHA in the CYE 2023 Annual Technical Report[127] and Mercy Care ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

[127] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf. Accessed on: Feb 23, 2025.

Table 5-95—Mercy Care ACC-RBHA Follow-Up to CYE 2023 NAV Recommendations

Prior Year's Recommendation From the EQR Technical Report for NAV
HSAG did not have any recommendations specific to Mercy Care ACC-RBHA's existing provider network coverage; therefore, the Contractor should continue to maintain current compliance with network standards.
Mercy Care ACC-RBHA's Response: Mercy Care continues existing processes to ensure that the plan maintains compliance with the AHCCCS-required network coverage requirements.
HSAG's Assessment: HSAG has determined that Mercy Care ACC-RBHA has satisfactorily addressed the prior year's recommendation.

Molina ACC

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2024, HSAG evaluated Molina ACC's data system for processing of each data type used for reporting the Contractor's CY 2023 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that Molina ACC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-96 displays HSAG's PMV findings for each data type reviewed during CYE 2024 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 5-96—CYE 2023 PMV Findings

Data Type	HSAG Findings
Medical Services Data	*No identified concerns*
Enrollment Data	*No identified concerns*
Provider Data	*No identified concerns*
Medical Record Review Process	*No identified concerns*
Supplemental Data	*No identified concerns*
Data Integration	*No identified concerns*

Results for Performance Measures

Table 5-97 presents the CY 2022 and CY 2023 Molina ACC performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and MY 2023. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and/or MY 2023. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 5-97—CY 2022 and CY 2023 Molina ACC Performance Measure Results

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	83.7%+	85.4%+	→	★★★
Postpartum Care	64.2%+	66.4%+	→	★
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	63.7%	57.3%	↓	★★
Effective Continuation Phase Treatment—Total (18+ Years)	48.1%	37.5%	↓	★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	30.8%	30.3%	→	★★★★
30-Day Follow-Up—Total (13+ Years)	40.5%	37.6%	→	★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	34.3%	46.3%	↑	★★★
30-Day Follow-Up—Total (6+ Years)	54.2%	63.3%	↑	★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	46.3%	42.0%	→	★★★
30-Day Follow-Up—Total (6+ Years)	56.3%	64.0%	→	★★★★
Use of Opioids at High Dosage				
*18+ Years**	1.6%	2.2%	→	★★★
Initiation and Engagement of Substance Use Disorder (SUD) Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	56.6%	56.7%	→	★★★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	21.8%	24.0%	→	★★★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	31.3%	41.7%	→	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	75.3%	76.7%	→	★
Care of Acute and Chronic Conditions				
Controlling High Blood Pressure				
18–85 Years	39.7%+	57.7%+	↑	★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0%)—Total (18–75 Years)	44.3%+	46.2%+	→	★

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
*Poor HbA1c Control (>9.0%)—Total (18–75 Years)**	49.1%+	44.0%+	→	★
Pediatric Health				
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	40.9%	41.4%	→	★★★
Childhood Immunization Status*				
Combination 3	61.1%+	58.9%+	→	★
Combination 7	55.2%+	50.1%+	→	★
Combination 10	26.3%+	18.2%+	↓	★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	78.6%+	80.5%+	→	★★
Combination 1 (Meningococcal, Tdap)	31.4%+	27.7%+	→	★
Oral Evaluation, Dental Services				
Total (0–20 Years)[N]	6.4%	3.3%	↓	—
Well-Child Visits in the First 30 Months of Life				
First 15 Months—Six or More Well-Child Visits	56.0%	63.1%	↑	★★★
15 Months to 30 Months—Two or More Well-Child Visits	54.6%	67.3%	↑	★★
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	39.6%	43.5%	↑	★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	47.3%	49.1%	↑	★★
Cervical Cancer Screening				
21–64 Years	37.7%+	43.6%+	→	★
Appropriate Utilization of Services				
Ambulatory Care				
Emergency Department (ED) Visits —Total (0–85+ Years)[F]	544.2	515.9	—	—
Plan All-Cause Readmissions				
*Observed/Expected (O/E) Ratio—Total (18–64 Years)**	1.2529	1.1562	—	★

* A lower rate indicates better performance for this measure.
** Table A-2 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
+ Indicates the measure was reported using hybrid methodology.
Cells shaded green indicate that the rate met or exceeded the MY 2022 and/or MY 2023 national Medicaid mean.

— Indicates a 2022–2023 comparison is not presented in the CYE 2024 Annual Technical Report because either the CY 2022 rate was not presented in the CYE 2023 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
[1]Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.
[2] Performance Levels for CY 2023 were based on comparisons of the HEDIS MY 2023 measure rates to national Medicaid Quality Compass HEDIS MY 2023 benchmarks.
[D] DNR indicates the measure received a Do Not Report designation for CY 2023.
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.
[N] Measure has no NCQA Medicaid mean for comparison.
↑ Indicates statistically significant improvement of measure rates.
↓ Indicates statistically significant decline of measure rates.
→ Indicates no statistically significant change in measure rates.
Performance Levels for 2023 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 5-98 presents strengths, opportunities for improvement, and recommendations for Molina ACC related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-98—Molina ACC Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group: • Nine of 13 Molina ACC measure rates (69.23 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023: **[Quality, Timeliness, Access]** – *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)* and *30-Day Follow-Up—Total (13+ Years)* – *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* – *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* – *Use of Opioids at High Dosage—18+ Years* – *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* and *Engagement of SUD Treatment—Total—Total (13+ Years)* • Molina ACC's performance measure rates for *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)* and *Follow-Up After ED Visit for Mental Illness—30-Day Follow-*

Strengths, Opportunities for Improvement, and Recommendations
Up—Total (6+ Years) were at or between the 75th and 89th percentile, indicating that most members received follow-up or coordinated care after an ED visit for substance use or mental illness. **[Quality, Timeliness, Access]** • Molina ACC's performance measure rate for *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* was at or above the 90th percentile, and the performance rate for *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* was at or between the 75th and 89th percentile, indicating that most members diagnosed with SUD initiated treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization treatment, or MAT within 14 days of diagnosis and had two more or more additional SUD services or medications within 34 days of the initiation visit.[128] **[Quality, Timeliness, Access]**
Opportunities for Improvement and Recommendations
While Molina ACC was successful in reporting valid rates for all AHCCCS-required performance measures for its ACC population, the audit identified a recommendation for future years' reporting. **[Quality]** Recommendation: HSAG recommends that Molina ACC continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES.
In the Maternal and Perinatal Care measure group, Molina ACC's performance measure rate for *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, indicating an opportunity to increase access to timely postpartum care. Timely and adequate postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.[129] **[Quality, Timeliness, Access]** Recommendation: While Molina ACC conducted a root cause analysis and implemented interventions specific to the *Prenatal and Postpartum Care—Postpartum Care* measure indicator, this rate remained low in MY 2023; therefore, HSAG recommends that Molina ACC continue to implement appropriate interventions to improve performance related to postpartum care. HSAG also recommends that Molina ACC monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care* measure, submitting the results of interventions as required by AHCCCS. HSAG recommends that Molina ACC consider whether there are disparities/SDOH within the Molina ACC population that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that Molina ACC implement

[128] National Committee for Quality Assurance. Initiation and Engagement of Substance Use Disorder Treatment. Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-substance-use-disorder-treatment/. Accessed on: Feb 13, 2025.
[129] National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/. Accessed on: Feb 13, 2025.

Strengths, Opportunities for Improvement, and Recommendations
appropriate interventions to reduce barriers to care. A few strategies could include providing expanded access appointments outside of business hours to accommodate work schedules or childcare needs. Further, HSAG recommends that Molina ACC identify payment structure types that will incentivize quality care. Bundling payments may cause disincentives for postpartum care, as providers might receive the same payment regardless of whether the member attends the postpartum visit.[130]
In the Behavioral Health measure group: • Molina ACC's performance measure rate for *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication—18–64 Years* fell below the 25th percentile, indicating an opportunity for diabetes screening testing to be done. **[Quality]** Recommendation: Heart disease and diabetes are among the top 10 leading causes of death in the United States. Since people with SMI who use antipsychotics are at increased risk of cardiovascular diseases and diabetes, screening and monitoring of these conditions is important. Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health, quality of life, and economic outcomes downstream.[131] HSAG recommend that Molina ACC evaluate barriers to screening such as coordinating with laboratories or communication between behavioral health providers and PCPs. HSAG recommends that Molina ACC build in automatic screening alerts into the EMR if screening tests are necessary. HSAG also recommends that Molina ACC encourage members to see a PCP, as people with at least one primary care visit were more likely to be screened. • Molina ACC's performance measure rate for *Adherence to Antipsychotic Medications for Individuals With Schizophrenia —18+ Years* fell below the 25th percentile, indicating an opportunity for members to increase adherence to antipsychotics for members with schizophrenia. Schizophrenia is a chronic and disabling psychiatric disorder that requires ongoing treatment and monitoring. Symptoms include hallucinations, illogical thinking, memory impairment, and incoherent speech. Medication nonadherence is common and a major concern in the treatment of

[130] Centers for Medicare & Medicaid Services. Lessons Learned about Payment Strategies to Improve Postpartum Care in Medicaid and CHIP. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/postpartum-payment-strategies.pdf. Accessed on: Feb 23, 2025.

[131] National Committee for Quality Assurance. Diabetes and Cardiovascular Screening Disease Screening and Monitoring for People With Schizophrenia or Bipolar Disorder (SSD) Available at: https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/. Accessed on: Feb 13, 2025.

Strengths, Opportunities for Improvement, and Recommendations
schizophrenia. Using antipsychotic medications as prescribed reduces the risk of relapse or hospitalization.[132] **[Quality]** Recommendation: While Molina ACC conducted a root cause analysis and implemented interventions specific to the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia —18+ Years* measure, this rate remained low in MY 2023. HSAG recommends that Molina ACC continue to monitor and expand on interventions currently in place to improve performance related to the continuous medication treatment for members with a diagnosis of schizophrenia.
In the Preventive Screening measure group, Molina ACC's performance measure rate for *Cervical Cancer Screening—21–64 Years* fell below the 25th percentile, indicating that women were not always receiving timely screening for cervical cancer. 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. Prolonged delays in screening may lead to delayed diagnoses, poor health consequences, and an increase in cancer disparities among women already experiencing health inequities.[133] **[Quality]** Recommendation: While Molina ACC conducted a root cause analysis and implemented interventions specific to the *Cervical Cancer Screening—21–64 Years* measure rate, this rate remained low in MY 2023; therefore, HSAG recommends that Molina ACC continue to monitor and expand on interventions currently in place to improve performance related to the *Cervical Cancer Screening—21–64 Years* measure, submitting the results of interventions to AHCCCS in its QM/PI Plan.
In the Pediatric Health measure group: • Molina ACC's performance measure rate for *Child and Adolescent Well-Care Visits—Total (3–21 Years)* fell below the 25th percentile, indicating that children and adolescents were not always receiving their well-care visits. Assessing physical, emotional, and social development is important at every stage of life, particularly for children and adolescents. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[134] **[Quality, Access]**

[132] National Committee for Quality Assurance. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA). Available at: https://www.ncqa.org/hedis/measures/adherence-to-antipsychotic-medications-for-individuals-with-schizophrenia/. Accessed on: Feb 13, 2025.

[133] Centers for Disease Control and Prevention. Sharp Declines in Breast and Cervical Cancer Screening. Available at: https://archive.cdc.gov/#/details?q=Sharp%20Declines%20in%20Breast%20and%20Cervical%20Cancer%20Screening&start=0&rows=10&url=https://www.cdc.gov/media/releases/2021/p0630-cancer-screenings.html. Accessed on: Feb 13, 2025.

[134] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Feb 13, 2025.

Strengths, Opportunities for Improvement, and Recommendations
Recommendation: While Molina ACC conducted a root cause analysis and implemented interventions specific to *Child and Adolescent Well-Care Visits—Total (3–21 Years)*, this rate remained low in MY 2023; therefore, HSAG recommends that Molina ACC continue to identify best practices to support children in receiving well-care visits according to recommended schedules. HSAG recommends that Molina ACC draw as needed from other states' performance improvement initiatives. For instance, as part of a federal performance initiative to improve well-child care, California and Virginia have focused on delays in newborn enrollment data, and Missouri and Texas focused on beneficiary barriers and implemented interventions such as utilizing patient portals and phone outreach. HSAG recommends that plans identify other barriers to care and conduct a focus group on identifying ways to address barriers.[135] • Molina ACC's performance measure rates for *Childhood Immunization Status* fell below the 25th percentile, indicating opportunities for children who turned 2 years old during the measurement year to have recommended childhood vaccines. Vaccination coverage must be maintained in order to prevent a resurgence of vaccine-preventable diseases.[136] **[Quality, Access]** Recommendation: HSAG recommends that Molina ACC provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.
In the Care of Acute and Chronic Conditions measure group: • Molina ACC's *Controlling High Blood Pressure—18–85 Years* measure rate fell below the 25th percentile, indicating that some members are not adequately controlling their blood pressure. **[Quality]** Recommendation: Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions. Healthcare providers and plans can help individuals manage their high blood pressure by prescribing medications and encouraging low-sodium diets, increased physical activity, and smoking cessation. While Molina ACC conducted a root cause analysis and implemented interventions specific to *Controlling High Blood Pressure—18–85 Years,* this rate remained low in MY 2023; therefore, HSAG recommends that Molina ACC continue to improve performance related to members' high blood pressure control. Molina ACC should submit updated barrier assessments and interventions as required by AHCCCS. HSAG recommends that Molina ACC identify trends within the data to identify which demographic groups and regions report lower blood pressure. HSAG recommends providing coverage for automated home blood pressure

[135] Centers for Medicare & Medicaid Services. Well-Child Care. Available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html. Accessed on: Feb 12, 2025.
[136] National Committee for Quality Assurance. Childhood Immunization Status (CIS). Available at: https://www.ncqa.org/hedis/measures/childhood-immunization-status/. Accessed on: Feb 13, 2025.

Strengths, Opportunities for Improvement, and Recommendations
monitors for patients, while educating members about these benefits. Further, HSAG recommends that Molina ACC provide incentives to members and providers to encourage blood pressure control. • Molina ACC's *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 %)—Total (18–75 Years)* and *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)* measure rates fell below the 25th percentile, indicating poor control over diabetes. **[Quality]** Recommendation: Diabetes is a complex group of diseases marked by high blood glucose (blood sugar) due to the body's inability to make or use insulin. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life. With support from healthcare providers, patients can manage their diabetes with self-care, taking medications as instructed, eating a healthy diet, being physically active, and quitting smoking.[137] While Molina ACC conducted a root cause analysis and implemented interventions specific to *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 %)—Total (18–75 Years)* and *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)* measure rates, these rates remained low in MY 2023; therefore, HSAG recommends that Molina ACC continue to improve performance related to members' control over diabetes. HSAG also recommends that Molina ACC monitor and expand on interventions currently in place to improve performance related to members' HbA1c control. HSAG recommends that Molina ACC consider providing coverage for personal CGMs for Type 1 and Type 2 diabetes. Offering coverage for CGMs coupled with education of providers and patients of this coverage might improve diabetes control. HSAG also recommends that Molina ACC identify whether self-monitoring interventions might be effective, such as EpxDiabetes, which has bidirectional text and call capabilities.[138]

[137] National Committee for Quality Assurance. Comprehensive Diabetes Care. Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Feb 13, 2025.

[138] Xu R, Xing M, Javaherian K, et al. Improving HbA1c with Glucose Self-Monitoring in Diabetic Patients with EpxDiabetes, a Phone Call and Text Message-Based Telemedicine Platform: A Randomized Controlled Trial. Telemedicine journal and e-health : the official journal of the American Telemedicine Association vol. 26,6 (2020): 784-793. Available at: https://read.qxmd.com/read/31621523/improving-hba-1c-with-glucose-self-monitoring-in-diabetic-patients-with-epxdiabetes-a-phone-call-and-text-message-based-telemedicine-platform-a-randomized-controlled-trial. Accessed on: Feb 19, 2025.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-99 presents performance measure recommendations made to Molina ACC in the CYE 2023 Annual Technical Report[139] and Molina ACC's follow-up to the recommendations, as well as an assessment of the degree to which Molina ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-99—Molina ACC Follow-Up to CYE 2023 Performance Measure Recommendations

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Recommendation 1:
While Molina ACC conducted a root cause analysis and implemented interventions specific to the *Prenatal and Postpartum Care—Postpartum Care* measure indicator, this rate remained low in CY 2022; therefore, HSAG recommended that Molina ACC continue to implement appropriate interventions to improve performance related to postpartum care. HSAG also recommended that Molina ACC monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care* measure, submitting the results of interventions as required by AHCCCS.
Molina ACC's Response: In response to HSAG's recommendation regarding the *Prenatal and Postpartum Care—Postpartum Care* measure, Molina prioritized improving performance through targeted interventions and ongoing monitoring. Building on the root cause analysis conducted in 2023, Molina expanded outreach efforts to engage members during critical postpartum periods, leveraging culturally sensitive communication and care coordination strategies. Additionally, Molina collaborated with providers to streamline scheduling and follow-up processes, ensuring timely access to postpartum care. To enhance accountability, Molina implemented a robust tracking system to monitor the effectiveness of interventions, refining strategies based on real-time data and outcomes. Results from these interventions, including measurable improvements in postpartum visit completion rates, were submitted to AHCCCS as required, reflecting Molina's commitment to addressing gaps and improving maternal health outcomes.
HSAG's Assessment: Molina ACC identified interventions that were implemented as a result of conducting a root cause analysis; therefore, HSAG determined that Molina ACC satisfactorily addressed these prior year's recommendations.
Recommendation 2:

[139] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf. Accessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Schizophrenia is a chronic and disabling psychiatric disorder that requires ongoing treatment and monitoring. Symptoms include hallucinations, illogical thinking, memory impairment, and incoherent speech. Medication nonadherence is common and a major concern in the treatment of schizophrenia. Using antipsychotic medications as prescribed reduces the risk of relapse or hospitalization.[140] HSAG recommended that Molina ACC conduct a root cause analysis to determine why members with a diagnosis of schizophrenia were not always receiving continuous medication treatment. Upon identification of a root cause, Molina ACC should continue to implement appropriate interventions to improve performance related to the *Adherence to Antipsychotic Medications for Individuals with Schizophrenia—18+ Years* measure rate. HSAG also recommended that Molina ACC monitor and expand on interventions currently in place to improve performance related to continuous medication treatment for members with a diagnosis of schizophrenia.
Molina ACC's Response: In alignment with HSAG's recommendation, Molina conducted a comprehensive root cause analysis to identify barriers to continuous medication adherence among members with schizophrenia. The analysis revealed key challenges, including access to medications, member engagement, and care coordination. To address these barriers, Molina implemented targeted interventions such as enhanced care coordination through care management, improved access to long-acting injectable antipsychotics, and increased collaboration with behavioral health providers. Educational initiatives for members and caregivers emphasized the importance of medication adherence in reducing relapse and hospitalization risks. Molina also expanded monitoring efforts, utilizing data analytics to track medication adherence trends and the impact of interventions. Results from these efforts have informed ongoing improvements, reflecting Molina's commitment to supporting members with schizophrenia through sustained and effective treatment plans.
HSAG's Assessment: Molina ACC identified interventions that were implemented as a result of conducting a root cause analysis; therefore, HSAG determined that Molina ACC satisfactorily addressed these prior year's recommendations.
Recommendation 3:
Heart disease and diabetes are among the top 10 leading causes of death in the United States. Because persons with SMI who use antipsychotics are at increased risk of cardiovascular diseases and diabetes, screening and monitoring of these conditions is important. Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic

[140] National Committee for Quality Assurance. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA). Available at: https://www.ncqa.org/hedis/measures/adherence-to-antipsychotic-medications-for-individuals-with-schizophrenia/. Accessed on: Feb 13, 2025.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health, quality of life, and economic outcomes downstream.[141]
Molina ACC's Response: Molina recognizes the critical importance of addressing the physical health needs of members with schizophrenia or bipolar disorder who use antipsychotic medications. In response to this recommendation, Molina implemented targeted interventions to enhance screening and monitoring for diabetes and cardiovascular disease in this population. These efforts included integrating physical and behavioral health services, ensuring members receive comprehensive care addressing both their mental and physical health needs. Care coordinators worked closely with providers to facilitate regular screenings for glucose and lipid levels, while also promoting evidence-based management of identified conditions. Member outreach campaigns emphasized the importance of preventive care with educational resources. By addressing these risks proactively, Molina is improving health outcomes, enhancing quality of life, and reducing avoidable healthcare costs for this vulnerable population.
HSAG's Assessment: Molina ACC identified interventions that were implemented as a result of conducting a root cause analysis; therefore, HSAG determined that Molina ACC satisfactorily addressed these prior year's recommendations.
Recommendation 4:
While Molina ACC conducted a root cause analysis and implemented interventions specific to the *Cervical Cancer Screening—21–64 Years* measure rate, this rate remained low in CY 2022; therefore, HSAG recommends that Molina ACC continue to monitor and expand on interventions currently in place to improve performance related to the *Cervical Cancer Screening—21–64 Years* measure, submitting the results of interventions to AHCCCS in its QM/PI Plan.
Molina ACC's Response: Molina has taken decisive steps to address the challenges identified in improving the *Cervical Cancer Screening (CCS)* rate for members ages 21–64, following HSAG's recommendation. Building on the root cause analysis conducted in 2023, Molina expanded member outreach initiatives, leveraging multi-channel communication strategies to increase awareness and accessibility of cervical cancer screenings. Partnerships with providers were strengthened to streamline scheduling processes, incorporate reminders during routine visits, and ensure culturally sensitive communication with members. Data monitoring was enhanced to track the effectiveness of interventions and identify additional opportunities for improvement. Results from these targeted actions, including member engagement metrics and screening completion rates, were submitted to AHCCCS through the QM/PI process, reflecting Molina's ongoing commitment to improving women's health outcomes and meeting quality benchmarks.

[141] National Committee for Quality Assurance. Diabetes and Cardiovascular Screening Disease Screening and Monitoring for People With Schizophrenia or Bipolar Disorder (SSD) Available at: https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/. Accessed on: Feb 13, 2025.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
HSAG's Assessment: Molina ACC identified interventions that were implemented as a result of conducting a root cause analysis; therefore, HSAG determined that Molina ACC satisfactorily addressed these prior year's recommendations.
Recommendation 5:
While Molina ACC conducted a root cause analysis and implemented interventions specific to *Child and Adolescent Well-Care Visits—Total (3–21 Years)*, this rate remained low in CY 2022; therefore, HSAG recommended that Molina ACC continue to identify best practices to support children in receiving well-care visits according to recommended schedules. HSAG also recommended that Molina ACC monitor and expand on interventions currently in place to improve performance related to well-care visits.
Molina ACC's Response: Molina prioritized improving *Child and Adolescent Well-Care Visits (3–21 Years)* in response to HSAG's recommendation. Building on the root cause analysis completed in 2023, Molina implemented best practices to engage families and ensure children receive well-care visits according to recommended schedules. These initiatives included outreach campaigns timed around back-to-school and sports physical seasons, targeted appointment reminders, and coordination with community organizations to promote preventive care. Molina also strengthened partnerships with pediatric providers to streamline scheduling and reduce barriers to access. Enhanced data monitoring allowed for real-time tracking of well-care visit completion rates, providing insights to refine strategies and expand successful interventions. These efforts reflect Molina's commitment to supporting the health and well-being of children and adolescents, as well as its dedication to achieving performance improvements in this critical measure.
HSAG's Assessment: Molina ACC identified interventions that were implemented as a result of conducting a root cause analysis; therefore, HSAG determined that Molina ACC satisfactorily addressed these prior year's recommendations.
Recommendation 6:
While Molina ACC conducted a root cause analysis and implemented interventions specific to the *Well-Child Visits in the First 30 Months of Life—15 Months–30 Months—Two or More Well-Child Visits* measure indicator, this rate remained low in CY 2022; therefore, HSAG recommended that Molina ACC continue to identify best practices to support children in receiving well-care visits according to recommended schedules. HSAG also recommended that Molina ACC monitor and expand on interventions currently in place to improve performance related to well-care visits.
Molina ACC's Response: Molina remains committed to improving the *Well-Child Visits in the First 30 Months of Life—15 to 30 Months* measure, following HSAG's recommendation. After conducting a root cause analysis in 2023, Molina implemented focused strategies to support families in completing well-care visits during this critical developmental period. Initiatives included enhanced outreach efforts, such as personalized reminders and education campaigns highlighting the importance of well-care visits for young

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
children. Molina collaborated closely with pediatric providers to streamline scheduling processes and address common barriers such as transportation and appointment availability. Monitoring systems were enhanced to track visit completion rates, evaluate intervention effectiveness, and identify additional opportunities for improvement. These efforts underscore Molina's dedication to promoting early childhood health and development while striving to meet quality benchmarks for this essential measure.
HSAG's Assessment: Molina ACC identified interventions that were implemented as a result of conducting a root cause analysis; therefore, HSAG determined that Molina ACC satisfactorily addressed these prior year's recommendations.
Recommendation 7:
Controlling high blood pressure is an important step in preventing heart attacks, stroke and kidney disease, and in reducing the risk of developing other serious conditions. Healthcare providers and plans can help individuals manage their high blood pressure by prescribing medications and encouraging low-sodium diets, increased physical activity, and smoking cessation. HSAG therefore recommends that Molina ACC monitor and expand on interventions currently in place to improve performance related to members' high blood pressure control. Molina ACC should submit updated barrier assessments and interventions as required by AHCCCS.
Molina ACC's Response: Molina recognizes the critical role of controlling high blood pressure in preventing serious health conditions and improving overall member well-being. In response to HSAG's recommendation, Molina enhanced its interventions to support members in managing their hypertension effectively. Initiatives included educational outreach on the benefits of medication adherence, low-sodium diets, regular physical activity, and smoking cessation. Molina also partnered with providers to streamline access to blood pressure monitoring tools and incorporate blood pressure checks into routine visits. Barrier assessments were conducted to identify and address challenges, such as medication access and member engagement, leading to the development of tailored interventions. Ongoing monitoring and evaluation ensured the effectiveness of these strategies, and updated results were submitted to AHCCCS as required. These efforts reflect Molina's commitment to improving health outcomes for members with hypertension.
HSAG's Assessment: Molina ACC identified interventions that were implemented as a result of conducting a root cause analysis; therefore, HSAG determined that Molina ACC satisfactorily addressed these prior year's recommendations.
Recommendation 8:
Diabetes is a complex group of diseases marked by high blood glucose (blood sugar) due to the body's inability to make or use insulin. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life. With support from healthcare providers, patients can

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
manage their diabetes with self-care, taking medications as instructed, eating a healthy diet, being physically active and quitting smoking.[142] HSAG therefore recommends that Molina ACC monitor and expand on interventions currently in place to improve performance related to members' HbA1c control. Molina ACC should submit updated barrier assessments and interventions as required by AHCCCS.
Molina ACC's Response: Molina recognizes the critical importance of supporting members in managing diabetes to prevent serious complications and improve quality of life. In response to HSAG's recommendation, Molina expanded its efforts to improve HbA1c control among members with diabetes. Interventions focused on enhancing member education regarding the importance of blood glucose management, medication adherence, and lifestyle changes such as healthy eating, regular physical activity, and smoking cessation. Molina collaborated with providers to implement care coordination strategies, including regular HbA1c testing and follow-up appointments, and facilitated access to resources such as diabetes management programs and nutritional counseling. Barrier assessments identified challenges such as medication access and member engagement, leading to tailored solutions to address these gaps. The effectiveness of these interventions was monitored continuously, with updated results and strategies submitted to AHCCCS as required. These efforts underscore Molina's dedication to improving diabetes care and health outcomes for members.
HSAG's Assessment: Molina ACC identified interventions that were implemented as a result of conducting a root cause analysis; therefore, HSAG determined that Molina ACC satisfactorily addressed these prior year's recommendations.

Validation of Performance Improvement Projects

Back to Basics PIP

In CYE 2024, Molina ACC continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 2, PIP validation activities focused on improvement from the baseline results. Molina ACC submitted Remeasurement 2 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes to or discontinuation of the interventions.

HSAG conducted an annual validation of the second remeasurement year reflective of CY 2023 (January 1, 2023, through December 31, 2023) using AHCCCS-calculated and validated indicator rates. HSAG evaluated Molina ACC's performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

[142] National Committee for Quality Assurance. Comprehensive Diabetes Care. Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Feb 13, 2025.

Validation Results

Table 5-100 displays the overall confidence levels for the Molina ACC *Back to Basics* PIP.

Table 5-100—Molina ACC *Back to Basics* PIP Overall Confidence Levels

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]
Molina ACC	*Low Confidence*	87%	89%	*High Confidence*	100%	100%

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

Measure Results

Table 5-101 and Table 5-102 provide the *Back to Basics* PIP baseline, Remeasurement Year 1, and Remeasurement Year 2 rates for each indicator for Molina ACC.

Table 5-101—Molina ACC *Back to Basics* PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: *W30 Rate 1*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2020*	CY 2022	CY 2023
Molina ACC	49.1%	56.0%	63.1%

* In CYE 2019, the Molina ACC performance measure rate for indicator 1 had a small denominator, which did not allow for reporting of the measure. CY 2020 served as baseline for indicator 1 for Molina ACC.
HSAG rounded percentages to the first decimal place.

Table 5-102—Molina ACC *Back to Basics* PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: *WCV*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
Molina ACC	33.9%	39.6%	43.5%

HSAG rounded percentages to the first decimal place.

Interventions

Table 5-103 presents PIP interventions for Molina ACC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-103—Molina ACC *Back to Basics* PIP Interventions

Contractor	Interventions
Molina ACC	• Contact Center member outreach: Used live call agents to outreach to members and assisted with connection to preventive care services and programs which included scheduling appointments, member check-in calls, and inbound support for program referrals. • Supplemental data sources: Remote access to provider electronic medical records (EMRs), EMR data feeds, and medical record requests for visits completed but not reported. • HEDIS 101: Designed to equip all Molina employees with the knowledge and skills necessary to understand and effectively implement the HEDIS measures. By training all employees, from frontline staff to management, to support consistent adherence to HEDIS standards, these activities will improve the quality of services, the continuum of care, and health care outcomes. Training included the following objectives: – Understand HEDIS Measures: Introduced employees to the purpose and significance of HEDIS measures in evaluating healthcare quality and performance. – Familiarize with HEDIS Domains: Provided an overview of the various domains covered by HEDIS, such as preventive care, chronic conditions management, and member experience. – Interpret Measure Requirements: Enabled employees to comprehend the high-level technical details of each HEDIS measure, including the numerator, denominator, and exclusions. – Compliance and Best Practices: Emphasized the importance of compliance with HEDIS guidelines and promote best practices for achieving high-quality delivery of care and services.

Contractor	Interventions
	– Quality Improvement Initiatives: Encouraged employees to identify opportunities for quality improvement based on HEDIS results. • Provider clinic days: Scheduled days with PCPs for Molina members to access services. During a clinic day, providers see a scheduled roster of Molina members, address their medical concerns, provide diagnoses, prescribe medications, perform procedures, and offer medical advice. Clinic days are an essential part of healthcare delivery, allowing for efficient and focused patient care in a more relaxed and less intense environment compared to when Molina members access care outside the clinic day period. • CLAS: Language access services (oral interpreting by trained and qualified interpreters, American Sign Language, access to telephonic interpreter services, member materials translated into alternative languages and made available in alternate formats); member materials written using Plain Language guidelines and content at a sixth-grade reading level or lower; ongoing cultural competency staff and provider trainings. Members who have access to culturally competent healthcare providers and staff are more likely to attend their appointments and comply with the providers' orders. These interventions helped members understand the conversations happening between them and their providers in the clinical setting, improving health literacy, clinical outcomes, member satisfaction, and member compliance. • Newborn member outreach: Highly collaborative and coordinated approach with real-time provider feedback and follow-ups, supportive scheduling, claims verifications, exclusions, and handling of member issues. These activities improved the quality of services, the continuum of care, and healthcare outcomes by improving member awareness about the importance of timely access to care through strength-based health promotion, supportive scheduling, and appointment reminders. • WCV Happy Birthday member outreach: For members with gaps in care, sent relay text messages and mailed postcards to parents of children and adolescents, as well as young adults, during the member's birth month to wish the member a happy birthday and a reminder to complete a comprehensive wellness exam each year. **Planned Interventions**: • SpectraMedix: Web-based portal for providers in a VBP contract or the Pay for Quality (P4Q) program to access their HEDIS performance scores and gaps in care. – The success of all VBP arrangements rely on data sharing and quality improvement support. Providers need timely and easy-to-understand reporting. VBP partners are provided scorecards outlining the contractual

Contractor	Interventions
	benchmarks and their current performance relative to the established targets. Moving forward, Molina will have this dedicated system to ensure providers have the tools, information, and transparency needed to be successful in a VBP arrangement. – Implementation delayed from May 2023 due to vendor challenges; to ensure there are no declines in quality efforts, delivery of provider HEDIS scorecards and gap in care reporting continues via the current process discussed in the existing interventions above. • Website updates: Annually reevaluate and update provider- and member-facing Molina website quality content to ensure appropriateness, accuracy, and relevance of information. Over time, some content on the website may become outdated or irrelevant. Regular evaluations give the opportunity to review and update content, ensuring it remains accurate, valuable, and aligned with current recommendations and guidance. • Provide a WCV Member Incentive for ages 3–7, 11–21; those with gaps in care will receive a gift card for completing their well-care visits. • WCV "Bicycle Incentive": Members ages 8, 9, and 10 with gaps in care will receive a bicycle for completing their well-care visits.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-104 presents strengths, opportunities for improvement, and recommendations for Molina ACC related to the *Back to Basics* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-104—Molina ACC Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • Molina ACC adhered to acceptable methodology through all phases of the PIP. **[Quality, Access]** • Molina ACC developed and implemented interventions that led to statistically significant improvement in both indicator outcomes between the baseline and Remeasurement 2. **[Quality, Access]**
Opportunities for Improvement and Recommendations
HSAG identified no opportunities for improvement related to the *Back to Basics* PIP.

Strengths, Opportunities for Improvement, and Recommendations
Recommendations: Although there were no opportunities for improvement identified, HSAG recommends that Molina ACC continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention as the PIP progresses.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-105 presents PIP recommendations made to Molina ACC in the CYE 2023 Annual Technical Report[143] and Molina ACC's follow-up to the recommendations, as well as an assessment of the degree to which Molina ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-105—Molina ACC Follow-Up to CYE 2023 PIP Recommendations

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG recommended that Molina ACC: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions as necessary. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.
Molina ACC's Response: Molina diligently advanced the *Back to Basics* PIP, which focuses on enhancing well-care and dental care for children and adolescents, by aligning with HSAG's recommendations. Molina revisited the causal and barrier analysis to ensure that identified interventions address key challenges, such as barriers to access, awareness, and member engagement. Based on this analysis, adjustments were made to interventions, including enhanced outreach strategies, partnerships with schools and community organizations, and streamlined provider workflows for scheduling preventive and dental visits. To measure progress effectively, Molina established clear intervention effectiveness measures, allowing for continuous monitoring and refinement. These efforts demonstrate Molina's commitment to improving access to essential preventive services and achieving sustainable quality outcomes for Arizona's children and adolescents.
HSAG's Assessment: HSAG has determined that Molina ACC has satisfactorily addressed these prior year's recommendations.

[143] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf. Accessed on: Feb 23, 2025.

Prenatal and Postpartum Care PIP

Overview

AHCCCS initiated the implementation of the *Prenatal and Postpartum Care* PIP for the ACC population in CYE 2022. The objective of the *Prenatal and Postpartum Care* PIP is to improve health outcomes for members and infants. This PIP focuses on increasing the number and percentage of members with live birth deliveries that 1) received a prenatal care visit, and 2) received a postpartum visit. In CYE 2024, Molina ACC continued to implement interventions to improve these outcomes and provided updates on the status of each intervention to AHCCCS.

Interventions

Table 5-106— Molina ACC *Prenatal and Postpartum Care* PIP Interventions

Contractor	Interventions
Molina ACC	New interventions to support the *Prenatal and Postpartum Care* PIP in CYE 2024 include:
	• Prenatal care incentive • Quality Improvement Training—HEDIS 101
	Continued interventions with enhancements made to support the *Prenatal and Postpartum Care* PIP in CYE 2024 include:
	• Prenatal and postnatal care management education and support • Provider outreach and education • Provider value-based agreements • Supplemental data abstraction
	Continued interventions to support the *Prenatal and Postpartum Care* PIP in CYE 2024 include:
	• High-risk assessment and care management outreach to high-risk OB members • HEDIS hybrid medical record abstraction • CLAS

Strengths, Opportunities for Improvement, and Recommendations

HSAG did not conduct validation on the *Prenatal and Postpartum Care* PIP in CYE 2024; therefore, strengths, opportunities for improvement, and recommendations are not provided.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])]

Table 5-107 presents PIP recommendations made to Molina ACC in the CYE 2023 Annual Technical Report[144] and Molina ACC's follow-up to the recommendations, as well as an assessment of the degree to which Molina ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-107—Molina ACC's Follow-Up to CYE 2023 PIP Recommendations

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG recommended that Molina ACC: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions as necessary. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. • Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.
Molina ACC's Response: Molina advanced the *Prenatal and Postpartum Care* PIP in alignment with HSAG's recommendations. To ensure meaningful progress, Molina revisited its causal and barrier analysis, refining interventions to address identified challenges such as timely member engagement, access to care, and care coordination with providers. Interventions were adjusted to include enhanced member outreach during early and late stages of pregnancy, partnerships with community organizations to promote prenatal and postpartum services and streamlined workflows for scheduling postpartum visits. Molina also prioritized developing interventions that reached a significant portion of the eligible population, such as targeted educational campaigns and culturally tailored communications. Clear effectiveness measures were established to monitor outcomes and guide continuous improvement. These efforts underscore Molina's commitment to improving maternal health outcomes and achieving measurable gains in the overall indicator rates for prenatal and postpartum care.
HSAG's Assessment: HSAG has determined that Molina ACC has satisfactorily addressed these prior year's recommendations.

[144] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf. Accessed on: Feb 23, 2025.

Compliance Reviews

Results

AHCCCS conducted a compliance review of Molina ACC in CYE 2022. On November 24, 2023, AHCCCS accepted and closed the remaining four CAPs for Molina ACC. Table 5-108 presents the updated CYE 2024 compliance review results for Molina ACC.

Table 5-108—Molina ACC Compliance Review Results

Compliance Focus Areas	CYE 2022 Molina ACC Scores	CYE 2022 Program-Level Average	CYE 2023 Molina ACC CAP Update	CYE 2024 Molina ACC CAP Update
CC	100%	99%	NA	NA
CIS	92%	96%	Partially Met	Met
DS	84%	91%	Partially Met	Met
GA	93%	92%	Met	NA
GS	99%	99%	NA	NA
MCH	76%	82%	Partially Met	Met
MM	93%	94%	Met	NA
MI	95%	96%	NA	NA
QM	69%	77%	Partially Met	Met
QI	89%	92%	Met	NA
RI	100%	100%	NA	NA
TPL	100%	100%	NA	NA
ISOC	97%	96%	NA	NA

NA = Not applicable. A CAP was not required as the CYE 2022 score was 95% or above or the CAP was closed by AHCCCS in CYE 2023.
Partially Met = AHCCCS approved the Contractor's proposed CAP. The Contractor must submit evidence of compliance.
Met = AHCCCS accepted and closed the Contractor's CAP.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-109 presents strengths, opportunities for improvement, and recommendations for Molina ACC based on compliance activities conducted in CYE 2024, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-109—Molina ACC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
Molina ACC has successfully closed out CAPs in the following focus areas: • Claims and Information Standards (CIS) **[Access]** • Delivery Systems (DS) **[Timeliness, Access]** • Adult, EPSDT and Maternal Child Health (MCH) **[Quality, Timeliness, Access]** • Quality Management (QM) **[Quality]**
Opportunities for Improvement and Recommendations
As a result of its CAP interventions, Molina ACC was found to be fully compliant within all focus areas and had no continuing corrective actions or recommendations.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-110 presents compliance recommendations made to Molina ACC in the CYE 2023 Annual Technical Report[145] and Molina ACC's follow-up to the recommendations, as well as an assessment of the degree to which Molina ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-110—Molina ACC Follow-Up to CYE 2023 Compliance Recommendations

Prior Year's Recommendation From the EQR Technical Report for Compliance
HSAG recommended that Molina ACC continue to work on outstanding CAP items and submit to AHCCCS in the approved time frame.
Molina ACC's Response: Molina successfully resolved all outstanding CAP items identified during the AHCCCS Operational Review. These items have been fully addressed and integrated into standard operational practices to ensure ongoing compliance and continuous quality improvement. Molina remains committed to maintaining these improvements and will continue to meet all AHCCCS requirements within the approved time frames. This proactive approach reflects Molina's dedication to operational excellence and delivering high-quality care to AHCCCS members.
HSAG's Assessment:

[145] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf. Accessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for Compliance
Based on the CAP closure for the CIS, DS, MCH, and QM focus areas, and the response provided, HSAG determined that Molina ACC has satisfactorily addressed the prior year's recommendations related to compliance.

Network Adequacy Validation

ISCA Results

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

Table 5-111 summarizes HSAG's validation ratings for Molina ACC by indicator type.

Table 5-111—Summary of Molina ACC's Validation Ratings by Indicator Type

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

Of the network adequacy indicators assessed, Molina ACC received *High Confidence* for both appointment availability and time/distance indicators. However, there were identified areas for improvement; please refer to the Contractor-specific Strengths, Opportunities for Improvement, and Recommendations section below for more details.

NAV Results

HSAG evaluated Molina ACC's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents CYE 2024 S1 validation findings specific to the ACC Program, with one results table for the following GSA:

- Central GSA: Gila, Maricopa, and Pinal counties

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

Table 5-112—Time/Distance Validation Results for Molina ACC Central GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	40.1^[1]	26.5^[1]	100.0^[1]
Behavioral Health Outpatient and Integrated Clinic, Pediatric	41.2^[1]	25.7^[1]	100.0^[1]
BHRF	NA	0.0[1]	NA
Cardiologist, Adult	100.0^	100.0^	100.0^
Cardiologist, Pediatric	100.0^	100.0^	100.0^
Dentist, Pediatric	100.0	99.3	100.0
Hospital	100.0[1]	96.2[1]	100.0[1]
OB/GYN	100.0	100.0	100.0
Pharmacy	100.0	99.1	100.0
PCP, Adult	100.0^	99.7^	100.0^
PCP, Pediatric	100.0^	99.5^	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.

^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

[1] In CYE 2024 S1, Molina ACC's data included decreased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; Behavioral Health Residential Facility; and Hospital. When contacted, Molina ACC indicated the reduction was a result of a coding error in how the system identifies these providers, resulting in failure to report its complete network. Molina ACC corrected the issue and identified steps to prevent this in the future. The decreased number of providers potentially influenced the validated compliance for these provider categories.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-113 presents strengths, opportunities for improvement, and recommendations for Molina ACC related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-113—Molina ACC Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • Molina ACC demonstrated its capability of ensuring the accuracy of its provider network by conducting rigorous quality assurance measures including outbound call outreach to providers who did not attest during their quarterly cycle, conducting secret shopper surveys, and daily audits of randomly selected provider data updates. **[Access]**

Strengths, Opportunities for Improvement, and Recommendations
• Molina ACC met all minimum network requirements for all assigned counties except Gila and Maricopa counties. **[Access]** • Molina ACC met all minimum network requirements for Cardiologist, Adult and Pediatric; Dentist, Pediatric; Hospital; OB/GYN; PCP, Adult and Pediatric; and Pharmacy. **[Access]** Note: Molina ACC provides coverage in the following counties: Gila, Maricopa, and Pinal.
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: • Isolated data issues may have contributed to specific instances affecting Molina ACC's compliance with time/distance standards. **[Access]** Recommendation: HSAG recommends that AHCCCS support Molina ACC in continuing to monitor the Contractor's processes for creating the PAT file and review this file for accuracy prior to submitting to AHCCCS. • Molina indicated that the QNXT database management system currently does not have the capability to capture active versus inactive providers. **[Access]** Recommendation: HSAG recommends that Molina ACC explore its system capabilities to capture active versus inactive providers in the provider database management system. • Molina ACC did not meet the minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; and BHRF. **[Access]** Recommendation: HSAG recommends that Molina ACC maintain current compliance with network standards and continue to address network gaps, as applicable.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-114 presents NAV recommendations made to Molina ACC in the CYE 2023 Annual Technical Report[146] and Molina ACC's follow-up to the recommendations, as well as an assessment of the degree to which Molina ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

[146] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf. Accessed on: Feb 23, 2025.

Table 5-114—Molina ACC Follow-Up to CYE 2023 NAV Recommendations

Prior Year's Recommendation From the EQR Technical Report for NAV
HSAG recommended that Molina ACC maintain current compliance with network standards but continue to address network gaps, as applicable.
Molina ACC's Response: Molina remains committed to maintaining full compliance with AHCCCS network standards while proactively addressing any identified network gaps. In 2024, Molina focused on ensuring provider access in underserved areas, enhancing member choice, and ensuring timely access to care across the network. Strategic provider alignment, coupled with targeted community partnerships, have enabled Molina to address gaps effectively. These actions are now embedded as part of Molina's standard network management practices, ensuring consistent compliance and support for AHCCCS members' diverse healthcare needs.
HSAG's Assessment: HSAG has determined that Molina ACC has satisfactorily addressed this prior year's recommendations.

UHCCP ACC

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2024, HSAG evaluated UHCCP ACC's data system for processing of each data type used for reporting the Contractor's CY 2023 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that UHCCP ACC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-115 displays HSAG's PMV findings for each data type reviewed during CYE 2024 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 5-115—CYE 2024 PMV Findings

Data Type	HSAG Findings
Medical Services Data	*No identified concerns*
Enrollment Data	*No identified concerns*
Provider Data	*No identified concerns*
Medical Record Review Process	*No identified concerns*
Supplemental Data	*No identified concerns*
Data Integration	*No identified concerns*

Results for Performance Measures

Table 5-116 presents the CY 2022 and CY 2023 UHCCP ACC performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and MY 2023. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and/or MY 2023. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 5-116—CY 2022 and CY 2023 UHCCP ACC Performance Measure Results

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	82.5%+	82.7%+	→	★★
Postpartum Care	67.6%+	71.8%+	→	★
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	61.0%	63.0%	↑	★★★
Effective Continuation Phase Treatment—Total (18+ Years)	42.0%	44.5%	↑	★★★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	32.5%	28.5%	↓	★★★
30-Day Follow-Up—Total (13+ Years)	41.9%	39.5%	→	★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	48.0%	49.5%	→	★★★★
30-Day Follow-Up—Total (6+ Years)	64.5%	67.0%	↑	★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	45.4%	42.7%	→	★★★
30-Day Follow-Up—Total (6+ Years)	56.9%	54.7%	→	★★★
Use of Opioids at High Dosage				
*18+ Years**	11.0%	10.5%	→	★
Initiation and Engagement of Substance Use Disorder (SUD) Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	53.3%	50.3%	↓	★★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	20.6%	18.6%	↓	★★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	47.3%	47.7%	→	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	77.4%	79.8%	↑	★★
Care of Acute and Chronic Conditions				
Controlling High Blood Pressure				
18–85 Years	65.2%+	65.2%	→	★★★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0%)—Total (18–75 Years)	54.5%+	58.6%+	→	★★★

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
*Poor HbA1c Control (>9.0%)—Total (18–75 Years)**	33.3%+	30.4%+	→	★★★
Pediatric Health				
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	48.2%	49.3%	→	★★★★
Childhood Immunization Status*				
Combination 3	62.0%+	67.2%+	→	★★★
Combination 7	55.0%+	61.3%+	→	★★★★
Combination 10	28.2%+	29.9%+	→	★★★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	87.8%+	82.7%+	↓	★★★
Combination 2 (Meningococcal, Tdap, HPV)	41.4%+	40.4%+	→	★★★
Oral Evaluation, Dental Services				
Total (0–20 Years)[N]	48.2%	48.6%	—	—
Well-Child Visits in the First 30 Months of Life				
First 15 Months—Six or More Well-Child Visits	61.8%	65.2%	↑	★★★★
15 Months to 30 Months—Two or More Well-Child Visits	63.6%	66.8%	↑	★★
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	47.4%	50.7%	↑	★★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	55.8%	57.4%	↑	★★★
Cervical Cancer Screening				
21–64 Years	58.9%+	51.6%+	↓	★★
Appropriate Utilization of Services				
Ambulatory Care				
Emergency Department (ED) Visits —Total (0–85+ Years)[F]	478.8	480.4	—	—
Plan All-Cause Readmissions				
*Observed/Expected (O/E) Ratio—Total (18–64 Years)**	0.9117	0.9494	—	★★★

* A lower rate indicates better performance for this measure.
** Table A-2 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
+ Indicates the measure was reported using hybrid methodology.
Cells shaded green indicate that the rate met or exceeded the MY 2022 and/or MY 2023 national Medicaid mean.

— Indicates a 2022–2023 comparison is not presented in the CYE 2024 Annual Technical Report because either the CY 2022 rate was not presented in the CYE 2023 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
[1] Aggregated rates were calculated and compared from CY 2023 to CY 2024, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.
[2] Performance Levels for CY 2023 were based on comparisons of the HEDIS MY 2023 measure rates to national Medicaid Quality Compass HEDIS MY 2023 benchmarks.
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.
[N] Measure has no NCQA Medicaid mean for comparison.
↑ Indicates statistically significant improvement of measure rates.
↓ Indicates statistically significant decline of measure rates.
→ Indicates no statistically significant change in measure rates.
Performance Levels for 2023 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 5-117 presents strengths, opportunities for improvement, and recommendations for UHCCP ACC related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-117—UHCCP ACC Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group: • Nine of 13 UHCCP ACC measure rates (69.23 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. **[Quality, Timeliness, Access]** – *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* – *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)* and *30-Day Follow-Up—Total (13+ Years)* – *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* – *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* – *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* and *Engagement of SUD Treatment—Total—Total (13+ Years)*

Strengths, Opportunities for Improvement, and Recommendations
• UHCCP ACC's performance measure rates for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* were at or between the 75th and 89th percentile, indicating adequate follow-up in the seven-days after a member was hospitalized for mental illness and that most members diagnosed with SUD initiated treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization treatment, or MAT within 14 days of diagnosis and had two more or more additional SUD services or medications within 34 days of the initiation visit.[147] **[Quality, Timeliness, Access]**
In the Care of Acute and Chronic Conditions measure group, all measure indicators for UHCCP ACC's rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. **[Quality]**
In the Pediatric Health measure group: • UHCCP ACC's rate for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)* was at or between the 75th and 89th percentile, indicating that most children and adolescents with ongoing antipsychotic medication use had metabolic testing performed. Metabolic monitoring (blood glucose and cholesterol testing) is an important component of ensuring appropriate management of children and adolescents on antipsychotic medications.[148] **[Quality]** • UHCCP ACC's rate for *Childhood Immunization Status—Combination 7* was at or between the 75th and 89th percentile, indicating that most children received recommended vaccinations. Receiving recommended vaccinations is the best defense against serious vaccine-preventable diseases, including diphtheria, measles, meningitis, polio, tetanus and whooping cough.[149] **[Quality]** • UHCCP ACC's rate for *Well-Child Visits in the First 30 Months of Life—First 15 Months—Six or More Well-Child Visits* was at or between the 75th and 89th percentile, indicating most child members had six or more well-child visits with a PCP during their first 15 months of life. **[Quality, Access]**

[147] National Committee for Quality Assurance. Initiation and Engagement of Substance Use Disorder Treatment. Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-substance-use-disorder-treatment/. Accessed on: Feb 13, 2025.
[148] National Committee for Quality Assurance. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM). Available at: https://www.ncqa.org/hedis/measures/metabolic-monitoring-for-children-and-adolescents-on-antipsychotics/. Accessed on: Feb 13, 2025.
[149] National Committee for Quality Assurance. Childhood Immunization Status (CIS). Available at: https://www.ncqa.org/hedis/measures/childhood-immunization-status/. Accessed on: Feb 13, 2025.

Strengths, Opportunities for Improvement, and Recommendations
Opportunities for Improvement and Recommendations
While UHCCP ACC was successful in reporting valid rates for all AHCCCS-required performance measures for its ACC population, the audit identified a recommendation for future years' reporting. **[Quality]** Recommendation: HSAG recommends that UHCCP ACC continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES. In addition, HSAG recommends that UHCCP ACC continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes AHCCCS' requirements for MCO-enrolled members who switch product lines or MCOs and members for whom UHCCP ACC does not hold the primary insurance contract.
In the Behavioral Health measure group, UHCCP ACC's performance measure rate for *Use of Opioids at High Dosage—18+ Years* fell below the 25th percentile, indicating an opportunity to identify trends leading to opioid use. **[Quality]** Recommendation: In 2016, opioid-related overdoses accounted for more than 42,000 deaths in the United States. Of those, 40 percent involved prescription opioids. Literature suggests there is a correlation between high dosages of prescription opioids and the risk of both fatal and nonfatal overdose. HSAG recommends that UHCCP ACC follow the CDC guidelines on opioid prescribing for chronic, nonmalignant pain, which recommend the use of "additional precautions" when prescribing dosages ≥50 MED and that providers avoid or "carefully justify" increasing dosages ≥90 mg MED. In 2019, the authors of the 2016 guidelines published commentary that cautioned providers, systems, payers, and states from developing policies and practices that are "inconsistent with and go beyond" the guideline recommendations. The commentary included cautions regarding strict enforcement of dosage and duration thresholds, as well as abrupt tapering of opioids. The opioid dosage assessed in this measure is a reference point for health plans to identify members who may be at high risk for opioid overuse and misuse. HSAG recommends outreach to members who fall within this category to assess and schedule interventions as necessary.[150] HSAG also recommends that UHCCP ACC identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts.
In the Maternal and Perinatal Health measure group, UHCCP ACC's performance measure rate for *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, indicating an opportunity to increase access to timely postpartum care. Timely and adequate prenatal and

[150] National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/. Accessed on: Feb 13, 2025.

Strengths, Opportunities for Improvement, and Recommendations
postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.[151] **[Quality, Timeliness, Access]** Recommendations: While UHCCP ACC conducted a root cause analysis and implemented interventions specific to the MY 2022 *Prenatal and Postpartum Care—Postpartum Care* rate, this rate remained low in MY 2023; therefore, HSAG recommends that UHCCP ACC continue to implement appropriate interventions to improve performance related to postpartum care. HSAG also recommends that UHCCP ACC monitor and expand on interventions currently in place to improve performance for the *Prenatal and Postpartum Care—Postpartum Care* measure indicator. HSAG also recommends that UHCCP ACC monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Postpartum Care* measure indicator, while adding interventions as appropriate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care*.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-118 presents performance measure recommendations made to UHCCP ACC in the CYE 2023 Annual Technical Report[152] and UHCCP ACC's follow-up to the recommendations, as well as an assessment of the degree to which UHCCP ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-118—UHCCP ACC Follow-Up to CYE 2023 Performance Measure Recommendations

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Recommendation 1:
In 2016, opioid-related overdoses accounted for more than 42,000 deaths in the United States. Of those, 40 percent involved prescription opioids. Literature suggests there is a correlation between high dosages of prescription opioids and the risk of both fatal and nonfatal overdose. HSAG recommended that UHCCP ACC follow the CDC guidelines on opioid prescribing for chronic, nonmalignant pain, which recommend the use of "additional precautions" when prescribing dosages ≥50 MED and that providers avoid or "carefully justify" increasing dosages ≥90 mg MED. In 2019, the authors of the 2016 guidelines published commentary that cautioned providers, systems, payers, and states from developing policies and practices that are "inconsistent with and go beyond" the guideline recommendations. The commentary included cautions regarding strict enforcement of dosage and duration thresholds, as well

[151] National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/. Accessed on: Feb 13, 2025.

[152] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf. Accessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
as abrupt tapering of opioids. The opioid dosage assessed in this measure is a reference point for health plans to identify members who may be at high risk for opioid overuse and misuse. HSAG recommended outreach to members who fall within this category to assess and schedule interventions as necessary. [153]
UHCCP ACC's Response: United HealthCare Community Plan (UHCCP) encourages prescribers to follow the CDC guidelines on opioid prescribing for chronic, nonmalignant pain. UHCCP provides provider education through various platforms including the UHCCP Provider Manual, uhcprovider.com website, Network Bulletins, mailings, and direct outreach. Education includes directing prescribers to the current "CDC Guidelines for Prescribing Opioid for Chronic Pain," "CDC Opioid Overdose Guidelines Resources," as well as the "Arizona Department of Health Services Opioid Prescribing guidelines" webpages. UHCCP implements multiple utilization management (UM) strategies as required by federal and state legislation as well as AHCCCS policy including federal opioid legislation (42 U.S.C. 1396A [OO]) monitoring requirements, Federal Opioid safety edits at the Point-of-Sale, Arizona Revised Statute 32-3248.01 requirements for when a healthcare professional may write for a prescription that is more than 90 MME per day, AHCCCS prior authorization requirement for all long-acting opioid prescription medications unless the member meets certain diagnosis exceptions, AHCCCS 5-Day supply limit of prescription short acting opioid medications with exceptions for certain conditions and care instances. Per the HSAG recommendation: "HSAG recommends outreach to members who fall within this category to assess and schedule interventions as necessary," UHCCP reviewed and considered this recommendation and who would be best suitable to impact member interventions. Upon that consideration, UHCCP will outreach to member's prescribers where the member is in the performance measure *Use of Opioids at High Dosage—18+ Years* to provide additional education to the prescriber and to request that the prescriber assess the member's use of opioids and schedule additional interventions as necessary.
HSAG's Assessment: UHCCP ACC identified interventions that were implemented as a result of conducting a root cause analysis; therefore, HSAG determined that UHCCP ACC satisfactorily addressed these prior year's recommendations.
Recommendation 2:
While UHCCP ACC conducted a root cause analysis and implemented interventions specific to the CY 2021 *Prenatal and Postpartum Care—Postpartum Care* rate, this rate remained low in CY 2022; therefore, HSAG recommends that UHCCP ACC continue to implement appropriate interventions to improve performance related to postpartum care. HSAG also recommends that UHCCP ACC monitor

[153] National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/ Accessed on: Feb 13, 2025.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
and expand on interventions currently in place to improve performance for the *Prenatal and Postpartum Care—Postpartum Care* measure indicator.

UHCCP ACC's Response:

The UHCCP clinical quality manager monitors the prenatal and postpartum care (PPC) PIP indicator rates monthly and reviews them with the PPC PIP workgroup during monthly meetings (2022, 2023, and part of 2024). Meetings are now quarterly (Q3 and Q4 2024). The PPC PIP workgroup is composed of various stakeholders and subject matter experts from within the plan, including the MCH manager and ACC medical director. The workgroup meets regularly to review PIP indicator rates, evaluate the effectiveness of current PIP interventions, and identify the root cause of performance deficiencies as well as new opportunities for improvement.

The PPC PIP workgroup reviewed the root cause and barrier analysis from 2022 and discovered additional barriers that were under the umbrella of provider claim and coding confusion. This barrier includes providers' issues with their billing systems, including clearinghouse and business rules set up to accept CPT II codes and claims with $0.0 billed, in spite of postpartum visits being completed appropriately. UHCCP clinical practice consultants (CPCs) are working closely with providers to educate them to develop solutions to overcome these barriers.

The PPC PIP workgroup collaborates on interventions' status and modifications for continued improvement as needed. The workgroup utilizes the PDSA method to evaluate interventions and determine next steps including modifications to meet the changing needs for improved member health outcomes and PPC rates. Most interventions undergo an effectiveness analysis to evaluate their impact by comparing members with open gaps in care to a later date (after interventions) to see if their gaps were closed and the intervention was effective.

UHCCP worked diligently during MY 2023 to develop and implement numerous and meaningful interventions (11 total) to improve member health outcomes and indicator rates. A few examples of UHCCP ACC PPC PIP interventions and effectiveness analysis are provided below, and all PIP interventions are detailed in the annual PIP Report and Intervention Template Analysis Reports:

1. Community Plan Health Equity Program Incentive (CP-HEPi). Identified providers are incentivized to close PPC care opportunities (prenatal and postpartum care visits) for racial and ethnic health disparities; includes Black or African American, Hispanic/Latino, Native American/Islander, and Asian American moms.
    - PDSA Cycle 1 Study/Effectiveness Analysis (MY 2023): Providers selected for the HEPi outperformed all other providers combined in PPC compliance rates, overall and in every category, and specifically for the Black, Indigenous, and People of Color (BIPOC) population.
        - PPC-Timeliness of Prenatal Care (TOPC) (Prenatal): BIPOC compliance rate for the 19 HEPi eligible providers was 70.5 percent (485/688); all other providers was 67.1 percent; therefore, the 19 HEPi providers outperformed all other providers combined for BIPOC population prenatal care visit rates.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures

  - PPC-PPC (Postpartum): BIPOC compliance rate for the 19 HEPi providers was 55.2 percent (380/688); for all other providers, the rate was 47.0 percent; therefore, the 19 HEPi providers outperformed all other providers in the BIPOC population postpartum care visit rates.

2. Community PPC Postpartum Care Audits. PDSA Cycle 1 Study/Effectiveness Analysis (MY 2023): CPCs audited providers on important PPC postpartum topics for members with open care gaps to identify and address barriers for members to receive postpartum care. CPCs audited provider groups and members' charts each with open postpartum care gaps. The goal was to determine top trends and root cause for postpartum open care gaps. Coding and billing issues, missed appointments, and untimely appointments were the top trends for no postpartum visit. Provider groups were identified with CPT II coding issues and received additional education. The CPC Monthly Talking Points (PPC Provider Education) will continue to address CPT II codes. Additionally, NCQA HEDIS requirements to complete postpartum visits by seven to 84 days after delivery were educated (not just submit the claim with OB global billing code right after delivery—i.e., before seven days). Topics identified from the audit will continue to be educated throughout the next year. This intervention is completed and there is no PDSA Cycle 2 planned but the provider education will continue via the CPC Monthly Talking Points.
3. CPC Monthly Talking Points PPC (Provider Education). PDSA Cycle 1 Study/Effectiveness Analysis (MY 2023): Approximately 60 OB provider groups were educated during 2023: February and April included UHCCP's Healthy First Steps (HFS) program and the importance of patients getting enrolled in the program (benefits of the program), postpartum care, and Telehealth HHS Best Practice Guide. September included CPT II Codes and HFS. Qualitative feedback from CPCs and their provider groups include:
    - HFS is helpful in tracking member early pregnancies and reaching out to confirm they will establish care.
    - The education on PPC CPT II codes is helpful; and due to the PPC audit, we realized most providers were not billing or using CPT II codes.
    - OB group implemented CPT II codes and noticed a difference in its rates. The group was not aware that the codes were needed.
    - Very helpful! The billing and coding department were not aware of CPT II coding for postpartum care. It never occurred to billing the necessary step to close the gap was to submit a $0.0 claim with dates of service (DOS) and CPT II code.
    - The HFS program obtained a 2 percent increase in identified total deliveries for all LOBs: In 2022 we identified 87 percent of the 7,516 total deliveries for HFS, and in 2023 we identified 89 percent of the 7,433 total deliveries for HFS.
    - Provider PPC CPT II Code Utilization increased by 50 percent from 2022 to 2023. The PIP workgroup concluded from the PDSA Cycle 1 Study that this intervention had high value and continued support.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Finally, both PIP indicator rates improved for MY 2023 compared to baseline MY 2022. UHCCP still has much work to do in this area and continues to review and adjust interventions to improve rates and member prenatal and postpartum care.
HSAG's Assessment: UHCCP ACC identified interventions that were implemented for CY 2023 as a result of conducting a root cause analysis; therefore, HSAG determined that UHCCP ACC satisfactorily addressed these prior year's recommendations.

Validation of Performance Improvement Projects

Back to Basics PIP

In CYE 2024, UHCCP ACC continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 2, PIP validation activities focused on improvement from the baseline results. UHCCP ACC submitted Remeasurement 2 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes to or discontinuation of the interventions.

HSAG conducted an annual validation of the second remeasurement year reflective of CY 2023 (January 1, 2023, through December 31, 2023) using AHCCCS-calculated and validated indicator rates. HSAG evaluated UHCCP ACC's performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

Validation Results

Table 5-119 displays the overall confidence levels for the UHCCP ACC *Back to Basics* PIP.

Table 5-119—UHCCP ACC *Back to Basics* PIP Overall Confidence Levels

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]
UHCCP ACC	*High Confidence*	100%	100%	*No Confidence*	33%	100%

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

Measure Results

Table 5-120 and Table 5-121 provide the *Back to Basics* PIP baseline, Remeasurement Year 1, and Remeasurement Year 2 rates for each indicator for UHCCP ACC.

Table 5-120—UHCCP ACC *Back to Basics* PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: *W30 Rate 1*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
UHCCP ACC	65.6%	61.9%	65.2%

HSAG rounded percentages to the first decimal place.

Table 5-121—UHCCP ACC *Back to Basics* PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: *WCV*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
UHCCP ACC	52.7%	47.4%	50.7%

HSAG rounded percentages to the first decimal place.

Interventions

Table 5-122 presents PIP interventions for UHCCP ACC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-122—UHCCP ACC *Back to Basics* PIP Interventions

Contractor	Interventions
UHCCP ACC	• The Provider Tip Sheet provided best practices for improving well-care visit rates. Tips included information on how providers can make practice changes to incorporate well-care visits with sick visits. The CPCs shared the document with providers, along with the Missed Opportunities report, and provided one-to-one education. • Myth vs Fact member letter was mailed to guardians of children in the *WCV* measure. • AHCCCS Back to School Campaign. • CPC Monthly Talking Points: Coordination of Benefits (COB) and secondary claims submissions. • QM Member Mailings: Newborn Well Child Letter (W30 CIS) • QM Member Mailings: Well Visit Self Mailer 6 Mos: W30 • QM Member Mailings: Immunizations Self Mailer 0 Yrs: CIS • QM Member Mailings: Immunization Member Letter 13/14 Mos: CIS • QM Member Mailings: Immunization Member Letter 17/21 Mos: CIS • QM Member Mailings: Well Visit & Immunizations Self Mailer 4–6 Yrs: WCV • QM Member Mailings: 2nd Well Child Reminder Non-Comp Self Mailer 18–20 Yrs: WCV • QM Member Mailings: 2nd Well Child Reminder Non-Comp Self Mailer 0–17 Yrs: W30 WCV • QM Member Mailings: Developmental Screen 9/18/29 Mos DEV • Patient Care Opportunity Report (PCOR): Providers with W30 • Patient Care Opportunity Report (PCOR): Providers with WCV gaps in care

Contractor	Interventions
	• QM Live Calls: WCV • QM Live Calls: W30 (4 Mos) • QM Live Calls: W30 and DEV (9 Mos) • QM Live Calls: 12/24 Mos: CIS • TTEC Live Calls and Member Letters (WCV) • Mpulse OmniChannel IVR Call: W30 Rate 1 • Mpulse OmniChannel IVR Call: W30 Rate 2 • Mpulse OmniChannel IVR Call: wcv_3_11_total • Mpulse OmniChannel IVR Call: wcv_12_17_total • Mpulse OmniChannel IVR Call: wcv_18_21_total • Mpulse OmniChannel IVR Call: CIS (Combo 3 total) • Mpulse OmniChannel Email: w30_rate1_total • Mpulse OmniChannel Email: w30_rate2_total • Mpulse OmniChannel Email: wcv_3_11_total • Mpulse OmniChannel Email: wcv_12_17_total • Mpulse OmniChannel Email: wcv_18_21_total • Mpulse OmniChannel Email: CIS (Combo 3 total) • Mpulse OmniChannel SMS: w30_rate1_total • Mpulse OmniChannel SMS: w30_rate2_total • Mpulse OmniChannel SMS: wcv_3_11_total • Mpulse OmniChannel SMS: wcv_12_17_total • Mpulse OmniChannel SMS: wcv_18_21_total • Mpulse OmniChannel SMS: CIS (Combo 3 total) • QM Provider Mailings: Newborn Provider Letter: W30 CIS • QM Provider Mailings: Immunizations Provider Letter 13/14 Mos: CIS • Email Campaigns: Virtual Visit • Provider EPSDT Toolkit • Community Plan Primary Care Provider Incentive (CP-PCPi) Program (WCV/W30) **Planned Interventions:** • Member Rewards • Pfizer Campaign IVR and Postcard

Strengths, Opportunities for Improvement, and Recommendations

Table 5-123 presents strengths, opportunities for improvement, and recommendations for UHCCP ACC related to the *Back to Basics* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-123—UHCCP ACC Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • UHCCP ACC performed accurate statistical testing between the baseline and Remeasurement 2 results. **[Quality**, **Access]** • UHCCP ACC developed and implemented measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 3. **[Quality**, **Access]**
Opportunities for Improvement and Recommendations
For Indicator 1, UHCCP ACC had a decline of 0.4 percentage points in the indicator rate between the baseline year and Remeasurement Year 2. UHCCP ACC had a decline of 2.0 percentage points in the indicator rate between the baseline year and Remeasurement Year 2 for Indicator 2. **[Quality**, **Access]** Recommendations: As the PIP progresses, HSAG recommends that UHCCP ACC: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. • Assure that all interventions are evaluated for effectiveness through a measure directly linked to the intervention.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-124 presents PIP recommendations made to UHCCP ACC in the CYE 2023 Annual Technical Report[154] and UHCCP ACC's follow-up to the recommendations, as well as an assessment of the degree to which UHCCP ACC has effectively addressed the recommendations. Language in this section is

[154] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf. Accessed on: Feb 23, 2025.

minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-124—UHCCP ACC Follow-Up to CYE 2023 PIP Recommendations

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG recommended that UHCCP ACC: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. • Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.
UHCCP ACC's Response: UHCCP recognized that both indicators (*W30* Rate 1 and *WCV*) fell short of their ACC PIP goals during Remeasurement Year 1 (RM1 – MY 2022). Baseline was 2019 and was pre-pandemic, and rates were better compared to the year(s) following (2020, 2021, and 2022) the PHE, which took a considerable toll on well-child visits, which are making a slow comeback. As discussed in The Arizona Partnership on Immunizations (TAPI), parents were leery of bringing their children in for well-child visits (in part due to COVID and also vaccine hesitancy). MY 2023 (RM2) well-child visit rates are significantly improved compared to the previous year. MY 2024 (RM3) well-child administrative rates are 3 percentage points better than the same time last year (STLY), and UHCCP is striving to meet PIP goals. UHCCP reviewed the root cause analysis (RCA) during MY 2023 (RM2) with the intent to identify other barriers and opportunities for improvement, including parent well-child visit hesitancy. The *Back to Basics* (B2B) PIP Work Group and CPC Team identified there were root cause issues with provider billing and claims submissions that affect most providers for all indicators/measures and closing quality gaps in care. The Ishikawa fishbone diagram was updated and additional work is in progress to understand this better. Provider and UHCCP collaboration on these barriers has already begun, and CPCs have reviewed best practices of one provider (submitting secondary claims), followed by encouraging and educating other providers to do the same. The barriers included: • Coordination of Benefit (COB) issues when a member has secondary insurance with UHCCP and the provider does not submit a secondary claim • Provider billing system that does not allow secondary billing with $0.0 billed, mostly due to Provider Clearinghouse and Business Rules set-up • EMRs not allowing flow of supplemental data and working with the UHCCP Data Aggregators As part of the interventions' PDSA cycles, UHCCP modified some interventions during 2023 to increase member and provider outreach with the intent of improved member health outcomes and rate

Prior Year's Recommendation From the EQR Technical Report for PIPs

performance. Additionally, increased effectiveness analysis was performed and reviewed during PIP workgroup meetings to identify intervention status and any need for improvement:

- The provider tip sheet. MY 2022 effectiveness analysis (PDSA Cycle 3: Study): Approximately 150 provider groups received the document tip sheet which keyed in on performing well-child visits during sick visits. Qualitative feedback from many provider groups was positive and supported continuation of this intervention in MY 2023 (PDSA Cycle 4). For 2023, the provider tip sheet was refreshed by the UHC Community and state provider marketing team for improved readability and posted on uhcprovider.com for easier and increased access by providers. Effectiveness analysis is planned for January 2025.
- The myth vs fact member/guardian/parent letter and flyer. An effectiveness analysis was completed by comparing the September 2022 Missed Opportunities Report and member address list to the CYE 2022 gaps in care report. On February 1, 2023, administrative data showed 6,151/11,012 (55.9 percent) of the ACC members who were sent the myth vs fact letters are now compliant as of CYE 2022 (PDSA Cycle 2: Study). The PIP workgroup determined to continue this intervention and PDSA Cycle 3 for MY 2023. UHCCP developed a separate letter and flyer for ages 18–21 years. Unfortunately, this took longer than expected to finalize and was not ready for MY 2023 implementation. However, they were implemented for PDSA Cycle 4/September 2024. Letters and flyers for ages 3–17 years were distributed during MY 2023 as planned. Effectiveness analysis for MY 2024 is planned for Q1 2025 (PDSA Cycle 4: Study).
- AHCCCS Back-to-School Gift Card Campaign. As part of a statewide Medicaid campaign to increase well-child visits, UHCCP participated in the AHCCCS Back-to-School Campaign. Members with WCV open care gaps were notified of their eligibility for a gift card after completing their visit for DOS starting June 5 through September 5, 2023. Important to note: UHCCP extended member eligibility DOS from September 5 to December 31, 2023, due to calls from parents/guardians stating they were unable to get an appointment before the original due date of September 5. Members were notified of their eligibility via mailed offer letters, AHCCCS and UHCCP website landing page information, and community events. Additionally, provider groups were notified via CPC monthly talking points, flyers, member eligibility lists and a Microsoft PowerPoint presentation. To further increase member awareness of the campaign and encourage participation, UHCCP added QM member outreach calls to 2,000 members. MY 2023 effectiveness analysis resulted in a 2.8 percent redemption rate which was improved by 2.0 percentage points compared to the previous year (MY 2022) redemption rate of 0.82 percent for the UHCCP WCV Member Rewards Program.

Finally, ACC MY 2023 final rates for the *B2B* PIP measures (*W30* R1 and *WCV*) exceeded the NCQA national averages, performed better than the previous year, but did not achieve their PIP goals. When comparing baseline rates (MY 2019) to remeasurement year 2 (MY 2023), no difference was found for the *W30* R1 rates ($p = 0.5272$). A statistically significant decline resulted for the *WCV* rates (p value=0.0001), even though *WCV* experienced a steady increase year-over-year (YOY) since 2020 (and since COVID-19) and increased UHCCP efforts were performed during MY 2023.

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG's Assessment: HSAG has determined that the Contractor has satisfactorily addressed these recommendations.

Prenatal and Postpartum Care PIP

Overview

AHCCCS initiated the implementation of the *Prenatal and Postpartum Care* PIP for the ACC population in CYE 2022. The objective of the *Prenatal and Postpartum Care* PIP is to improve health outcomes for members and infants. This PIP focuses on increasing the number and percentage of members with live birth deliveries that 1) received a prenatal care visit, and 2) received a postpartum visit. In CYE 2024, UHCCP ACC continued to implement interventions to improve these outcomes and provided updates on the status of each intervention to AHCCCS.

Interventions

Table 5-125—UHCCP ACC *Prenatal and Postpartum Care* PIP Interventions

Contractor	Interventions
UHCCP ACC	New interventions to support the *Prenatal and Postpartum Care* PIP in CYE 2024 include:
	• CPT II Code Dashboard and/or Report • Gellert support for pregnant members • Doula pilot • PPC audit deep dive • Babyscripts • TTEC Live Calls Prenatal Care • Health Equity Program Incentive (HEPi)
	Continued interventions with enhancements made to support the *Prenatal and Postpartum Care* PIP in CYE 2024 include:
	• CPC Monthly Talking Points/Provider Education and PCOR Review • CP-PCPi includes OB providers (PPC-TOPC) • Healthy First Steps • Maternity Episode of Care (EOC) Program
	Continued interventions to support the *Prenatal and Postpartum Care* PIP in CYE 2024 include:
	• HFS 2.0 Modernization: Rising Risk BIPOC Population • AZ State Specific Provider Training: OB/GYN Care Provider Toolkit - HEDIS Hybrid Medical Record Abstraction

Strengths, Opportunities for Improvement, and Recommendations

HSAG did not conduct validation on the *Prenatal and Postpartum Care* PIP in CYE 2024; therefore, strengths, opportunities for improvement, and recommendations are not provided.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-126 presents PIP recommendations made to UHCCP ACC in the CYE 2023 Annual Technical Report[155] and UHCCP ACC's follow-up to the recommendations, as well as an assessment of the degree to which UHCCP ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-126—UHCCP ACC's Follow-Up to CYE 2023 PIP Recommendations

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG recommended that UHCCP ACC: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. • Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.
UHCCP ACC's Response: The UHCCP clinical quality manager monitors the *Prenatal and Postpartum Care* (PPC) PIP indicator rates monthly and reviews them with the PPC PIP workgroup during monthly meetings (2022, 2023, and part of 2024). Meetings are now quarterly (Q3 and Q4 2024). The PPC PIP workgroup is composed of various stakeholders and subject matter experts from within the plan, including the MCH manager and ACC medical director. The workgroup meets regularly to review PIP indicator rates, evaluate the effectiveness of current PIP interventions, and identify root cause of performance deficiencies as well as new opportunities for improvement. The PPC PIP workgroup reviewed the root cause and barrier analysis from 2022 and discovered additional barriers that were under the umbrella of provider claim and coding confusion. This barrier includes providers' issues with their billing systems, including clearinghouse and business rules set-up to accept CPT II codes and claims with $0.0 billed, in spite of postpartum visits being completed

[155] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf. Accessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for PIPs
appropriately. UHCCP CPCs are working closely with providers to educate them to develop solutions to overcome these barriers. The PPC PIP workgroup collaborates on interventions' status and modifications for continued improvement as needed. The workgroup utilizes the PDSA method to evaluate interventions and determine next steps including modifications to meet the changing needs for improved member health outcomes and PPC rates. Most interventions undergo an effectiveness analysis to evaluate their impact by comparing members with open gaps in care to a later date (after interventions) to see if their gaps were closed and the intervention was effective. UHCCP worked diligently during MY 2023 to develop and implement numerous and meaningful interventions (11 total) to improve member health outcomes and indicator rates. A few examples of UHCCP ACC PPC PIP interventions and effectiveness analysis are provided below, and all PIP interventions are detailed in the annual PIP Report and Intervention Template Analysis Reports: 1. Community Plan Health Equity Program Incentive (CP-HEPi). Identified providers are incentivized to close PPC care opportunities (prenatal and postpartum care visits) for racial and ethnic health disparities; includes Black or African American, Hispanic/Latino, Native American/Islander, and Asian American moms. • PDSA Cycle 1 Study/Effectiveness Analysis (MY 2023): Providers selected for the HEPi outperformed all other providers combined in PPC compliance rates, overall and in every category, and specifically for the BIPOC population. – PPC-TOPC (Prenatal): BIPOC compliance rate for the 19 HEPi eligible providers was 70.5 percent (485/688); for all other providers the rate was 67.1 percent; therefore, the 19 HEPi providers outperformed all other providers combined for BIPOC population prenatal care visit rates. – PPC-PPC (Postpartum): BIPOC compliance rate for the 19 HEPi providers was 55.2 percent (380/688); for all other providers the rate was 47.0 percent; therefore, the 19 HEPi providers outperformed all other providers in the BIPOC population postpartum care visit rates. 2. PPC Postpartum Care Audits. PDSA Cycle 1 Study/Effectiveness Analysis (MY 2023): CPCs audited providers on important PPC postpartum topics for members with open care gaps to identify and address barriers for members to receive postpartum care. CPCs audited provider groups and members' charts each with open postpartum care gaps. The goal was to determine top trends and root cause for postpartum open care gaps. Coding and billing issues, missed appointments, and untimely appointments were the top trends for no postpartum visit. Provider groups were identified with CPT II coding issues and received additional education. The CPC monthly talking points (PPC provider education) will continue to address CPT II codes. Additionally, NCQA HEDIS requirements to complete postpartum visits by seven to 84 days after delivery was educated (not just submit claim with OB global billing code right after delivery—i.e.,

Prior Year's Recommendation From the EQR Technical Report for PIPs
before seven days). Topics identified from the audit will continue to be educated throughout the next year. This intervention is completed and there is no PDSA Cycle 2 planned, but the provider education will continue via the CPC Monthly Talking Points. 3. CPC Monthly Talking Points PPC (Provider Education). PDSA Cycle 1 Study/Effectiveness Analysis (MY 2023): Approximately 60 OB provider groups were educated during 2023: February and April included UHCCP's HFS program and the importance of patients getting enrolled in the program (benefits of the program), postpartum care, and Telehealth HHS Best Practice Guide. September included CPT II Codes and HFS. Qualitative feedback from CPCs and their provider groups include: • HFS is helpful in tracking members' early pregnancies and reaching out to confirm they will establish care. • The education on PPC CPT II codes is helpful and due to the PPC audit, we realized most providers were not billing or using CPT II codes. • OB group implemented CPT II codes and noticed a difference in its rates. The group was not aware that the codes were needed. • The billing and coding department were not aware of CPT II coding for postpartum care. It never occurred to billing the necessary step to close the gap was to submit a $0.0 claim with DOS and CPT II code. • The HFS program obtained a 2 percent increase in identified total deliveries for all LOBs: In 2022 we identified 87 percent of the 7,516 total deliveries for HFS and in 2023 we identified 89 percent of the 7,433 total deliveries for HFS. • Provider PPC CPT II Code Utilization increased by 50 percent from 2022 to 2023. The PIP workgroup concluded from the PDSA Cycle 1 Study that this intervention had high value and continued support. Finally, both PIP indicator rates improved for MY 2023 compared to baseline MY 2022. UHCCP still has much work to do in this area and continues to review trends, root cause, and interventions to improve rates and member prenatal and postpartum care.
HSAG's Assessment: HSAG has determined that the Contractor has satisfactorily addressed these recommendations.

Compliance Reviews

Results

AHCCCS conducted a compliance review of UHCCP ACC in CYE 2022. On January 17, 2024, AHCCCS accepted and closed the remaining three CAPs for UHCCP ACC. Table 5-127 presents the compliance review results for UHCCP ACC.

Table 5-127—UHCCP ACC Compliance Review Results

Focus Areas	CYE 2022 UHCCP ACC Scores	CYE 2022 Program-Level Average	CYE 2023 UHCCP ACC CAP Update	CYE 2024 UHCCP ACC CAP Update
CC	93%	99%	Partially Met	Met
CIS	99%	96%	NA	NA
DS	98%	91%	NA	NA
GA	100%	92%	NA	NA
GS	100%	99%	NA	NA
MCH	95%	82%	NA	NA
MM	97%	94%	NA	NA
MI	95%	96%	NA	NA
QM	84%	77%	Partially Met	Met
QI	100%	92%	NA	NA
RI	100%	100%	NA	NA
TPL	100%	100%	NA	NA
ISOC	86%	96%	Partially Met	Met

NA = Not applicable. A CAP was not required as the CYE 2022 score was 95% or above or the CAP was closed by AHCCCS in CYE 2023.
Partially Met = AHCCCS approved the Contractor's proposed CAP. The Contractor must submit evidence of compliance.
Met = AHCCCS accepted and closed the Contractor's CAP.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-128 presents strengths, opportunities for improvement, and recommendations for UHCCP ACC based on compliance activities conducted in CYE 2024, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-128—UHCCP ACC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
UHCCP ACC has successfully closed out CAPs in the following focus areas: • Corporate Compliance (CC) **[Quality, Access]** • Quality Management (QM) **[Quality]** • Integrated Systems of Care (ISOC) **[Quality, Access]**

Strengths, Opportunities for Improvement, and Recommendations
Opportunities for Improvement and Recommendations
As a result of its CAP interventions, UHCCP ACC was found to be fully compliant within all focus areas and had no continuing corrective actions or recommendations.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-129 presents compliance recommendations made to UHCCP ACC in the CYE 2023 Annual Technical Report[156] and UHCCP ACC's follow-up to the recommendations, as well as an assessment of the degree to which UHCCP ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-129—UHCCP ACC Follow-Up to CYE 2023 Compliance Recommendations

Prior Year's Recommendation From the EQR Technical Report for Compliance
HSAG recommended that UHCCP ACC continue to work on outstanding CAP items and submit to AHCCCS in the approved time frame.
UHCCP ACC's Response: UHCCP implemented and remediated CAPs for the CC, QM, and ISOC focus areas that were listed under HSAG recommendations. All ACC CAPs were approved and closed by AHCCCS on January 17, 2024.
HSAG's Assessment: Based on the CAP closure for the CC, QM, and ISOC focus areas, and the response provided, HSAG determined that UHCCP ACC has satisfactorily addressed the prior year's recommendations related to compliance.

Network Adequacy Validation

ISCA Results

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

[156] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf. Accessed on: Feb 23, 2025.

Table 5-130 summarizes HSAG's validation ratings for UHCCP ACC by indicator type.

Table 5-130—Summary of UHCCP ACC's Validation Ratings by Indicator Type

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

Of the network adequacy indicators assessed, UHCCP ACC received *High Confidence* for both appointment availability and time/distance indicators. However, there were identified areas for improvement; please refer to the Contractor-specific Strengths, Opportunities for Improvement, and Recommendations section below for more details.

NAV Results

HSAG evaluated UHCCP ACC's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents CYE 2024 S1 validation findings specific to the ACC Program, with one results table for each of the following GSAs:

- Central GSA: Gila, Maricopa, and Pinal counties
- South GSA: Pima County

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

Table 5-131—Time/Distance Validation Results for UHCCP ACC Central GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^	99.3^	100.0^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0^	99.3^	100.0^
BHRF	NA	96.9	NA
Cardiologist, Adult	100.0^	99.9^	100.0^
Cardiologist, Pediatric	100.0^	100.0^	100.0^
Dentist, Pediatric	58.6	99.2	100.0
Hospital	100.0	99.9	100.0
OB/GYN	100.0	100.0	100.0
Pharmacy	100.0	99.0	100.0

Minimum Network Requirement	Gila	Maricopa	Pinal
PCP, Adult	100.0^	99.7^	100.0^
PCP, Pediatric	100.0^	99.7^	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.
^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.

Table 5-132—Time/Distance Validation Results for UHCCP ACC South GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Pima
Behavioral Health Outpatient and Integrated Clinic, Adult	98.0^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	98.1^
BHRF	90.4
Cardiologist, Adult	99.8^
Cardiologist, Pediatric	100.0^
Dentist, Pediatric	98.8
Hospital	99.5
OB/GYN	99.8
Pharmacy	98.5
PCP, Adult	99.9^
PCP, Pediatric	99.8^

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-133 presents strengths, opportunities for improvement, and recommendations for UHCCP ACC related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-133—UHCCP ACC Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • UHCCP ACC had processes in place to maintain accurate and complete provider data, including a quarterly attestation process, secret shopper campaigns, and quality assurance reviews. **[Access]** • UHCCP ACC met all minimum network requirements for all assigned counties except Gila County. **[Access]** • UHCCP ACC met all minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; BHRF; Cardiologist, Adult and Pediatric; Hospital; OB/GYN; PCP, Adult and Pediatric; and Pharmacy. **[Access]** Note: UHCCP ACC provides coverage in the following counties: Gila, Maricopa, Pima, and Pinal.
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: • UHCCP ACC had a high level of compliance mismatch between its submitted results and HSAG's calculated results. **[Access]** Recommendation: HSAG recommends that UHCCP continue to work with AHCCCS and HSAG to reduce the amount of compliance discrepancies**.** • UHCCP ACC did not meet the minimum network requirements for Dentist, Pediatric. **[Access]** Recommendation: HSAG recommends that UHCCP ACC maintain current compliance with network standards and continue to address network gaps, as applicable.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 5-134 presents NAV recommendations made to UHCCP ACC in the CYE 2023 Annual Technical Report[157] and UHCCP ACC's follow-up to the recommendations, as well as an assessment of the degree to which UHCCP ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

[157] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdf. Accessed on: Feb 23, 2025.

Table 5-134—UHCCP ACC Follow-Up to CYE 2023 NAV Recommendations

Prior Year's Recommendation From the EQR Technical Report for NAV
HSAG recommended that UHCCP ACC maintain current compliance with network standards but continue to address network gaps, as applicable.
UHCCP ACC's Response: UHCCP ACC evaluates the contracted network quarterly via the quarterly PAT File monitoring and review process. When gaps in the network are identified, UHCCP ACC conducts a review of the area and category that has underperformed. A thorough audit of the provider community is conducted and includes a review of any noncontracted providers and new providers who enter the county. UHCCP ACC will continue to monitor and review the PAT file for any opportunities to our network quarterly.
HSAG's Assessment: HSAG has determined that UHCCP ACC has satisfactorily addressed this prior year's recommendation.

6. ACC-RBHA SMI-Designated Population Program-Level Comparative Results

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

This section includes ACC-RBHA program-level comparative results for the SMI-Designated population, organized by EQR-related activity, which includes strengths, opportunities for improvement, and HSAG's recommendations for program-level performance improvement. This section also includes information about the extent to which each Contractor was able to address the prior year's recommendations for each activity.

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2024, HSAG evaluated each ACC-RBHA SMI-Designated Population Program Contractor's data system for processing of each data type used for reporting the Contractor's CY 2023 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. A summary of these findings by ACC-RBHA Program Contractor is provided in Table 6-1. Table 6-1 also displays whether or not each ACC-RBHA Program Contractor met the assessed IS standards, which demonstrates whether or not the Contractor has effective IS practices and control procedures for data reporting. Additional information about each ACC-RBHA Program Contractor's general findings for each data type reviewed can be found in Section 7. ACC-RBHA SMI-Designated Population Program Contractor-Specific Results. Additional information regarding the CMS EQR Protocol 2 audit requirements, including more information about the levels of scoring, can be found in the Validation of Performance Measures section in Appendix A. Methodology.

Table 6-1—Performance Measure Validation Contractor Comparison: CMS EQR Protocol 2 Validation Results for ACC-RBHA Program Contractors

Data Type	AzCH-CCP ACC-RBHA	Care1st ACC-RBHA	Mercy Care ACC-RBHA
Medical Services Data	*Met*	*Met*	*Met*
Enrollment Data	*Met*	*Met*	*Met*
Provider Data	*Met*	*Met*	*Met*

Data Type	AzCH-CCP ACC-RBHA	Care1st ACC-RBHA	Mercy Care ACC-RBHA
Medical Record Review Processes	*Met*	*Met*	*Met*
Supplemental Data	*Met*	*Met*	*Met*
Data Preproduction Processing	*Met*	*Met*	*Met*
Data Integration and Reporting	*Met*	*Met*	*Met*

Results for Performance Measures

Table 6-2 presents the CY 2023 aggregate performance measure results for the ACC-RBHA SMI-Designated Population Program Contractors. Performance measure rate cells shaded green indicate that aggregate performance met or exceeded NCQA's Quality Compass national Medicaid HMO mean for HEDIS MY 2023. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the national Medicaid mean are shaded green. Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 6-2—CY 2023 Aggregate Performance Measure Results for the ACC-RBHA Program Contractors

Measure	AzCH–CCP ACC-RBHA	Care1st ACC-RBHA	Mercy Care ACC-RBHA	ACC-RBHA Program Aggregate
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	68.8%+	NA ++	NR#	68.8%
Postpartum Care	65.0%+	NA ++	NR#	62.2%
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	54.9%	63.3%	50.6%	52.3%
Effective Continuation Phase Treatment—Total (18+ Years)	41.0%	50.6%	37.5%	39.0%
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	48.0%	45.0%	53.2%	50.6%
30-Day Follow-Up—Total (13+ Years)	67.7%	67.9%	71.1%	69.7%
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	63.3%	59.6%	71.6%	69.0%
30-Day Follow-Up—Total (6+ Years)	79.5%	77.7%	86.0%	84.0%
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	50.4%	59.7%	55.9%	54.9%

Measure	AzCH–CCP ACC-RBHA	Care1st ACC-RBHA	Mercy Care ACC-RBHA	ACC-RBHA Program Aggregate
30-Day Follow-Up—Total (6+ Years)	69.5%	74.7%	72.4%	72.0%
Use of Opioids at High Dosage				
*18+ Years**	10.1%	4.4%	8.7%	8.3%
Initiation and Engagement of Substance Use Disorder (SUD) Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	53.5%	35.0%	54.0%	52.3%
Engagement of SUD Treatment—Total—Total (13+ Years)	18.0%	7.2%	16.1%	16.0%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	58.6%	60.9%	58.9%	59.0%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	86.1%	77.1%	87.9%	86.5%
Care of Acute and Chronic Conditions				
Controlling High Blood Pressure				
18–85 Years	65.5%+	62.8%+	68.6%+	67.3%+
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0 %)—Total (18–75 Years)	61.3%+	47.7%+	63.3%+	61.3%+
*Poor HbA1c Control (>9.0 %)—Total (18–75 Years)**	31.9%+	44.0%+	27.5%+	30.3%+
Pediatric Health				
Oral Evaluation, Dental Services				
Total (0–20 Years)[N]	21.4%	14.3%	28.6%	26.2%
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	46.1%	50.0%	44.4%	45.0%
Cervical Cancer Screening				
21–64 Years+	44.8%+	32.8%+	44.3%+	43.0%+
Appropriate Utilization of Services				
Ambulatory Care				
Emergency Department (ED) Visits —Total (0–85+ Years)[F]	1,224.5	1,181.8	1,256.6	1,239.1
Plan All-Cause Readmissions				
*Observed/Expected (O/E) Ratio—Total (18–64 Years)**	1.1704	1.4972	1.3712	1.3218

* A lower rate indicates better performance for this measure.
+ Indicates the measure was reported using hybrid methodology.
++ NA indicates the denominator was too small to report a valid rate, based on the applicable measure specification.

[#] NR indicates the measure was not reported because the MCO was not required to report the measure.
Cells shaded green indicate that the rate met or exceeded the MY 2023 national Medicaid mean.
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months.
[N] Measure has no NCQA Medicaid mean for comparison

Table 6-3 presents the CY 2023 aggregate performance measure results for the ACC-RBHA SMI-Designated Population Program Contractors. Performance measure rate cells shaded green indicate that aggregate performance met or exceeded NCQA's Quality Compass national Medicaid HMO mean for HEDIS MY 2023. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the national Medicaid mean are shaded green. Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 6-3—CY 2023 Performance Measure Aggregate Results for ACC-RBHA Program Contractors

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care[≥]	76.6%[+]	68.8%	→	★
Postpartum Care[≥]	66.1%[+]	62.2%	→	★
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	53.4%	52.3%	→	★
Effective Continuation Phase Treatment—Total (18+ Years)	38.1%	39.0%	→	★★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	56.8%	50.6%	↓	★★★★★
30-Day Follow-Up—Total (13+ Years)	73.5%	69.7%	→	★★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	67.4%	69.0%	→	★★★★★
30-Day Follow-Up—Total (6+ Years)	82.6%	84.0%	→	★★★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	57.1%	54.9%	→	★★★★
30-Day Follow-Up—Total (6+ Years)	72.0%	72.0%	→	★★★★
Use of Opioids at High Dosage				
*18+ Years**	10.6%	8.3%	→	★
Initiation and Engagement of Substance Use Disorder (SUD) Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	50.2%	52.3%	→	★★★★

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Engagement of SUD Treatment—Total—Total (13+ Years)	13.7%	16.0%	↑	★★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	56.9%	59.0%	↑	★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	85.3%	86.5%	→	★★★★
Care of Acute and Chronic Conditions				
Controlling High Blood Pressure				
18–85 Years	64.8%+	67.3%+	↑	★★★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0 Percent)—Total (18–75 Years)	62.7%+	61.3%+	→	★★★★
*Poor HbA1c Control (>9.0 Percent)—Total (18–75 Years)**	29.9%+	30.3%+	→	★★★
Pediatric Health				
Oral Evaluation, Dental Services				
Total (0–20 Years)[N]	20.8%	26.2%	→	—
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	40.3%	45.0%	↑	★
Cervical Cancer Screening				
21–64 Years	49.9%+	43.0%+	↓	★
Appropriate Utilization of Services				
Ambulatory Care				
Emergency Department (ED) Visits—Total (0–85+ Years)[F]	1,175.8	1,239.1	—	—
Plan All-Cause Readmissions				
*Observed/Expected (O/E) Ratio—Total (18–64 Years)**	1.3174	1.3218	—	★

* A lower rate indicates better performance for this measure.
+ Indicates the measure was reported using hybrid methodology.
≥ Indicates the measure had variation in reporting designation or methodology in CY 2023 (each applicable program contracted MCO performance measure table should be reviewed for specifics) and hybrid methodology in CY 2022.
Cells shaded green indicate that the rate met or exceeded the MY 2022 and/or MY 2023 and/or national Medicaid mean.
— Indicates a 2022–2023 comparison is not presented in the CYE 2024 Annual Technical Report because either the CY 2022 rate was not presented in the CYE 2023 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
[1]Aggregated rates were calculated and compared from CY 2022 to CY 2023, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.
[2] Performance Levels for CY 2023 were based on comparisons of the HEDIS MY 2023 measure rates to national Medicaid Quality Compass HEDIS MY 2023 benchmarks.

[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.
[N] Measure has no NCQA Medicaid mean for comparison
↑ Indicates statistically significant improvement of measure rates.
↓ Indicates statistically significant decline of measure rates.
→ Indicates no statistically significant change in measure rates.
Performance Levels for 2023 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Table 6-4 highlights the ACC-RBHA SMI-Designated Population Program Contractors' performance for the current year by measure group. The table illustrates the Contractors' CY 2023 measure rates and their performance relative to the NCQA national Medicaid Quality Compass HEDIS MY 2023 percentiles, where applicable. The performance level star ratings are defined as follows:

★★★★★ = 90th percentile and above
★★★★ = 75th percentile to 89th percentile
★★★ = 50th percentile to 74th percentile
★★ = 25th percentile to 49th percentile
★ = Below the 25th percentile

Table 6-4—CY 2023 National Percentiles Comparison for the ACC-RBHA Program Contractors

Measure	AzCH–CCP ACC-RBHA	Care1st ACC-RBHA	Mercy Care ACC-RBHA	ACC-RBHA Program Aggregate
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	★	NA[++]	NR[#]	★
Postpartum Care	★	NA[++]	NR[#]	★
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	★	★★★	★	★
Effective Continuation Phase Treatment—Total (18+ Years)	★★	★★★★	★	★★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	★★★★★	★★★★★	★★★★★	★★★★★
30-Day Follow-Up—Total (13+ Years)	★★★★★	★★★★★	★★★★★	★★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	★★★★★	★★★★★	★★★★★	★★★★★
30-Day Follow-Up—Total (6+ Years)	★★★★★	★★★★★	★★★★★	★★★★★
Follow-Up After ED Visit for Mental Illness				

Measure	AzCH–CCP ACC-RBHA	Care1st ACC-RBHA	Mercy Care ACC-RBHA	ACC-RBHA Program Aggregate
7-Day Follow-Up—Total (6+ Years)	★★★★	★★★★	★★★★	★★★★
30-Day Follow-Up—Total (6+ Years)	★★★★	★★★★★	★★★★	★★★★
Use of Opioids at High Dosage				
18+ Years	★	★★	★	★
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	★★★★	★	★★★★	★★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	★★★	★	★★★	★★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	★★	★★	★★	★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	★★★★	★	★★★★★	★★★★
Care of Acute and Chronic Conditions				
Controlling High Blood Pressure				
18–85 Years	★★★	★★	★★★	★★★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0 Percent)—Total (18–75 Years)	★★★★	★	★★★★	★★★★
*Poor HbA1c Control (>9.0 Percent)—Total (18–75 Years)**	★★★	★	★★★★	★★★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	★	★★	★	★
Cervical Cancer Screening				
21–64 Years	★	★	★	★
Appropriate Utilization of Services				
Plan All-Cause Readmissions				
*Observed/Expected (O/E) Ratio—Total (18–64 Years)**	★	★	★	★

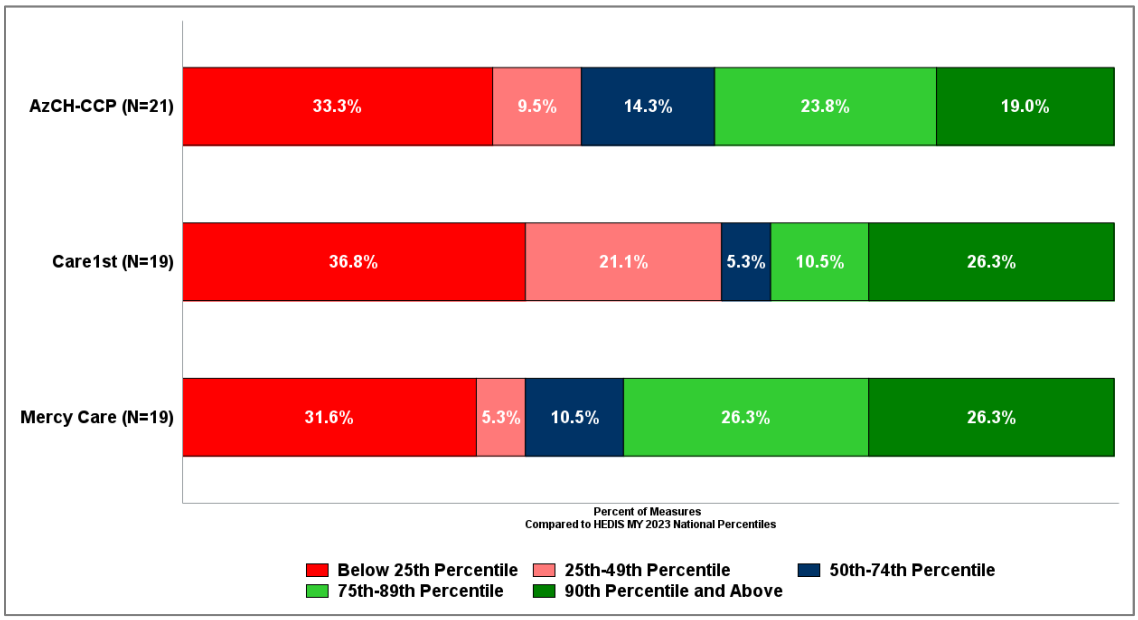
++ NA indicates the denominator was too small to report a valid rate, based on the applicable measure specification.

NR indicates the measure was not reported because the MCO was not required to report the measure.

* A lower rate indicates better performance for this measure.

Figure 6-1 displays the ACC-RBHA SMI-Designated Population Program Contractors' HEDIS MY 2023 performance compared to NCQA MY 2022 National Percentiles. HSAG analyzed results from 15 performance measures for HEDIS MY 2023 for a total of 22 measure rates.

Figure 6-1—Comparison of Measure Rates to HEDIS Medicaid National Percentiles for ACC-RBHA Program Contractors



Strengths and Opportunities for Improvement

Table 6-5 presents program-level strengths and opportunities for improvement for the ACC-RBHA SMI-Designated Population Program as related to performance measures.

Table 6-5—ACC-RBHA Program Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group: • The *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)* and *30-Day Follow-Up—Total (13+ Years)* measure rates for all ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Population Program Aggregate rate met or exceeded the NCQA national Medicaid Quality Compass HEDIS MY 2023 90th percentile. These results may indicate that members enrolled with these Contractors may be receiving timely follow-up visits for substance use abuse or dependence after an ED visit. Timely follow-up care for individuals with substance use abuse or dependence who were seen in the ED is associated with a reduction in substance use and

Strengths, Opportunities for Improvement, and Recommendations
future ED use and hospital admissions, as well as a decrease in bed days.[158] **[Quality, Timeliness, Access]** • The *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* measure rates for all ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Population Program Aggregate rate met or exceeded the national Medicaid Quality Compass HEDIS MY 2023 75th percentile. These results may indicate that members may be receiving timely follow-up visits for mental illness after an ED visit. Research suggests that follow-up care for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function, and increased compliance with follow-up instructions.[159] **[Quality, Timeliness, Access]** • The *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* measure rates for all ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Population Program Aggregate rate met or exceeded NCQA national Medicaid Quality Compass HEDIS MY 2023 90th percentile. These results may indicate that members enrolled with these Contractors may be receiving timely follow-up visits with a mental health provider after inpatient discharge for a diagnosis of mental illness or intentional self-harm. Providing follow-up care to patients after a psychiatric hospitalization can improve patient outcomes and decrease the likelihood of rehospitalization and the overall cost of outpatient care.[160] **[Quality, Timeliness, Access]** • For the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years* measure, the rates for two of the three ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Population Program Aggregate rate met or exceeded the NCQA national Medicaid Quality Compass HEDIS MY 2023 75th percentile. This performance indicates that members receiving antipsychotic medications for schizophrenia who were enrolled with these Contractors may be receiving diabetes screenings. Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health, quality of life, and economic outcomes downstream.[161] **[Quality, Timeliness, Access]**
In the Care of Acute and Chronic Conditions measure group, the rates for two of the ACC-RBHA

[158] National Committee for Quality Assurance. Follow-Up After ED Visit for Substance Use. Available at: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-substance-use/. Accessed on: Feb 19, 2025.
[159] National Committee for Quality Assurance Follow-Up After ED Visit for Mental Illness. Available at: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/. Accessed on: Feb 19, 2025.
[160] National Committee for Quality Assurance. Follow-Up After Hospitalization for Mental Illness. Available at: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/. Accessed on: Feb 19, 2025.
[161] National Committee for Quality Assurance. Diabetes and Cardiovascular Disease Screening and Monitoring for People With Schizophrenia or Bipolar Disorder. Available at: https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/. Accessed on: Feb 19, 2025.

Strengths, Opportunities for Improvement, and Recommendations
Contractors and the ACC-RBHA SMI-Designated Population Program Aggregate rate met or exceeded the NCQA national Medicaid Quality Compass HEDIS MY 2023 75th percentile for the *Hemoglobin A1c Control for Patients With Diabetes —HbA1c Control (<8.0 %)—Total (18–75 Years)* measure rate. Based on evidence-based guidelines, high performance on this measure rate may indicate that members with diabetes may be able to manage their condition through the appropriate use of medications, diet and nutrition, or physical activity. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[162] **[Quality]**
Opportunities for Improvement
In the Maternal and Perinatal Care measure group, the rates for one ACC-RBHA Contractor and the ACC-RBHA SMI-Designated Population Program Aggregate rate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and also fell below the 25th percentile, indicating that not all women were having timely prenatal and postpartum care visits. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.[163] **[Quality, Timeliness, Access]** Recommendation: While two of the ACC-RBHA Contractors conducted a root cause analysis and implemented targeted interventions specific to their MY 2022 *Prenatal and Postpartum Care* rates, the rates for *Timeliness of Prenatal Care* and *Postpartum Care* still remained low for MY 2023, as well as for the two previous years. HSAG therefore recommends that these Contractors continue to implement appropriate interventions to improve performance relative to prenatal and postpartum care. HSAG also recommends that the Contractors continue to monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measures. In addition, HSAG recommends that Contractors consider whether there are disparities/SDOH within their populations that contributed to lower access to care. A few strategies could include providing expanded access appointments outside of business hours to accommodate work schedules or childcare needs. Further, HSAG recommends that Contractors identify payment structure types that will incentivize quality care. Bundling payments may cause disincentives for postpartum care, as providers might receive the same payment regardless of whether the member attends the postpartum visit.[164]
In the Behavioral Health measure group, for two of three ACC-RBHA Contractors, the performance rates for *Use of Opioids at High Dosage—18+ Years* and the Program Aggregate rate remained below the 25th percentile. This result indicates a continued opportunity for these Contractors to monitor

[162] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Feb 19, 2025.
[163] National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/. Accessed on: Feb 19, 2025.
[164] Centers for Medicare & Medicaid Services. Lessons Learned about Payment Strategies to Improve Postpartum Care in Medicaid and CHIP. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/postpartum-payment-strategies.pdf. Accessed on: Feb 23, 2025.

Strengths, Opportunities for Improvement, and Recommendations
prescribing and utilization data and to implement interventions to improve care and services around opioid prescribing. The CDC guidelines on opioid prescribing for chronic, nonmalignant pain recommend the use of "additional precautions" when prescribing dosages ≥50 MED and that providers avoid or "carefully justify" increasing dosages ≥90 mg MED.[165] **[Quality]** Recommendation: While two of the ACC-RBHA Contractors conducted a root cause analysis and implemented interventions to determine why there was a higher proportion of members receiving prescriptions for opioids, their performance remained low in MY 2023. HSAG therefore recommends that these Contractors continue to implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid misuse. HSAG also recommends that Contractors monitor and expand on interventions currently in place to improve performance related to the *Use of Opioids at High Dosage—18+ Years* measure. HSAG also recommends that the Contractors identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts.
In the Preventive Screening measure group: • The rates for two of three ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Population Program Aggregate rate for *Breast Cancer Screening—Total (50–74 Years)* fell below the NCQA Quality Compass national Medicaid HMO HEDIS MY 2023 25th percentile, indicating that not all women were receiving timely screening for breast cancer. Early detection reduces the risk of dying from this type of cancer and can lead to a greater range of treatment options and lower healthcare costs.[166] **[Quality]** • The rates for all three ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Population Program Aggregate rate for *Cervical Cancer Screening—21–64 Years* fell below both the NCQA Quality Compass national Medicaid HMO HEDIS MY 2023 25th percentile, indicating that not all women were receiving timely screening for cervical cancer. Cervical cancer is one of the most common causes of cancer-related deaths for American women; effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate.[167] **[Quality]** Recommendation: While these Contractors conducted a root cause analysis and implemented interventions specific to their MY 2023 *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* rates, these rates remained low for both CY 2021 and CY 2022. HSAG therefore recommends that the ACC-RBHA Contractors leverage the current PIP activities to continue to implement appropriate interventions to improve performance related to preventive screenings. HSAG also recommends that these Contractors monitor and expand on

[165] National Committee for Quality Assurance. Use of Opioids at High Dosage (HDO). Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/. Accessed on: Feb 21, 2025.
[166] National Committee for Quality Assurance. Breast Cancer Screening (BCS). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Feb 21, 2025.
[167] National Committee for Quality Assurance. Cervical Cancer Screening (CCS). Available at: https://www.ncqa.org/hedis/measures/cervical-cancer-screening/. Accessed on: Feb 13, 2025.

Strengths, Opportunities for Improvement, and Recommendations
interventions currently in place to improve performance related to these measures. HSAG recommends that Contractors consider utilizing one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve screenings. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness.
In the Appropriate Utilization of Services measure group, the *Plan All-Cause Readmissions—O/E Ratio—Total (18–64 Years)* measure rates for the ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Population Program Aggregate rate fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023, indicating that some members experienced unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay. [**Quality**] Recommendation: While these Contractors initiated efforts to identify best practices for reducing unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay, their rates remained below the 25th percentile for CY 2023. The Contractors also followed the recommendation of conducting a root cause analysis to identify factors contributing to members experiencing unplanned acute readmissions, which should include evaluating that appropriate follow-up care is available to members upon discharge from an acute inpatient admission or observation. However, HSAG recommends that these Contractors continue to follow through on these performance improvement strategies to increase provider and member outreach and improve follow-up care after discharge from an acute inpatient admission or observation. HSAG recommends that Contractors consider reviewing the Re-Engineered Discharge (RED), which has been shown to reduce readmissions and posthospital ED visits.[168] Other interventions that might be effective include technology platforms, including AI or machine learning, that can assist the plans in identifying members more at risk of readmission. HSAG recommends that Contractors utilize case management strategies which focus on person-centered techniques, addressing barriers and/or SDOH as needed.
Starting as part of MY 2022 performance measure reporting, RES is required based on NCQA HEDIS specifications. While HSAG did not identify Contractor-specific opportunities to improve RES, all ACC-RBHA Contractors could benefit from continuing to focus on refining RES reporting where required in keeping with measure specifications. **[Quality]** Recommendation: HSAG recommends that the ACC-RBHA Contractors explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratifications related to RES. The Contractors should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information.

[168] Agency for Healthcare Research and Quality. Re-Engineered Discharge (RED) Toolkit. Available at: https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool1.html. Accessed on Feb 13, 2025.

Validation of Performance Improvement Projects

Preventive Screening PIP

Breast cancer is the most common female cancer in the United States for every major ethnic group, the second most common cause of cancer death in women,[169] and accounts for 15 percent of all new cancer diagnoses in the U.S.[170] Ensuring that all women receive regular breast cancer screening is critically important in disease prevention, early detection, and treatment. In 2019, an estimated 268,600 new cases of invasive breast cancer will be diagnosed among women.[171] Breast cancer screening for women is aimed at identifying breast abnormalities as early as possible, and ideally, before warning signs or symptoms are present when the chances of survival are the highest. Approximately one in eight women (13 percent) will be diagnosed with invasive breast cancer in their lifetime and one in 39 women (3 percent) will die from breast cancer.[172]

Breast cancer is most frequently diagnosed among women ages 55–64 with the median age of diagnosis at 62 years of age. While there are other factors that affect a woman's risk of developing breast cancer, age is a primary risk factor. By age 40, the chances are 1 in 68; by age 50 it becomes 1 in 43; by age 60, it is 1 in 29.[173] Even if breast cancer incidences cannot be substantially reduced for some women who are at high risk for developing the disease, the risk of death from breast cancer can be reduced by regular screening.

Cervical cancer is a type of cancer that occurs in the cells of the cervix. All women are at risk for cervical cancer; however, it occurs most often in women over age 30.[174] According to the American Cancer Society, in the United States for 2020, about 13,800 new cases of invasive cervical cancer will be diagnosed and about 4,290 women will die from the disease.[175] The risk of developing cervical cancer can be reduced by having screening tests and receiving a vaccine that protects against human papillomavirus (HPV) infection. Women who smoke, had many children, used birth control pills for a long time, or have a human immunodeficiency virus (HIV) infection are at higher risk. Cervical cancer used to be the leading cause of cancer death for women in the United States. However, in the past 40 years, the number of cases and the number of deaths from cervical cancer have decreased significantly

[169] Jemal A, Siegel R, Ward E, et al. Cancer Statistics, 2009. *CA: A Cancer Journal for Clinicians*. 2009 Jul-Aug;59(4):225-49. Epub 2009 May 27.
[170] Howlader N, Noone AM, Krapcho M, et al., eds. SEER Cancer Statistics Review, 1975-2016, National Cancer Institute. Bethesda, MD; 2016.
[171] American Cancer Society. Breast Cancer Facts & Figures 2019-2020. Atlanta: American Cancer Society, Inc. 2019.
[172] Howlader N, Noone AM, Krapcho M, et al., eds. SEER Cancer Statistics Review, 1975-2016. Bethesda, MD: National Cancer Institute; 2019.
[173] National Business Group on Health. 2011. "Pathways to Managing Cancer in the Workplace." (May 8, 2012).
[174] Centers for Disease Control and Prevention. (2019, October 18). National Breast and Cervical Cancer Early Detection Program. Available at: https://www.cdc.gov/breast-cervical-cancer-screening/about/?CDC_AAref_Val=https://www.cdc.gov/cancer/nbccedp/about.htm. Accessed on: Feb 13, 2025.
[175] Fontham ETH, Wolf AMD, Church TR, et al. Cervical Cancer Screening for Individuals at Average Risk: 2020 Guideline Update from the American Cancer Society. *CA Cancer J Clin*. 2020. Available at: https://doi.org/10.3322/caac.21628. Accessed on: Feb 13, 2025.

due to women getting screened regularly. The HPV vaccine protects against the types of HPV that most often cause cervical, vaginal, and vulvar cancers. However, the most important thing someone can do to help prevent cervical cancer is to have regular screenings starting at the age of 21.

Between 30–50 percent of all cancer cases are preventable.[176] Breast and cervical cancer screenings increase the chances of detecting certain cancers early, when they might be easier to treat. Prevention offers the most cost-effective long-term strategy for the control of cancer. Policies, programs, and projects should be implemented to raise awareness, to reduce exposure to cancer risk factors, and to ensure that individuals are provided with the information and support needed to participate in preventive screenings.

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Preventive Screening* PIP for the ACC-RBHA population. The objective of the *Preventive Screening* PIP is to increase the number and percentage of breast cancer screenings and cervical cancer screenings.

ACC-RBHA Program-Level Validation Results

Table 6-6 displays the overall confidence levels for the ACC-RBHA Program *Preventive Screening* PIP.

Table 6-6—ACC-RBHA Program *Preventive Screening* PIP Overall Confidence Levels

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

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

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

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

[176] World Health Organization. (2007). Cancer. Available at: https://www.who.int/cancer/prevention/en/. Accessed on: Feb 13, 2025.

ACC-RBHA Program-Level Measure Results

Table 6-7 and Table 6-8 provide the *Preventive Screening* PIP baseline, Remeasurement Year 1, and Remeasurement Year 2 rates for each ACC-RBHA Program Contractor.

Table 6-7—ACC-RBHA Program Contractors' *Preventive Screening* PIP Comparative Rates for Indicator 1

Contractor	PIP Indicator 1: *Breast Cancer Screening*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
AzCH-CCP ACC-RBHA	38.5%	39.1%	46.1%
Mercy Care ACC-RBHA	35.8%	41.1%	44.4%

HSAG rounded percentages to the first decimal place.

Table 6-8—ACC-RBHA Program Contractor' *Preventive Screening* PIP Comparative Rates for Indicator 2

Contractor	PIP Indicator 2: *Cervical Cancer Screening*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
AzCH-CCP ACC-RBHA	43.9%	36.7%	42.2%
Mercy Care ACC-RBHA	43.5%	37.4%	38.2%

HSAG rounded percentages to the first decimal place.

ACC-RBHA Program-Level Interventions

For the *Preventive Screening* PIP, all Contractors provided lists of interventions that were in place for this validation cycle. These lists detailed the identified population, the intervention(s) in place, and whether or not the intervention(s) will be continued. The most common interventions across the ACC-RBHA Program Contractors included targeting members and providers for outreach and education related to breast cancer screenings and cervical cancer screenings. Outreach methods included IVR, person-to-person, and automated phone calls; text message campaigns; emails; and letters and other mailing materials. Provider and member incentives were used as well as mobile services. Gap in care reports including supplemental data for providers identified members in need of screenings. For further descriptions of each Contractor's interventions, see Section 7. ACC-RBHA SMI-Designated Population Program Contractor-Specific Results.

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

Table 6-9 presents program-level strengths, opportunities for improvement, and recommendations for the ACC-RBHA Program related to the *Preventive Screening* PIPs.

Table 6-9—ACC-RBHA Program Strengths, Opportunities for Improvement, and Recommendations Related to the *Preventive Screening* PIPs

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG noted that at the program-level, both Contractors adhered to acceptable methodology through all phases of the PIP. Both Contractors were able to measure the effectiveness of interventions and perform accurate statistical testing between the baseline rates and the Remeasurement 2 rates. Both Contractors were able to achieve statistically significant improvement for Performance Indicator 1 (*BCS*) when comparing the baseline rate to the Remeasurement 2 rate. **[Quality, Access]**
Opportunities for Improvement and Recommendations
The Indicator 2 (*CCS*) rates for both Contractors demonstrated a decline at Remeasurement 2 compared to baseline indicator rates for the *Preventive Screening* PIP. **[Quality, Access]** Recommendations: To support successful progression of the PIPs in the next calendar year, HSAG recommends that the Contractors: • Seek technical assistance from HSAG to understand the PIP submission requirements, if needed. • Revisit the causal/barrier analysis used to develop interventions and adjust the existing interventions or develop new interventions to facilitate improvement for the *CCS* performance indicator. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.

Prenatal and Postpartum Care PIP

According to the CDC, at least 50,000 women in the United States are affected by severe morbidity due to unexpected pregnancy-related health problems. In addition, more than 700 women die each year from pregnancy-related problems or delivery complications. Racial disparities exist among pregnancy-related deaths, as the CDC reports, "American Indian, Alaska Native, and Black women are two to three times more likely to die of pregnancy-related causes than White women."[177] Every death related to pregnancy is a tragedy, especially considering the CDC found that four in five of the deaths are preventable.[178]

According to Healthy People 2030, "women's health before, during, and after pregnancy can have a major impact on infants' health and well-being."[179] Strategies, such as maintaining a healthy lifestyle,

[177] Centers for Disease Control and Prevention. Hear Her Campaign. Pregnancy-Related Deaths in the United States. Available at: https://www.cdc.gov/hearher/pregnancy-related-deaths/index.html. Accessed on: Feb 13, 2025.
[178] Ibid.
[179] U.S. Department of Health and Human Services. Healthy People 2030. Pregnancy and Childbirth. Available at: https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth#:~:text=Women's%20health%20before%2C%20during%2C%20and%20after%20pregnancy%20can%20have%20a,and%20to%20have%20healthy%20babies. Accessed on: Feb 13, 2025.

receiving proper health care, and adopting healthy habits before and during pregnancy help prevent pregnancy complications and improve health outcomes for women and their babies. In addition, these strategies may assist in promoting infant health, development, and overall well-being.

In CYE 2022 (October 1, 2021, through September 30, 2022), AHCCCS implemented the *Prenatal and Postpartum Care* PIP for the ACC-RBHA population. The objective of the *Prenatal and Postpartum Care* PIP is to improve health outcomes for members and infants. This PIP focuses on increasing the number and percentage of members with live birth deliveries that 1) received a prenatal care visit, and 2) received a postpartum visit. As requested by AHCCCS, HSAG did not conduct a validation of the *Prenatal and Postpartum Care* PIP in CYE 2024 as the PIP was in an intervention year (for CY 2023), in alignment with *CMS EQR Protocols* cited earlier in this report.

The ACC-RBHA program-level interventions are presented below.

ACC-RBHA Program-Level Interventions

For the *Prenatal and Postpartum Care* PIP, all Contractors provided AHCCCS lists of interventions that were in place for CYE 2024. These lists detailed the identified population, the intervention(s) in place, and whether or not the intervention(s) will be continued. The most common new interventions across ACC-RBHA Program Contractors included data dashboards and technology advancements to support members' access to care and education materials. The most common continued interventions across the ACC-RBHA Program Contractors included targeting members and providers for outreach and education related to prenatal and postpartum visits. Outreach methods included person-to-person phone calls; text message campaigns; a mobile application; a Web portal; emails; and letters and other mailing materials. Additionally, provider and member incentives were used. Gap in care and NOP reports for providers/strategic partners identified members in need of prenatal and postpartum visits.

For further descriptions of each Contractor's interventions, see Section 7. ACC-RBHA SMI-Designated Population Program Contractor-Specific Results.

Compliance Reviews

AHCCCS includes the following focus areas in its compliance review activity. Table 6-10 presents the focus areas, including each associated acronym, used by AHCCCS during its compliance review.

Table 6-10—Focus Areas and Associated Acronyms

Focus Area	Acronym
Corporate Compliance	CC
Claims and Information Standards	CIS
Delivery Systems	DS
General Administration	GA
Grants Management	GM

Focus Area	Acronym
Grievance Systems	GS
Adult; EPSDT; and Maternal Child Health	MCH
Medical Management	MM
Member Information	MI
Quality Management	QM
Quality Improvement	QI
Reinsurance	RI
Third-Party Liability	TPL
Integrated Systems of Care	ISOC

ACC-RBHA Program-Level Results

AHCCCS conducts a full compliance review for each Contractor every three years. This current three-year review cycle spans from CYE 2022 to CYE 2024. In December 2023, AHCCCS conducted compliance reviews for AzCH-CCP ACC-RBHA and Care1st ACC-RBHA and conducted a compliance review for Mercy Care ACC-RBHA in February 2024. AHCCCS also assessed CAPs for these three Contractors for standards with a total score of less than 95 percent. Table 4-11 presents program-level and comparative results for the ACC-RBHA Program for compliance reviews based on the review of all focus areas. Results and CAP updates for all ACC-RBHA Contractors are available in Section 7. ACC-RBHA SMI-Designated Population Program Contractor-Specific Results.

Table 6-11—ACC-RBHA Program-Level Compliance Review Results

Focus Areas	AzCH-CCP ACC-RBHA	Care1st ACC-RBHA	Mercy Care ACC-RBHA	CYE 2024 Program-Level Average
CC	93%	93%	100%	95%
CIS	100%	99%	99%	99%
DS	100%	97%	97%	97%
GA	98%	98%	96%	97%
GM	100%	100%	100%	100%
GS	100%	100%	100%	100%
MCH	97%	97%	96%	96%
MM	98%	93%	97%	95%
MI	99%	96%	90%	94%
QM	85%	89%	95%	89%

Focus Areas	AzCH-CCP ACC-RBHA	Care1st ACC-RBHA	Mercy Care ACC-RBHA	CYE 2024 Program-Level Average
QI	100%	100%	100%	100%
RI	100%	100%	100%	100%
TPL	100%	100%	100%	100%
ISOC	99%	99%	99%	99%

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

Table 6-12 presents program-level strengths, opportunities for improvement, and recommendations for the ACC-RBHA Program related to compliance.

Table 6-12—ACC-RBHA Program Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
The ACC-RBHA Program-level average score was at or above 95 percent in the following focus areas: • Corporate Compliance (CC) **[Quality, Access]** • Claims and Information Standards (CIS) **[Access]** • Delivery Systems (DS) **[Timeliness, Access]** • General Administration (GA) **[Timeliness, Access]** • Grants Management (GM) **[Quality, Access]** • Grievance Systems (GS) **[Timeliness, Access]** • Adult, EPSDT, and Maternal Child Health (MCH) **[Quality, Timeliness, Access]** • Medical Management (MM) **[Timeliness, Access]** • Quality Improvement (QI) **[Quality, Access]** • Reinsurance (RI) **[Quality]** • Third-Party Liability (TPL) **[Quality, Timeliness, Access]** • Integrated Systems of Care (ISOC) **[Quality, Access]** Two of the three ACC-RBHA Program Contractors successfully completed all CAPs during CYE 2024.

Strengths, Opportunities for Improvement, and Recommendations
Opportunities for Improvement and Recommendations
The ACC-RBHA Program-level average score was below 95 percent in the following focus areas: • Member Information (MI) **[Quality]** • Quality Management (QM) **[Quality]** Recommendation: HSAG recommends that the ACC-RBHA Program Contractors continue to work on any outstanding CAPs during CYE 2025.

Network Adequacy Validation

ACC-RBHA Program-Level Results

ISCA Results

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

Based on the results of the ISCAs combined with the detailed validation of each NAV indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and whether the ACC-RBHA Program Contractors' interpretation of data was accurate. All ACC-RBHA Program Contractors received *High Confidence* for both appointment availability and time/distance indicators. However, there were identified areas for improvement for some of the ACC-RBHA Program Contractors; please refer to Section 7. ACC-RBHA SMI-Designated Population Program Contractor-Specific Results.

NAV Results

HSAG's validation of the ACC-RBHA Program Contractors' results showed minor discrepancies between the ACC-RBHA Program Contractors' self-reported ACOM 436 results and HSAG's time/distance calculations for all ACC-RBHA Program Contractors for which data could be compared. While minor differences (i.e., less than 1 percentage point) between HSAG's time/distance calculation results and each ACC-RBHA Program Contractor's time/distance calculation results were common, these findings are most likely attributable to the timing of the input data or software versions used by

each ACC-RBHA Program Contractor, or due to a small number of members eligible for inclusion in time/distance calculations for the standard and county.

Table 6-13 summarizes HSAG's assessment of each ACC-RBHA Program Contractor's compliance with AHCCCS' minimum time/distance network standards. A check mark indicates that the ACC-RBHA Program Contractor met the minimum network standard for all assigned counties during the CYE 2024 S1 assessment, and an "X" indicates that the ACC-RBHA Program Contractor did not meet one or more minimum network standards in any assigned county. Section 7. ACC-RBHA SMI-Designated Population Program Contractor-Specific Results contains NAV results specific to each ACC-RBHA Program Contractor.

Table 6-13—Summary of CYE 2024 Compliance With Minimum Time/Distance Network Requirements for ACC-RBHA Program Contractors

Minimum Network Requirement	AzCH-CCP ACC-RBHA	Care1st ACC-RBHA	Mercy Care ACC-RBHA
Behavioral Health Outpatient and Integrated Clinic, Adult	✓	✓	✓
BHRF (Only Maricopa and Pima Counties)	✓	NA	✓
Cardiologist, Adult	✓	✓	✓
Cardiologist, Pediatric	✓	✓	✓
Crisis Stabilization Facility	✓	✓	✓
Dentist, Pediatric	X	✓	✓
Hospital	✓	✓	✓
OB/GYN	✓	✓	✓
Pharmacy	✓	✓	✓
PCP, Adult	✓	✓	✓
PCP, Pediatric	✓	✓	✓

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

The ACC-RBHA Program Contractors' performance consistently met the Behavioral Health Outpatient and Integrated Clinic, Adult; BHRF; Cardiologist, Adult and Pediatric; Crisis Stabilization Facility; Hospital; OB/GYN; PCP, Adult and Pediatric; and Pharmacy.

Isolated data issues may have contributed to specific instances affecting the compliance of ACC-RBHA Program Contractors serving the SMI-Designated Population in CYE 2024 with time/distance standards. Specific examples include the following:

- In CYE 2024 S1, one ACC-RBHA Program Contractor's ACOM 436 resubmission for the ACC-RBHA Program may not accurately represent the following standards for Maricopa County, when

compared to information gathered from the ISCA: Cardiologist, Pediatric and OB/GYN. Please use caution when comparing HSAG-calculated results to ACC-RBHA Program Contractor-submitted results.

- In CYE 2024 S1, one ACC-RBHA Program Contractor's data included substantially increased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Adult and Hospital. When contacted, the ACC-RBHA Program Contractor indicated that it inadvertently included home office addresses in its report of service addresses, raising the number of providers in the count. This potentially influenced the validated compliance for these provider categories.

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

Overall, the applicable ACC-RBHA Program Contractors met all minimum time/distance network standards in Apache, Coconino, Gila, Graham, Greenlee, La Paz, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. Based on the CYE 2024 S1 NAV results, Care1st ACC-RBHA and Mercy Care ACC-RBHA met all requirements for all standards in their respective counties.

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

Table 6-14 presents program-level strengths, opportunities for improvement, and recommendations for the ACC-RBHA Program related to NAV.

Table 6-14—ACC-RBHA Program Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • The ACC-RBHA Program Contractors received *High Confidence* for both appointment availability and time/distance indicators. **[Access]** • The applicable ACC-RBHA Program Contractors met all minimum time/distance network standards in Cochise, Graham, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. **[Access]** • The ACC-RBHA Program Contractors consistently met Behavioral Health Outpatient and Integrated Clinic, Adult; BHRF; Cardiologist, Adult and Pediatric; Crisis Stabilization Facility; Hospital; OB/GYN; PCP, Adult and Pediatric; and Pharmacy standards. **[Access]**

Strengths, Opportunities for Improvement, and Recommendations
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: • Isolated data issues may have contributed to specific instances affecting the ACC-RBHA Program Contractors' compliance with time/distance standards. **[Access]** Recommendation: HSAG recommends that AHCCCS support the ACC-RBHA Program Contractors in continuing to monitor their processes for creating the PAT file and review this file for accuracy prior to submitting to AHCCCS.

Consumer Assessment of Healthcare Providers and Systems Results

ACC-RBHA SMI-Designated Population Program Results

HSAG administered member experience surveys on AHCCCS' behalf to adult members enrolled with an ACC-RBHA SMI-Designated Population Program Contractor from the statewide sample and the ACC-RBHA SMI-Designated Population Program oversample provided by AHCCCS.

HSAG calculated results for four global rating questions, four composite measures, one individual item measure, and three medical assistance with smoking and tobacco use cessation items.

Table 6-15 shows the 2024 scores and overall member experience ratings on each CAHPS measure for the adult Medicaid population.

Table 6-15—National Comparisons

Measures	Adult Medicaid
Global Ratings	
Rating of Health Plan	★ 55.7%
Rating of All Health Care	★ 52.2%
Rating of Personal Doctor	★★ 64.6%
Rating of Specialist Seen Most Often	★ 60.0%
Composite Measures	

Measures	Adult Medicaid
Getting Needed Care	★★ 78.2%
Getting Care Quickly	★★ 76.3%
How Well Doctors Communicate	★ 90.9%
Customer Service	★ 83.6%
Individual Item Measure	
Coordination of Care	★★ 84.5%
Medical Assistance With Smoking and Tobacco Use Cessation Items	
Advising Smokers and Tobacco Users to Quit	★★★ 75.8%
Discussing Cessation Medications	★★★★ 61.3%
Discussing Cessation Strategies	★★★ 49.2%

Star Assignments Based on Percentiles:
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

ACC-RBHA SMI-Designated Population Program Strengths, Opportunities for Improvement, and Recommendations Related to Consumer Assessment of Healthcare Providers and Systems Results

Table 6-16 presents the ACC-RBHA SMI-Designated Population Program strengths, opportunities for improvement, and recommendations for the 2024 adult Medicaid SMI-Designated population CAHPS results.

Table 6-16—ACC-RBHA SMI-Designated Population Program Strengths, Opportunities for Improvement, and Recommendations Related to CAHPS

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths for the ACC-RBHA SMI-Designated Population Program's adult Medicaid population:

Strengths, Opportunities for Improvement, and Recommendations
• The ACC-RBHA SMI-Designated Population Program's member experience rating for *Discussing Cessation Medications* was at or between the 75th and 89th percentile for the adult Medicaid population. **[Quality]**
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement for the ACC-RBHA SMI-Designated Population Program's adult Medicaid population: • The ACC-RBHA SMI-Designated Population Program's member experience ratings for *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, and *Customer Service* were below the 25th percentile for the adult Medicaid population. **[Quality]** • The ACC-RBHA SMI-Designated Population Program's member experience ratings for *Rating of Personal Doctor*, *Getting Needed Care, Getting Care Quickly*, and *Coordination of Care* were at or between the 25th and 49th percentile for the adult Medicaid population. **[Quality, Timeliness, Access]** Recommendation: HSAG recommends that the ACC-RBHA SMI-Designated Population Program Contractors explore what may be driving lower experience scores and develop initiatives designed to improve the quality of and access to care, including a focus on improving adult members' overall experiences with their health plan, overall health care, the specialist they see most often, their doctor's ability to communicate, coordination of care, customer service, and getting needed care in a timely manner.

7. ACC-RBHA SMI-Designated Population Program Contractor-Specific Results

ACC-RBHA Contractors are responsible for the provision of services for the SMI-Designated population.

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

AzCH-CCP ACC-RBHA

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2024, HSAG evaluated AzCH-CCP ACC-RBHA's data system for processing of each data type used for reporting the Contractor's CY 2023 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that AzCH-CCP ACC-RBHA followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 7-1 displays HSAG's PMV findings for each data type reviewed during CYE 2024 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 7-1—CYE 2024 PMV Findings

Data Type	HSAG Findings
Medical Services Data	*No identified concerns*
Enrollment Data	*No identified concerns*
Provider Data	*No identified concerns*
Medical Record Review Process	*No identified concerns*
Supplemental Data	*No identified concerns*
Data Integration	*No identified concerns*

Results for Performance Measures

Table 7-2 presents the CY 2022 and CY 2023 AzCH-CCP ACC-RBHA results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and MY 2023. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and/or MY 2023. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 7-2—CY 2022 and CY 2023 AzCH-CCP ACC-RBHA Performance Measure Results

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	71.4%+	68.8%+	→	★
Postpartum Care	54.1%+	65.0%+	→	★
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	60.5%	54.9%	↓	★
Effective Continuation Phase Treatment—Total (18+ Years)	44.1%	41.0%	→	★★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	61.9%	48.0%	↓	★★★★★
30-Day Follow-Up—Total (13+ Years)	73.4%	67.7%	→	★★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	61.3%	63.3%	→	★★★★★
30-Day Follow-Up—Total (6+ Years)	79.3%	79.5%	→	★★★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	54.0%	50.4%	→	★★★★
30-Day Follow-Up—Total (6+ Years)	70.9%	69.5%	→	★★★★
Use of Opioids at High Dosage				
*18+ Years**	12.3%	10.1%	→	★
Initiation and Engagement of Substance Use Disorder (SUD) Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	54.2%	53.5%	→	★★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	17.0%	18.0%	→	★★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	58.5%	58.6%	→	★★

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	82.7%	86.1%	↑	★★★★
Care of Acute and Chronic Conditions				
Controlling High Blood Pressure				
18–85 Years	64.5%+	65.5%	→	★★★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0 Percent)—Total (18–75 Years)	57.7%+	61.3%+	→	★★★★
*Poor HbA1c Control (>9.0 Percent)—Total (18–75 Years)**	35.8%+	31.9%+	→	★★★
Pediatric Health				
Oral Evaluation, Dental Services				
Total (0–20 Years)[N]	24.1%	21.4%	→	—
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	39.1%	46.1%	↑	★
Cervical Cancer Screening				
21–64 Years	49.9%+	44.8%+	→	★
Appropriate Utilization of Services				
Ambulatory Care				
Emergency Department (ED) Visits—Total (0–85+ Years)[F]	1,161.0	1,224.5	—	—
Plan All-Cause Readmissions				
*Observed/Expected (O/E) Ratio—Total (18–64 Years)**	1.3425	1.1704	—	★

* A lower rate indicates better performance for this measure.
+ Indicates the measure was reported using hybrid methodology.
Cells shaded green indicate that the rate met or exceeded the MY 2022 and/or MY 2023 and/or national Medicaid mean.
— Indicates a 2022–2023 comparison is not presented in the CYE 2024 Annual Technical Report because either the CY 2022 rate was not presented in the CYE 2023 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
[1]Aggregated rates were calculated and compared from CY 2022 to CY 2023, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.
[2] Performance Levels for CY 2023 were based on comparisons of the HEDIS MY 2023 measure rates to national Medicaid Quality Compass HEDIS MY 2023 benchmarks.
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.
[N] Measure has no NCQA Medicaid mean for comparison.
↑ Indicates statistically significant improvement of measure rates.
↓ Indicates statistically significant decline of measure rates.
→ Indicates no statistically significant change in measure rates.

Performance Levels for 2023 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 7-3 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC-RBHA related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 7-3—AzCH-CCP ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group: • Nine of 13 AzCH-CCP ACC-RBHA measure rates (69.23 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. **[Quality, Timeliness, Access]** • AzCH-CCP ACC-RBHA's performance measure rates for *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)*, *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18-64 Years* as well as *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* were between the 75th and 89th percentile, indicating strength in providing follow-up behavioral healthcare to members. **[Quality, Timeliness, Access]** • AzCH-CCP ACC-RBHA's performance measure rates for *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)* and *30-Day Follow-Up—Total (13+ Years)*, and *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* were at or above the 90th percentile, indicating strength in providing follow-up behavioral healthcare to members. **[Quality, Timeliness, Access]**
In the Care of Acute and Chronic Conditions measure group: • All three of AzCH-CCP ACC-RBHA's measure rates (100.0 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. **[Quality]** • AzCH-CCP ACC-RBHA's performance measure rate for *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 %)—Total (18–75 Years)* was between the 75th and 89th percentile, indicating strength in providing follow-up care of acute and chronic conditions to members. **[Quality]**

Strengths, Opportunities for Improvement, and Recommendations
Opportunities for Improvement and Recommendations
While AzCH-CCP ACC-RBHA was successful in reporting valid rates for all AHCCCS-required performance measures for its SMI-Designated population, the audit identified some considerations and recommendations for future years' reporting. **[Quality]** Recommendations: • HSAG recommends that AzCH-CCP ACC-RBHA continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES. • HSAG recommends that AzCH-CCP ACC-RBHA continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes AHCCCS' requirements for MCO-enrolled members who switch product lines or MCOs and members for whom AzCH-CCP ACC-RBHA does not hold the primary insurance contract.
In the Maternal and Perinatal Care measure group, AzCH-CCP ACC-RBHA's performance measure rates for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* remain below the 25th percentile, indicating continued opportunity to increase access to timely prenatal and postpartum care. **[Quality, Timeliness, Access]** Recommendation: While AzCH-CCP ACC-RBHA conducted a root cause analysis and implemented targeted interventions specific to the MY 2023 *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* rates, these rates remained low for both MY 2023, as well as for the prior two years. HSAG recommends that AzCH-CCP ACC-RBHA continue to implement appropriate interventions to improve performance relative to prenatal and postpartum care. HSAG also recommends that AzCH-CCP ACC-RBHA monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Postpartum Care* measure indicators, while adding interventions as appropriate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care*.
In the Behavioral Health measure group, AzCH-CCP ACC-RBHA's performance measure rate for *Use of Opioids at High Dosage—18+ Years* remains below the 25th percentile. This result indicates a continued opportunity for AzCH-CCP ACC-RBHA to monitor prescribing and utilization data and to implement interventions to improve care and services around opioid prescribing. The CDC guidelines on opioid prescribing for chronic, nonmalignant pain recommend the use of "additional precautions" when prescribing dosages ≥50 MED and that providers avoid or "carefully justify" increasing dosages ≥90 mg MED.[180] **[Quality]**

[180] National Committee for Quality Assurance. Use of Opioids at High Dosage (HDO). Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/. Accessed on: Feb 19, 2025.

Strengths, Opportunities for Improvement, and Recommendations
Recommendation: While AzCH-CCP ACC-RBHA conducted a root cause analysis and implemented targeted interventions specific to the MY 2022 *Use of Opioids at High Dosage—18+ Years* rates, this rate remained low for both MY 2023. HSAG also recommends that AzCH-CCP ACC-RBHA monitor and expand on interventions currently in place to improve performance related to the *Use of Opioids at High Dosage—18+ Years* measure. HSAG recommends outreach to members who fall within this category to assess and schedule interventions as necessary. [181] HSAG also recommends that AzCH-CCP ACC-RBHA identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts.
In the Preventive Screening measure group, AzCH-CCP ACC-RBHA's performance measure rates for *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* remain below the 25th percentile, indicating that not all women were receiving timely screening for breast and cervical cancers. Early detection reduces the risk of dying from these types of cancers and can lead to a greater range of treatment options and lower healthcare costs.[182] **[Quality]** Recommendation: While AzCH-CCP ACC-RBHA conducted a root cause analysis and implemented interventions specific to the MY 2022 *Breast Cancer Screening* and *Cervical Cancer Screening* rates, these rates remained low for MY 2023, as well as the previous two years. HSAG therefore recommends that AzCH-CCP ACC-RBHA continue to implement appropriate interventions to improve performance related to preventive screenings. HSAG also recommends that AzCH-CCP ACC-RBHA monitor and expand on interventions currently in place to improve performance related to the *Breast Cancer Screening* and *Cervical Cancer Screening* measures. HSAG recommends that AzCH-CCP ACC-RBHA consider utilizing one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve cervical cancer screening rates. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness.
In the Appropriate Utilization of Services measure group, AzCH-CCP ACC-RBHA's performance measure rates for *Plan All-Cause Readmissions O/E Ratio—Total (18–64 Years)* remained below the 25th percentile. **[Quality]** Recommendation: While AzCH-CCP ACC-RBHA initiated efforts to identify best practices for reducing unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay, its rates remained below the 25th percentile for MY 2023. HSAG recommends that AzCH-CCP ACC-RBHA continue to follow through on these performance improvement strategies in order to increase provider and member outreach and improve follow-up care after discharge from an acute inpatient admission or observation. HSAG recommends that AzCH-CCP ACC-RBHA consider reviewing the Re-Engineered Discharge (RED), which has been shown to

[181] National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/ Accessed on: Feb 19, 2025.
[182] National Committee for Quality Assurance. Breast Cancer Screening (BCS). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Feb 19, 2025.

Strengths, Opportunities for Improvement, and Recommendations
reduce readmissions and posthospital ED visits.[183] Other interventions that might be effective include technology platforms, including AI or machine learning, that can assist the plan in identifying members more at risk of re-admission. HSAG recommends that AzCH-CCP ACC-RBHA utilize case management strategies that focus on person-centered techniques, addressing barriers and/or SDOH as needed.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 7-4 presents performance measure recommendations made to AzCH-CCP ACC-RBHA in the CYE 2023 Annual Technical Report[184] and AzCH-CCP ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which AzCH-CCP ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 7-4—AzCH-CCP ACC-RBHA Follow-Up to CYE 2023 Performance Measure Recommendations

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Recommendation 1:
HSAG recommended that AzCH-CCP ACC-RBHA continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes AHCCCS' requirements for Contractor-enrolled members who switch product lines or Contractors and members for whom AzCH-CCP ACC-RBHA does not hold the primary insurance contract.
AzCH-CCP ACC-RBHA's Response: • AzCH-CCP ACC-RBHA is continuing to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. • AzCH-CCP ACC-RBHA is continuing to conduct and complete formal reviews of the source code, including a complete test plan, live system validation of data, and correct any discrepancies identified.
HSAG's Assessment: HSAG determined that AzCH-CCP ACC-RBHA satisfactorily addressed these prior year's recommendations.
Recommendation 2:

[183] Agency for Healthcare Research and Quality. Re-Engineered Discharge (RED) Toolkit. Available at: https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool1.html. Accessed on Feb 19, 2025.

[184] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Jan 13, 2025.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
AzCH-CCP ACC-RBHA had some difficulty reconciling the reported rates for measures with additional stratification, such as age groups for *Follow-Up After ED Visit for Substance Use*. This was due to the timing of when rates were initially calculated by the Contractor's corporate team, and then reported out with revised rate runs later in the year. HSAG therefore recommended that AzCH-CCP ACC-RBHA ensure subpopulations are totaled to reflect the full population and conduct live system validation of data after its vendor's first run of MY 2023 rates, prior to reporting any performance measure data to AHCCCS.
AzCH-CCP ACC-RBHA's Response: • AzCH-CCP ACC-RBHA identified the HEDIS engine does not have the certain age specifications for measures with additional stratifications. Moving forward AzCH-CCP ACC-RBHA will run both Child and Adult CMS Core measures to ensure data are received in a timely manner for performance measures such as *Follow-Up After ED Visit for Substance Use*.
HSAG's Assessment: AzCH-CCP ACC-RBHA did not demonstrate the same performance concerns during the CY 2023 audit; therefore, HSAG determined that AzCH-CCP ACC-RBHA satisfactorily addressed these prior year's recommendations.
Recommendation 3:
HSAG also recommended that AzCH-CCP ACC-RBHA continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race and ethnicity data to support performance measure reporting that requires stratification related to race and ethnicity. HSAG recommends that AzCH-CCP ACC-RBHA continue to ensure that the mapping of provider specialties to HEDIS provider types is compliant with AHCCCS' requirements for PMV reporting.
AzCH-CCP ACC-RBHA's Response: • AzCH-CCP ACC-RBHA utilizes a corporate contracted third party to incorporate indirect race and ethnicity member data. AzCH-CCP ACC-RBHA acknowledges that this is simply a step to help illuminate the served population; however, AzCH-CCP ACC-RBHA's goal is to increase the overall percentage of direct collected member race and ethnicity data. AzCH-CCP ACC-RBHA and a corporate partner are working to improve direct collection by expanding the member portal to allow members to provide their race, ethnicity, language (written and spoken), sexual orientation, gender identity, and pronoun preference once the changes have received AHCCCS approval.
HSAG's Assessment: HSAG determined that AzCH-CCP ACC-RBHA satisfactorily addressed these prior year's recommendations.
Recommendation 4:
While AzCH-CCP ACC-RBHA conducted a root cause analysis and implemented targeted interventions specific to the CY 2020 *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* rates, these rates remained low for both CY 2021 and CY 2022. HSAG therefore recommends that AzCH-CCP ACC-RBHA continue to implement appropriate interventions

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
to improve performance relative to prenatal and postpartum care. HSAG also recommends that AzCH-CCP ACC-RBHA continue to monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measures.

AzCH-CCP ACC-RBHA's Response:

AzCH-CCP ACC-RBHA's performance measure rate for *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, indicating an opportunity to increase access to timely postpartum care. The root cause analysis focuses on increasing access to postpartum care by identifying those barriers such as collaboration with providers and the health plan, successful communication with members, and effective gap lists. In response to identified barriers, the following interventions were implemented:

- SSFB program effectively educates and encourages members via text messaging and emails.
- PPC Provider Form supplies providers with educational material and engages providers for education, technical assistance, and performance improvement.
- Implementation of a mobile application that provides a specialized care plan for members with tailored daily health checklists, provides alerts, care gaps, progress tracking to CMS, and allows for two-way video/text communication with care management.
- Weekly newborn calls outreach birthing parents and educate and assist with scheduling postpartum appointments. In Q4 CY 2023, 1,843 calls were attempted with a 22.0 percent reach rate, with a total of 4,128 calls completed throughout the year.
- NOP reports are sent to strategic partners and provider groups for member outreach. The goal of this report is to create a proactive outreach list so members can be engaged early with prenatal care and educated about the importance of postpartum care, available resources and community supports.
- PPC Workgroup is an internal monthly workgroup to include CM, QM, and Health Equity to identify/address racial disparities and increase prenatal/postpartum outcome measures.
- In addition, in CY 2024 AzCH-CCP ACC-RBHA implemented a Health Equity committee, a cross-functional monthly committee convened to review identified measures by contract stratified by race and ethnicity to determine opportunities to close disparity gaps and implement health equity-focused interventions.

AzCH-CCP ACC-RBHA has implemented the following interventions to increase member engagement around *Prenatal and Postpartum Care—Postpartum Care— Timeliness of Prenatal Care* and *Postpartum Care*:

- SSFB program, enrollment into care management (until six weeks after delivery), effectively educate and encourage members via text messaging and emails.
  - In Q2 CY 2023, 73 percent of RBHA members who were identified as having a high-risk pregnancy were enrolled in the SSFB Care Management Program. QI and MCH/CM

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
collaborated to create reports to build a proactive outreach program including weekly NOP reports to providers and SSFB packets sent to members in CY 2023. Totals include: o NOP reports (Q4 CY 2023): 1,606; Pregnancy packet: 1,167; and Newborn packet: 1,355—Please note this is inclusive of both ACC and RBHA members. • AzCH-CCP ACC-RBHA Prenatal and Postpartum Work Group continues to meet monthly to discuss initiatives to increase related measures and has begun to review high level member data stratified by race/ethnicity to identify any potential disparities. AzCH-CCP ACC-RBHA will explore possible implementations as a result of collaboration with other plans. • The DCM team was fully staffed at four care managers by end of 2023, addressing the needs of both our OB and Adult Non-SMI-Designated population. Wellframe was a successful tool in communicating with members and disease management. The various care programs educate and coach members to improve their self-management of conditions.
HSAG's Assessment: AzCH-CCP ACC-RBHA identified interventions that were implemented for CY 2023 as a result of conducting a root cause analysis; therefore, HSAG determined that AzCH-CCP ACC-RBHA satisfactorily addressed these prior year's recommendations.
Recommendation 5:
While AzCH-CCP ACC-RBHA conducted a root cause analysis and implemented interventions to determine why there was a higher proportion of members receiving prescriptions for opioids, performance remained below the 25th percentile in CY 2022. HSAG therefore recommends that AzCH-CCP ACC-RBHA continue to implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse. HSAG also recommends that AzCH-CCP ACC-RBHA monitor and expand on interventions currently in place to improve performance related to the *Use of Opioids at High Dosage—18+ Years* measure.
AzCH-CCP ACC-RBHA's Response: AzCH-CCP ACC-RBHA's performance measure rates for *Use of Opioids at High Dosage* fell below the 25th percentile, indicating an opportunity to increase provider and member outreach. The root cause analysis focuses on increasing member and provider outreach by identifying those barriers such as, lack of education to members and lack of education to providers regarding best practices around opioid misuse and support. Interventions in place in response to the barriers identified: • Implementation of a medication adherence reward program which incentivizes members for taking daily medication. • Path to 5, a reference guide for providers used to educate on quality and performance measures. Includes best practices on closing quality care gaps. • Provider letters are sent to the providers prescribing opioids at a high dosage along with other medications that may put members at a higher risk for HDO overdose. The letter offers education and additional assistance to develop a process to reduce patient risk. • The PQL who are building relationships with the top providers to increase performance and member satisfaction, improve knowledge, and provide technical assistance.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
AzCH-CCP ACC-RBHA has implemented the following interventions to increase member engagement around *Use of Opioids at High Dosage in Persons Without Cancer*: • Wellth, a medication adherence reward program that incentivizes members to take their daily prescribed medication for opioid use disorder treatment. – At the end of Dec 2023, there were 571 AzCH-CCP ACC-RBHA members active in the Wellth program. Medication adherence improved by an average increase of 17 percent for these members in key drug classes addressing behavioral health conditions, such antidepressant, antipsychotic, and antileptic medications. • Max Opioid Dosage Provider Outreach Campaign to educate providers regarding members receiving dosages that exceed the recommended guidelines. – During Q4 CY 2023, there were 45 members identified for provider outreach through the Max Opioid Dosage Provider Outreach Campaign. • Provide education to providers regarding members receiving dosages that exceed the recommended guidelines. – For Q4 CY 2023, there were 127 initial prescriber letters sent with three follow-up/reminders. The highest category of outreach was for members with a diagnosis for chronic opioid use request at 47, followed closely by 46 letters for multiple prescribers.
HSAG's Assessment: AzCH-CCP ACC-RBHA identified interventions that were implemented for CY 2023 as a result of conducting a root cause analysis; therefore, HSAG determined that AzCH-CCP ACC-RBHA satisfactorily addressed these prior year's recommendations.
Recommendation 6:
While AzCH-CCP ACC-RBHA conducted a root cause analysis and implemented interventions specific to the CY 2020 *Breast Cancer Screening* and *Cervical Cancer Screening* rates, these rates remained low for both CY 2021 and CY 2022. HSAG therefore recommended that AzCH-CCP ACC-RBHA continue to implement appropriate interventions to improve performance related to preventive screenings. HSAG also recommended that AzCH-CCP ACC-RBHA monitor and expand on interventions currently in place to improve performance related to the *Breast Cancer Screening* and *Cervical Cancer Screening* measures.
AzCH-CCP ACC-RBHA's Response: AzCH-CCP ACC-RBHA's performance measure rates for *Breast Cancer Screening* and *Cervical Cancer Screening* fell below the 25th percentile, indicating that women were not receiving timely screening for breast and cervical cancers. The root cause analysis focuses on increasing the number of members receiving timely screenings and looking at those barriers affecting members, such as access to care/services, scheduling of appointments, and education. All performance measures and interventions are monitored, and their effectiveness is discussed during monthly meetings held by the Performance Improvement Subcommittee (PISC) and Quality Improvement Committee (QIC). Interventions in place in response to the barriers identified:

Prior Year's Recommendation From the EQR Technical Report for Performance Measures

- Mobile mammogram events increase access to members as they are open to the public.
- Collaboration with radiology facilities consisting of direct outreach.
- Blitz call campaign served as an initiative to educate, encourage, and assist members to schedule necessary appointments.
- CM and QM Collaboration Workgroup meets monthly to coordinate efforts, refine interventions, and identify barriers and opportunities.
- Motivational Interviewing training developed in conjunction with the American Cancer Society and is catered to providers to encourage the utilization of motivational interviewing techniques to address screening hesitancy with members.

AzCH-CCP ACC-RBHA has implemented the following interventions to increase member engagement around breast cancer and cervical cancer screenings:

- Promotoras are community service workers who conduct outreach to members in Yuma who have identified care gaps. They assist in scheduling appointments and address barriers to completing those appointments.
  - The Promotoras in CY 2023 conducted at total of 5,954 calls to Medicaid members with a reach rate of 49 percent. Although, Promotoras outreach has been successful for MCD members, in CY 2023 outreach to our RBHA members was determined insignificant with only two members being outreached.
- Mobile mammogram events are a collaboration with an imaging company to provide mammograms to the public at no cost.
  - AzCH-CCP ACC-RBHA held eight mammogram events in CY 2023. Please note this is inclusive of ACC, RBHA and uninsured populations and was not effective for members in the RBHA population as there were no confirmed RBHA members who participated.
- My Health Pays Rewards is a member incentive program that provides an annual reward for members who obtain their cervical cancer screening.
  - A total of 805 My Health Pays rewards were provided to members over the course of CY 2023.
- Breast Cancer Screening Mailers reminding members to obtain their breast cancer screenings. Mailers are sent via email if available, or physical mail if no email is available. These mailers include reminders for cervical cancer screening as well.
  - Breast Cancer Screening Mailers had a total of 2,2687 mailers sent in CY 2023 with a 13% care gap closure rate. Please note this includes the RBHA population as well.
- QM & CM Partnership to train staff on the necessity of breast cancer screenings. QM provided desktop talking points, electronic health record (EHR) resource information, and EHR-based letters to send out to members. CM is inputting touchpoints with members into the EHR HEDIS Structured Notes.
  - HEDIS Structured Notes are specific progress notes that assist in appropriately capturing HEDIS-specific information during member and care manager interaction.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
• Motivational Interviewing training was held in Q4 2023. Provider quality liaisons continue to focus on sending information regarding the training to provider groups so they may provide it to their members. Additionally, the promotion of the training opportunity continues to be presented within integrated provider meetings. – In CY 2023, a total of four Motivational Interviewing trainings were provided with a total of 40 providers who participated. There is an opportunity to review the current Motivational Interviewing flyer and consider language that clarifies to include all levels of staff and outreach providers to confirm and/or better understand barriers to staff attendance.
HSAG's Assessment: AzCH-CCP ACC-RBHA identified interventions that were implemented for CY 2023 as a result of conducting a root cause analysis; therefore, HSAG determined that AzCH-CCP ACC-RBHA satisfactorily addressed these prior year's recommendations.
Recommendation 7:
While AzCH-CCP ACC-RBHA initiated efforts to identify best practices for reducing unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay, its rates remained below the 25th percentile for CY 2022. AzCH-CCP ACC-RBHA also followed the recommendation of conducting a root cause analysis to identify factors contributing to members experiencing unplanned acute readmissions, which should include evaluating whether appropriate follow-up care is available to members on discharge from an acute inpatient admission or observation. HSAG recommends that AzCH-CCP ACC-RBHA continue to follow through on these performance improvement strategies in order to increase provider and member outreach and improve follow-up care after discharge from an acute inpatient admission or observation.
AzCH-CCP ACC-RBHA's Response: AzCH-CCP ACC-RBHA's performance measure rates for *Plan All-Cause Readmissions O/E Ratio—Total* fell below the 25th percentile, indicating an opportunity to increase provider and member outreach. The root cause analysis focuses on increasing member and provider outreach by identifying those barriers such as lack of education to members and lack of education to providers regarding best practices around appropriate follow-up care after discharge from an acute inpatient admission or observation. Interventions in place in response to the barriers identified: • Implementation of a mobile application designed to help members in developing a support system and support members with SDOH. • CM and QM Collaboration Workgroup meets monthly to coordinate efforts, refine interventions, and identify barriers and opportunities. • Daily behavioral health Inpatient Reports to available for AzCH-CCP ACC-RBHA Care Management and for Health Homes to begin discharge planning and coordinating care immediately. The process was enhanced by automating the movement of the reports daily to individual secure file transfer protocol (SFTP) sites.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
• Path to 5, a reference guide for providers, was used to educate on quality and performance measures and includes best practices on closing quality care gaps. • Population Health Management Workgroup, a cross-functional workgroup focused on performance improvement strategies to increase effectiveness of population health programming. AzCH-CCP ACC-RBHA has implemented the following interventions to increase member engagement around *Plan All-Cause Readmissions O/E Ratio—Total*: • Pyx Health, a mobile application to address loneliness, social isolation, assist in developing a support system and support with SDOH. – There are 4,300 AzCH-CCP ACC-RBHA members utilizing the Pyx mobile application. Pyx compassionate call representatives build trust and a good rapport with members, as well as providing resources and support to address their SDOH needs. • Wellframe mobile application (app) provides a specialized care plan (based on certain tracks) for members with a specialized daily health checklist; providers' alerts, care gaps, and progress tracking to CMs; allows for two-way video/text communication with care management. – The Digital Care Management team (DCM) was fully staffed at four care managers by the end of 2023, addressing the needs of both our OB and adult Non-SMI-Designated population. Wellframe was a successful tool in communicating with members and disease management. The various care programs educate and coach members to improve their self-management of conditions. • Population Health Management (PHM) cross-functional workgroup focused on performance improvement strategies to increase effectiveness of population health programming. – PHM workgroup is held quarterly with the goal to improve health outcomes by identifying health trends and opportunities for improvement. In August CY 2023, the workgroup presented a PHM playbook and a summary of available reports. The next workgroup to be held in CY 2024 and will narrow down the focus on data points.
HSAG's Assessment: AzCH-CCP ACC-RBHA identified interventions that were implemented for CY 2023 as a result of conducting a root cause analysis; therefore, HSAG determined that AzCH-CCP ACC-RBHA satisfactorily addressed these prior year's recommendations.

Validation of Performance Improvement Projects

Preventive Screening PIP

In CY 2024, AzCH-CCP ACC-RBHA continued the *Preventive Screening* PIP, which was initiated in CYE 2019. As the PIP had progressed through Remeasurement 2, PIP validation activities focused on improvement from the baseline results. AzCH-CCP ACC-RBHA submitted Remeasurement 2 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes to or possible discontinuation of the interventions.

HSAG conducted an annual validation of the second remeasurement year reflective of CY 2023 (January 1, 2023, through December 31, 2023) using AHCCCS-calculated and validated indicator rates. HSAG evaluated AzCH-CCP ACC-RBHA's performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

Validation Results

Table 7-5 displays the overall confidence levels for the AzCH-CCP ACC-RBHA *Preventive Screening* PIP.

Table 7-5—AzCH-CCP ACC-RBHA *Preventive Screening* PIP Overall Confidence Levels

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

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

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

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

Measure Results

Table 7-6 and Table 7-7 provide the *Preventive Screening* PIP baseline, Remeasurement Year 1, and Remeasurement Year 2 rates for each indicator for AzCH-CCP ACC-RBHA.

Table 7-6—AzCH-CCP ACC-RBHA *Preventive Screening* PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: *Breast Cancer Screening*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
AzCH-CCP ACC-RBHA	38.5%	39.1%	46.1%

Table 7-7—AzCH-CCP ACC-RBHA *Preventive Screening* PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: *Cervical Cancer Screening*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
AzCH-CCP ACC-RBHA	43.9%	36.7%	42.2%

HSAG rounded percentages to the first decimal place.

Interventions

Table 7-8 presents PIP interventions for AzCH-CCP ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 7-8—AzCH-CCP ACC-RBHA *Preventive Screening* PIP Interventions

Contractor	Intervention
AzCH-CCP ACC-RBHA	• Mobile mammogram events increased access to breast cancer screenings. Please note, these events are open to the public to encourage breast cancer screening education, reduce stigma, and encourage completion. • Promotoras (community health workers/representatives) served those members who are hard to locate in the community by linking them with resources that support health education, access to care, and prevention, as well as addressing any social determinants that may impact their ability to get the services they need. • Education and promotion of the annual MHP member incentive for members who obtained their cervical cancer screening. • Multi-prong member outreach campaigns consisted of mailers and emails that educated and encouraged members to obtain needed screenings and tests. • Quarterly Provider-Facing Motivational Interviewing Training focused on how to address barriers and engage members to complete recommended cancer screenings. • Court Ordered Treatment (COT) Care Gap Initiative—Quarterly gap lists sent to the AzCH-CCP ACC-RBHA COT team for coordination with each COT member's assigned health home. • Wellth Gap Closure Program—Members who are already enrolled in the Wellth Program for psychiatric medication adherence and based on the member's open care gaps, the member was prompted through behavioral prompts and check-ins to explore more information relevant to the member's health and services that are beneficial to the member inclusive of breast cancer and cervical cancer screening.

Contractor	Intervention
	• BHRF Care Gap Initiative. Targeting Integrated SMI/RBHA adult members (ages 18–64) admitted to a BHRF. Collaboration with BHRFs to coordinate preventive care for members within their care reducing transportation issues and increasing communication, education, and access to care. • Population Health Management Workgroup to achieve three main goals: Advance the health of populations, improve member experience, and deliver systemwide transformation to better serve member population health needs. • Care Management and Quality Management Collaboration Workgroup met monthly to coordinate efforts, refine interventions, and identify barriers and opportunities. • Path to 5—provider educational material. • Care Gap Passport, a customized list of open care gaps sent out to members and how to access member rewards per their health plan. • Catalytic Care Gap Initiative—Coordination with Catalytic Health Partners who serve high acuity and vulnerable members referred by case management. This initiative seeks to capitalize on the existing outreach to engage members in physical healthcare measures.

Strengths, Opportunities for Improvement, and Recommendations

Table 7-9 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC-RBHA related to the *Preventive Screening* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 7-9—AzCH-CCP ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to the *Preventive Screening* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG noted that AzCH-CCP ACC-RBHA adhered to acceptable methodology through all phases of the PIP and was able to measure the effectiveness of interventions and perform accurate statistical testing between the baseline rate and the Remeasurement 2 rate. AzCH-CCP ACC-RBHA was able to achieve statistically significant improvement for Performance Indicator 1 (*BCS*) when comparing the baseline rate to Remeasurement 2 rate. **[Quality**, **Access]**
Opportunities for Improvement and Recommendations
For Indicator 2, AzCH-CCP ACC-RBHA had a decline of 1.7 percentage points between the baseline year and Remeasurement Year 2. **[Quality**, **Access]**

Strengths, Opportunities for Improvement, and Recommendations
Recommendations: To support successful progression of the PIP in the next calendar year, HSAG recommends that AzCH-CCP ACC-RBHA: • Seek technical assistance from HSAG to understand the PIP submission requirements, if needed. • Revisit the causal/barrier analysis used to develop interventions and adjust the existing interventions or develop new interventions to facilitate improvement for the *CCS* performance indicator. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 7-10 presents PIP recommendations made to AzCH-CCP ACC-RBHA in the CYE 2023 Annual Technical Report [185] and AzCH-CCP ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which AzCH-CCP ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 7-10—AzCH-CCP ACC-RBHA Follow-Up to CYE 2023 PIP Recommendations

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG recommended that AzCH-CCP ACC-RBHA: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. • Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates,
AzCH-CCP ACC-RBHA's Response: AzCH-CCP RBHA identified the following barriers to assist in focusing interventions to better engage members in care:

[185] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for PIPs
• Member engagement was low across the board for preventive measures due to the COVID-19 pandemic. Additionally, due to the increase of provider burden because of the COVID-19 pandemic, the majority of member and provider outreach was paused for a portion of CY 2020. • Lack of member awareness of why the screenings are important to complete. • Lack of easily accessible transportation or alternative opportunities for care. • Lack of knowledge of need and safety of preventive care. AzCH-CCP RBHA has assessed the impact and effectiveness of the following interventions during the second remeasurement year:

Interventions Assessment		
Interventions	Timeline	Impact/Effectiveness
Mobile mammograms events to increase access to breast cancer screenings. Please note these events are open to the public to encourage breast cancer screening education, reduce stigma, and completion.	Q1 2019 – Q4 2022 This intervention has been incorporated as a standard business practice.	This intervention's expected impact is to provide additional opportunities for access to care and encourage members to take the necessary steps to increase utilization.
Promotoras (community health workers/representatives) serve those members that are hard to locate in the community by linking them with resources to support health education, access to care, prevention as well as addressing any social determinants that may impact their ability to get the services they need.	Q2 2019 – Q4 2022 This intervention has been incorporated as a standard business practice.	This intervention's expected impact is to provide additional opportunities for access to care and encourage members to take the necessary steps to increase positive outcomes and reduce stigma within the community and family setting.
Education and promotion of the annual My Health Pays member incentive for members who obtain their cervical cancer screening.	Q3 2019 – Q4 2022 This intervention has been incorporated as a standard business practice.	This intervention's expected impact is to provide incentives to increase comfortability with obtaining cervical cancer screenings and reduce stigma around obtaining such screenings.
Multi-prong member outreach campaigns consisting of mailers and emails to educate and	Q1 2021 – Ongoing	Impact to enrolled population would be an increase of member's health literacy for

Prior Year's Recommendation From the EQR Technical Report for PIPs		
encourage members to obtain needed screenings and tests.		BCS and CCS, as well as an increase in scheduled and kept appointments.
Motivational Interviewing Training. Quarterly Provider-Facing Motivational Interviewing Training focused on how to address barriers and engage members to complete recommended cancer screenings.	Q1 2021 – Ongoing	Impact to enrolled population would be increasing the number of providers who engage members into care by assisting with reducing stigma. MI training in CY 2023 saw an effectiveness in communicating MI training opportunities through provider calls and PQL meetings to continue engagement to increase member cancer screenings.
Population Health Management Workgroup to achieve three main goals: Advance the health of populations, improve member experience, and deliver systemwide transformation to better serve member population health needs.	Q1 2023 – Ongoing	Impact to enrolled population will be to increase effective engagement by identifying processes already in place with opportunities. The Population Health Workgroup was successful in establishing goals and identified the best approach for successful discussions around current initiatives to better drive the workgroup in CY 2024.
CM & QM Collaboration Workgroup meets monthly to coordinate efforts, refine interventions, and identify barriers and opportunities.	Q1 2022 – Ongoing	Impact to enrolled population will be to increase member engagement and education around preventive screenings. The collaborative meetings have been successful in focusing on how to close open care gaps, provide additional training, and incorporating data components for review to further discuss barriers and areas of opportunities.

Prior Year's Recommendation From the EQR Technical Report for PIPs		
Care Gap Passport, a customized list of open care gaps sent out to members and how to access member rewards per their health plan.	Q1 2024 – Ongoing	Impact to enrolled population will be to increase provider knowledge and engagement around outreach.

AzCH-CCP RBHA's plan for sustaining improvement in indicator rates will be analyzed via the PDSA cycle to ensure ongoing improvement and appropriate corrections are made. Indicator rates along with identified interventions are evaluated via specific intervention PDSA cycles and during PISC and QIC monthly meetings. Additionally, indicator rates and interventions are monitored through the Performance Measure Monitoring Report (PMMR) to ensure performance improvement during each quarter:

- A total of eight mammogram events were held in CY 2023. Please note this is inclusive of ACC, RBHA and uninsured populations and was not effective for members in the RBHA population as there were no confirmed RBHA members who participated. The consensus from the community liaisons was that attendance was not up to par. Attendance to mobile mammogram events is a known issue with AzCH having several interventions in place to increase member engagement. Additionally, mobile mammogram events have been placed on hold until Spring 2024.
- There was a total of four Motivational Interviewing trainings provided during CY 2023 with a total of 40 providers who participated. MI training in CY 2023 saw an effectiveness in communicating MI training opportunities through provider calls and PQL meetings to continue engagement to increase member cancer screenings.
- By year-end 2023, a total of 805 cervical cancer screening My Health Pay rewards were earned.
- The CM & QM collaboration workgroup meets monthly to coordinate efforts, refine interventions, and identify barriers and opportunities. Throughout CY 2023, monthly collaborative meetings continued to identify additional interventions and increased discussion around shared performance measures such as breast cancer screening and cervical cancer screening, for greater impact.

HSAG's Assessment:

HSAG has determined that the Contractor has satisfactorily addressed these prior year's recommendations.

Prenatal and Postpartum Care PIP

Overview

AHCCCS initiated the implementation of the *Prenatal and Postpartum Care* PIP for the ACC population in CYE 2022. The objective of the *Prenatal and Postpartum Care* PIP is to improve health outcomes for members and infants. This PIP focuses on increasing the number and percentage of members with live birth deliveries that 1) received a prenatal care visit, and 2) received a postpartum

visit. In CYE 2024, AzCH-CCP ACC-RBHA continued to implement interventions to improve these outcomes and provided updates on the status of each intervention to AHCCCS.

Interventions

Table 7-11 presents PIP interventions for AzCH-CCP ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 7-11—AzCH-CCP ACC-RBHA *Prenatal and Postpartum Care* PIP Interventions

Contractor	Interventions
AzCH-CCP ACC-RBHA	New interventions to support the *Prenatal and Postpartum Care* PIP in CYE 2024 include:
	• Strategic partner collaboration to target members for prenatal care. Strategic partner assists by outreaching, scheduling, and completing in-home or telehealth visits with appropriate physician. • PPC Workgroup is an internal monthly workgroup to include CM, QM, and other stakeholders to increase prenatal/postpartum outcome measures. • HEDIS Stratification Dashboard—will provide an NCQA-directed race and ethnicity stratification of applicable HEDIS performance measures. • Health Equity Committee Coordination with the PPC Workgroup—Health Equity Committee meets with the PPC workgroup to review the stratified dashboard and address accessibility of care. • Local Health Disparity Dashboard—will allow stratification of performance measures by race/ethnicity, age, sex, county, city, and ZIP Code. • Pyx Health, a mobile application to address loneliness, social isolation, assist in developing a support system and support with loneliness and resources. • Member outreach through live calls, SMS text messaging, mailers, emails, and POM campaigns encouraging members with open care gaps to complete PPC visits.
	Continued interventions with enhancements made to support the *Prenatal and Postpartum Care* PIP in CYE 2024 include:
	• Wellframe mobile application provides specialized care plan (based on certain tracks) for members with specialized daily health checklist; provider alerts, care gaps, and progress tracking to CMs; allows for two-way video/text communication with care management. • NOP Reports are sent to strategic partners and FQHCs to begin outreach and engage members timely for prenatal and postpartum care. Report is now automated to reduce manual requirements.
	Continued interventions to support the *Prenatal and Postpartum Care* PIP in CYE 2024 include:

Contractor	Interventions
	• SSFB program, enrollment into care management (until six weeks after delivery).

Strengths, Opportunities for Improvement, and Recommendations

HSAG did not conduct validation on the *Prenatal and Postpartum Care* PIP in CYE 2024; therefore, strengths, opportunities for improvement, and recommendations are not provided.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 7-12 presents PIP recommendations made to AzCH-CCP ACC-RBHA in the CYE 2023 Annual Technical Report [186] and AzCH-CCP ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which AzCH-CCP ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 7-12—AzCH-CCP ACC-RBHA Follow-Up to CYE 2023 PIP Recommendations

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG recommended that AzCH-CCP ACC-RBHA: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. • Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.
AzCH-CCP ACC-RBHA's Response: AzCH-CCP RBHA identified the following barriers to assist in focusing interventions to better engage members in care: • Members do not see prenatal and postpartum care as a priority if they are feeling well. • Reduced availability of alternative resource access so members can independently educate and participate fully in their care management. • Lack of alternative methods of engaging members in care management beyond the standard phone and letter outreach.

[186] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for PIPs
• Lack of ongoing QI & MCH/CM collaboration needed to effectively evaluation and implement interventions. • Traditional gap list reporting is not effective due to measure timelines. • Reduced availability of health equity/disparity actionable data. • Lack of health equity influence.

AzCH-CCP RBHA has assessed the impact and effectiveness of the following interventions during the intervention year:

Interventions Assessment		
Interventions	**Timeline**	**Impact/Effectiveness**
SSFB program, enrollment into care management (until six weeks after delivery)	Q3 2018 – Ongoing	Educating members on the importance of prenatal and postpartum care even if they are feeling well.
Wellframe Mobile Application provides specialized care plan (based on certain tracks) for members with a specialized daily health checklist; provider alerts, care gaps, and progress tracking to CMs; allows for two-way video/text communication with care management	Q2 2021 – Paused Q2 2022 Reinstated in Q3 2023 – Ongoing	Utilizing an application and chat-based system to engage members will increase member engagement for those who prefer such methods.
NOP Reports are sent to strategic partners and FQHCs to begin outreach and engage members timely for prenatal and postpartum care. Report is now automated to reduce manual requirements.	Q3 2022 – Ongoing	Creating proactive reporting increases the likelihood of engaging members due to being able to leverage strategic partners and FQHCs effectively.
PPC Workgroup is an internal monthly workgroup to include CM, QM, and other stakeholders to increase prenatal/postpartum outcome measures.	Q1 2023 – Ongoing	Increasing effectiveness of implemented interventions by both MCH/CM and QI will reduce overlap, member abrasion, and missed opportunities of engagement.

Prior Year's Recommendation From the EQR Technical Report for PIPs		
HEDIS Stratification Dashboard—will provide a NCQA-directed race and ethnicity stratification of applicable HEDIS performance measures.	Q4 2023 – Ongoing	This intervention will provide actionable data about the population served so disparities can be quickly identified, and intervention responses coordinated.
Pyx Health, a mobile application to address loneliness, social isolation, assist in developing a support system and support with loneliness and resources.	CY 2020 – Ongoing	Utilizing an application and chat-based system to engage members will increase member engagement for those who prefer such methods.
Member outreach through live calls, SMS text messaging, mailers, emails, and POM campaigns encouraging members with open care gaps to complete PPC visits.	CY 2017 – Ongoing	Educating members on the importance of prenatal and postpartum care even if they are feeling well.
Health Equity Committee Coordination with the PPC Workgroup—Health equity meets with the PPC workgroup to review stratified dashboard and address accessibility of care.	Q3 2023 – Ongoing	This intervention's expected impact is to multilayer coordination between AzCH-CCP ACC's departments to ensure a wide range of input with a direct-action path for intervention modification and implementation.
Local Health Disparity Dashboard will allow stratification of performance measures by race/ethnicity, age, sex, county, city, and ZIP Code.	04/01/2018 – 12/31/2022 – This intervention has been incorporated as a standard business practice.	This intervention will provide actionable data about the population served so disparities can be quickly identified, and intervention responses coordinated.

AzCH-CCP RBHA's plan for sustaining improvement in indicator rates will be analyzed via the PDSA cycle to ensure ongoing improvement and appropriate corrections are made. Indicator rates along with identified interventions are evaluated via specific intervention PDSA cycles and during Performance Improvement Subcommittees' monthly meetings and quarterly Quality Improvement Committees. Additionally, indicator rates and interventions are monitored through the Performance Measure Monitoring Report (PMMR) to ensure performance improvement during each quarter:

Prior Year's Recommendation From the EQR Technical Report for PIPs
• AzCH-CCP has identified the opportunity to make NOP reports a widespread opportunity for all providers by including in the provider portal for all providers to access. For CY 2023, total NOP mailings were 6,940; Guide to Pregnancy booklets, 4,504; and Life After Delivery booklets, 5,211. • PPC workgroup has noted effectiveness through the monthly multidisciplinary meetings to facilitate information sharing and brainstorming.
HSAG's Assessment: HSAG has determined that AzCH-CCP ACC-RBHA has satisfactorily addressed these prior year's recommendations.

Compliance Reviews

Results

AHCCCS conducted a compliance review of AzCH-CCP ACC-RBHA from December 11, 2023, through December 15, 2023. On March 8, 2024, AHCCCS finalized the report findings, provided AzCH-CCP ACC-RBHA with a CAP submission matrix, and required a CAP for any standard with a total score of less than 95 percent. On May 31, 2024, AHCCCS accepted AzCH-CCP ACC-RBHA's proposed CAPs and required the Contractor to submit updated policies, manuals, desktop procedures, and other vital documents to provide evidence of CAP completion. On July 31, 2024, AHCCCS reviewed AzCH-CCP ACC-RBHA's CAP status and determined that all CAPs had been completed and approved for closure.

Table 7-13—AzCH-CCP ACC-RBHA Compliance Review Results

Compliance Focus Areas	CYE 2024 AzCH-CCP ACC-RBHA Scores	CYE 2024 Program-Level Average	CYE 2024 AzCH-CCP ACC-RBHA CAP Update
CC	93%	95%	Met
CIS	100%	99%	NA
DS	100%	97%	NA
GA	98%	97%	NA
GM	100%	100%	NA
GS	100%	100%	NA
MCH	97%	96%	NA
MM	98%	95%	NA
MI	99%	94%	NA
QM	85%	89%	Met
QI	100%	100%	NA
RI	100%	100%	NA

Compliance Focus Areas	CYE 2024 AzCH-CCP ACC-RBHA Scores	CYE 2024 Program-Level Average	CYE 2024 AzCH-CCP ACC-RBHA CAP Update
TPL	100%	100%	NA
ISOC	99%	99%	NA

NA = Not applicable. A CAP was not required as the CYE 2024 score was 95% or above.
Met = AHCCCS accepted and closed the Contractor's CAP.

Strengths, Opportunities for Improvement, and Recommendations

Table 7-14 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC-RBHA based on compliance activities conducted in CYE 2024, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 7-14—AzCH-CCP ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
AzCH-CCP ACC-RBHA scored at or above 95 percent in the following focus areas: • Claims and Information Standards (CIS) **[Access]** • Delivery Systems (DS) **[Timeliness, Access]** • General Administration (GA) **[Timeliness, Access]** • Grants Management (GM) **[Quality, Access]** • Grievance Systems (GS) **[Timeliness, Access]** • Adult, EPSDT and Maternal Child Health (MCH) **[Quality, Timeliness, Access]** • Medical Management (MM) **[Timeliness, Access]** • Member Information (MI) **[Quality]** • Quality Improvement (QI) **[Quality, Access]** • Reinsurance (RI) **[Quality]** • Third-Party Liability (TPL) **[Quality, Timeliness, Access]** • Integrated Systems of Care (ISOC) **[Quality, Access]**
Opportunities for Improvement and Recommendations
AzCH-CCP ACC-RBHA scored below 95 percent in the following focus areas: • Corporate Compliance (CC) **[Quality, Access]** • Quality Management (QM) **[Quality]**

Strengths, Opportunities for Improvement, and Recommendations
As a result of its CAP interventions implemented in CYE 2024, Az-CH CCP ACC-RBHA was found to be fully compliant within all focus areas and had no continuing corrective actions or recommendations.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Compliance review recommendations were not included in the CYE 2023 EQR technical report as compliance review activities were not conducted in CYE 2023; therefore, no follow-up was required by AzCH-CCP ACC-RBHA.

Network Adequacy Validation

ISCA Results

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

Table 7-15 summarizes HSAG's validation ratings for AzCH-CCP ACC-RBHA by indicator type.

Table 7-15—Summary of AzCH-CCP ACC-RBHA's Validation Ratings by Indicator Type

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

Of the network adequacy indicators assessed, AzCH-CCP ACC-RBHA received *High Confidence* for both appointment availability and time/distance indicator types. However, there were identified areas for improvement; please refer to the Contractor-specific Strengths, Opportunities for Improvement, and Recommendations section below for more details.

NAV Results

HSAG evaluated AzCH-CCP ACC-RBHA's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents CYE 2024 S1 validation findings specific to the ACC-RBHA program, with one results table for the following GSA:

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

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

Table 7-16—Time/Distance Validation Results for AzCH-CCP ACC-RBHA South GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Cochise	Graham	Greenlee	La Paz	Pima	Santa Cruz	Yuma
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^	100.0^	100.0^	100.0^	99.4^	100.0^	100.0^
BHRF	NA	NA	NA	NA	95.5	NA	NA
Cardiologist, Adult	100.0^	100.0^	100.0	100.0^	99.5^	100.0^	100.0^
Cardiologist, Pediatric	100.0^	100.0*^	NR*	NR*^	100.0^	100.0*^	100.0^
Crisis Stabilization Facility	99.8	100.0	100.0	95.1	99.4	100.0	99.8
Dentist, Pediatric	80.0	100.0*	NR*	NR*	99.1	100.0*	100.0
Hospital	100.0	100.0	100.0	100.0	99.6	100.0	100.0
OB/GYN	100.0	100.0	100.0*	100.0*	99.7	100.0	100.0
Pharmacy	99.5	100.0	100.0	95.1	98.6	100.0	99.7
PCP, Adult	99.8^	100.0^	100.0^	100.0^	99.9^	100.0^	99.7^
PCP, Pediatric	100.0^	100.0*^	NR*^	NR*^	99.1^	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.

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

* indicates that fewer than 10 members were included in the denominator of HSAG's results.

^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

Strengths, Opportunities for Improvement, and Recommendations

Table 7-17 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC-RBHA related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 7-17—AzCH-CCP ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • AzCH-CCP ACC-RBHA had established processes to research daily and monthly missing or incomplete data from the 834 files that included a Queued Error report that captured any critical data elements determined to be missing. **[Access]** • AzCH-CCP ACC-RBHA had established a robust process to maintain data accuracy and completeness by utilizing a reference file and multiple internal reports to compare the provider data loaded into Portico weekly. **[Access]** • AzCH-CCP ACC-RBHA met all the minimum network requirements for all assigned counties except Cochise County. **[Access]** • AzCH-CCP ACC-RBHA met all minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Adult; BHRF; Cardiologist, Adult and Pediatric; Crisis Stabilization Facility; Hospital; OB/GYN; PCP, Adult and Pediatric; and Pharmacy. **[Access]** Note: AzCH-CCP ACC-RBHA provides coverage in the following counties: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma.
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: • AzCH-CCP ACC-RBHA did not meet the minimum network requirements for Dentist, Pediatric. **[Access]** Recommendation: HSAG recommends that AzCH-CCP ACC-RBHA maintain current compliance with network standards and continue to address network gaps, as applicable.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 7-18 presents NAV recommendations made to AzCH-CCP ACC-RBHA in the CYE 2023 Annual Technical Report[187] and AzCH-CCP ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which AzCH-CCP ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language

[187] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 7-18—AzCH-CCP ACC-RBHA Follow-Up to CY 2023 NAV Recommendations

Prior Year's Recommendation From the EQR Technical Report for NAV
HSAG recommended that AzCH-CCP ACC-RBHA maintain current compliance with network standards but continue to address network gaps, as applicable.
AzCH-CCP ACC-RBHA's Response: HSAG found that isolated data issues may have contributed to specific instances affecting AzCH-CCP ACC RBHA's compliance with time/distance standards. And AzCH-CCP ACC-RBHA failed to meet the time/distance standard for at least one quarter and/or county for Dentist, Pediatric, and PCP, Pediatric. AzCH-CCP ACC-RBHA has identified a lack of additional providers within the South GSA which affects the adequate coverage within adequacy guidelines. AzCH-CCP ACC-RBHA continues to work alongside Pharmacy Services and its contracted dental benefits administrator to search for available providers and add to our network to increase adequacy coverage. Outlined below are AzCH-CCP's strategies, efforts, and exception requests as of October 2024, applicable to both the Medicaid and CHIP populations, to address the identified areas of noncompliance: • *Pharmacy—La Paz County (South GSA)*—Currently, 83.4 percent of AzCH-CCP members have access to a pharmacy provider within the defined time and distance standards. The decrease in adequacy is due to a pharmacy being terminated from the network due to past audits and actions from the State Board of Pharmacy, which impacted members. AzCH-CCP outreached members to assist with transferring their medications to either a pharmacy in Parker, AZ, Blythe, CA, or a mail-order pharmacy. AzCH-CCP continues to pursue recruitment efforts for pharmacy providers in La Paz County to add to our network; however, there are currently no providers available to assist with closing the gap. • *Dentist—Pediatric—Greenlee County (South GSA)*—Currently, 67.9 percent of AzCH-CCP pediatric members have access to a dental provider within the defined time and distance standards. On July 17, 2024, AHCCCS approved the AzCH-CCP Network Exception submitted for Dentist—Pediatric—Greenlee County. AzCH-CCP partners with a dental benefits administrator to administer the dental program. We will continue to closely monitor any changes to the network and identify potential recruitment opportunities to close this gap. • *Dentist—Pediatric—La Paz County (South GSA)*—Currently, 52.8 percent of AzCH-CCP pediatric members have access to a dental provider within the defined time and distance standards. On August 25, 2023, AHCCCS approved the AzCH-CCP Network Exception submitted for Dentist—Pediatric—La Paz County. AzCH-CCP partners with a dental benefits administrator to administer the dental program. We will continue to closely monitor any changes to the network and identify potential recruitment opportunities to close this gap. • *Dental—Pediatric—Cochise County (South GSA)*—Currently, 80 percent of AzCH-CCP pediatric members have access to a dental provider within the defined time and distance standards. The

Prior Year's Recommendation From the EQR Technical Report for NAV

decrease in adequacy for Cochise County is due to member movement. There are pediatric dental members who are outside of time and distance standards, with the first provider being 39.1 miles and 42.6 minutes away. AzCH-CCP and its contracted dental benefits administrator utilized the Saturation Report and identified that there were no additional providers within adequacy guidelines to increase adequacy coverage. AzCH-CCP will continue to search for pediatric dental providers in Cochise County to add to our network. AzCH-CCP will be submitting an exception request.

- *Dental—Pediatric—La Paz County (South GSA)*—Currently, 50 percent of AzCH-CCP pediatric members have access to a dental provider within the defined time and distance standards. The decrease in adequacy for La Paz County is due to pediatric members being without access to a dental provider within the time and distance standard. AzCH-CCP and its contracted dental benefits administrator identified that there were no additional providers within adequacy guidelines to increase adequacy coverage. AzCH-CCP will continue to search for pediatric dental providers in La Paz County to add to our network. AzCH-CCP will be submitting an exception request.
- *Pharmacy—La Paz County (South GSA)*—Currently, 86.8 percent of AzCH-CCP members have access to a pharmacy provider within the defined time and distance standard. The decrease in adequacy for La Paz County is due to a pharmacy being terminated from the network due to past audits and actions from the State Board of Pharmacy. Members were impacted across all Medicaid products; outreach was made to assist members with transferring their medications to either a pharmacy in Parker, AZ, Blythe, CA, or a mail-order pharmacy. AzCH-CCP and its contracted dental benefits administrator identified that there were no additional providers within adequacy guidelines to increase adequacy coverage. AzCH-CCP and its contracted dental benefits administrator will continue to search for available pharmacy providers in and around La Paz County to add to our network. As an alternative, AzCH-CCP provides mail-order home delivery of prescriptions. AzCH-CCP will be submitting an exception request.

Additionally, AzCH-CCP ACC does provide education and awareness of the available telehealth services for all members to utilize. Below are the counties where telehealth services are available:

Provider Types	Cochise	Gila	Graham	Greenlee	La Paz	Maricopa	Pima	Pinal	Santa Cruz	Yuma
Behavioral Health Outpatient Clinic & Integrated Clinic, Adult	X	X	X		X	X	X	X	X	X

Prior Year's Recommendation From the EQR Technical Report for NAV										
Behavioral Health Outpatient Clinic & Integrated Clinic, Pediatric	X	X	X		X	X	X	X	X	X
Cardiologist, Adult	X	X	X		X	X	X	X	X	X
Cardiologist, Pediatric	X	X	X		X	X	X	X	X	X
PCP, Adult	X	X	X	X	X	X	X	X	X	X
PCP, Pediatric	X	X	X	X	X	X	X	X	X	X

HSAG's Assessment:

HSAG has determined that AzCH-CCP ACC-RBHA has satisfactorily addressed these prior year's recommendations.

Care1st ACC-RBHA

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2024, HSAG evaluated Care1st ACC-RBHA's data system for processing of each data type used for reporting the Contractor's CY 2023 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that Care1st ACC-RBHA followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 7-19 displays HSAG's PMV findings for each data type reviewed during CYE 2024 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 7-19—CYE 2024 PMV Findings

Data Type	HSAG Findings
Medical Services Data	*No identified concerns*
Enrollment Data	*No identified concerns*
Provider Data	*No identified concerns*
Medical Record Review Process	*No identified concerns*
Supplemental Data	*No identified concerns*
Data Integration	*No identified concerns*

Results for Performance Measures

The Care1st ACC-RBHA contract went into effect on October 1, 2022; therefore, there are no performance measure results to present for CY 2022. Table 7-20 presents the CY 2023 Care1st ACC-RBHA results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 7-20—CY 2022 and CY 2023 Care1st ACC-RBHA Performance Measure Results

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	—	NA[++]	—	—
Postpartum Care	—	NA[++]	—	—
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	—	63.3%	—	★★★
Effective Continuation Phase Treatment—Total (18+ Years)	—	50.6%	—	★★★★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	—	45.0%	—	★★★★★
30-Day Follow-Up—Total (13+ Years)	—	67.9%	—	★★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	—	59.6%	—	★★★★★
30-Day Follow-Up—Total (6+ Years)	—	77.7%	—	★★★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	—	59.7%	—	★★★★
30-Day Follow-Up—Total (6+ Years)	—	74.7%	—	★★★★★
Use of Opioids at High Dosage				
*18+ Years**	—	4.4%	—	★★
Initiation and Engagement of Substance Use Disorder (SUD) Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	—	35.0%	—	★
Engagement of SUD Treatment—Total—Total (13+ Years)	—	7.2%	—	★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	—	60.9%	—	★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	—	77.1%	—	★
Care of Acute and Chronic Conditions				
Controlling High Blood Pressure				
18–85 Years	—	62.8%[+]	—	★★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0 Percent)—Total (18–75 Years)	—	47.7%[+]	—	★

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
*Poor HbA1c Control (>9.0 Percent)—Total (18–75 Years)**	—	44.0%+	—	★
Pediatric Health				
Oral Evaluation, Dental Services				
Total (0–20 Years)[N]	—	14.3%	—	—
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	—	50.0%	—	★★
Cervical Cancer Screening				
21–64 Years	—	32.8%+	—	★
Appropriate Utilization of Services				
Ambulatory Care				
Emergency Department (ED) Visits—Total (0–85+ Years)[F]	—	1,181.8	—	—
Plan All-Cause Readmissions				
*Observed/Expected (O/E) Ratio—Total (18–64 Years)**	—	1.4972	—	★

* A lower rate indicates better performance for this measure.
+ Indicates the measure was reported using hybrid methodology.
++ NA indicates the denominator was too small to report a valid rate, based on the applicable measure specification
Cells shaded green indicate that the rate met or exceeded the MY 2022 and/or MY 2023 and/or national Medicaid mean.
— Indicates a 2022–2023 comparison is not presented in the CYE 2024 Annual Technical Report because either the CY 2022 rate was not presented in the CYE 2023 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
[1]Aggregated rates were calculated and compared from CY 2022 to CY 2023, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.
[2] Performance Levels for CY 2023 were based on comparisons of the HEDIS MY 2023 measure rates to national Medicaid Quality Compass HEDIS MY 2023 benchmarks.
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.
[N] Measure has no NCQA Medicaid mean for comparison.
↑ Indicates statistically significant improvement of measure rates.
↓ Indicates statistically significant decline of measure rates.
→ Indicates no statistically significant change in measure rates.
Performance Levels for 2023 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 7-21 presents strengths, opportunities for improvement, and recommendations for Care1st ACC-RBHA related to performance measures, as well as the related domains (Quality, Access, and/or

Timeliness) for each strength and opportunity for improvement. As of October 1, 2024, Care1st ACC-RBHA no longer holds an AHCCCS contract; therefore, the information in this section does not include recommendations.

Table 7-21—Care1st ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group: • Nine of 13 Care1st ACC-RBHA measure rates (69.23 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 **[Quality, Timeliness, Access]** – *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total (18+ Years)* – *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)* and *30-Day Follow-Up—Total (13+ Years)* – *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* – *Follow-Up After ED for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)* – *Use of Opioids at High Dosage—18+ Years* • Care1st ACC-RBHA's performance measure rates for *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)* and *30-Day Follow-Up—Total (13+ Years), Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)*, and *Follow-Up After ED for Mental Illness—30-Day Follow-Up—Total (6+ Years)* met or exceeded the 90th percentile, indicating good follow-up and continuity of care provided to members with substance use or mental illness, whether they are hospitalized or in the ED. **[Quality, Timeliness, Access]**
Opportunities for Improvement and Recommendations
In the Behavioral Health measure group: • Care1st ACC-RBHA's performance measure rates for *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* and *Engagement of SUD Treatment—Total—Total (13+ Years)* remain below the 25th percentile. This result indicates a continued opportunity for Care1st ACC-RBHA to assist members with diagnosed SUD initiated treatment to initiate and/or engage with SUD treatment, which might include an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth treatment, or MAT. **[Quality]** • Care1st ACC-RBHA's performance measure rate for *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* remained below the

Strengths, Opportunities for Improvement, and Recommendations
25th percentile. This result indicates a continued opportunity for diabetes screening testing to be done. **[Quality]**
In the Preventive Screening measure group, Care1st ACC-RBHA's performance measure rate *Cervical Cancer Screening—21–64 Years* remained below the 25th percentile, indicating that not all women were receiving timely screening for cervical cancers. Early detection reduces the risk of dying from these types of cancers and can lead to a greater range of treatment options and lower healthcare costs.[188] **[Quality]**
In the Care of Acute and Chronic Conditions measure group, Care1st ACC-RBHA's performance measure rates for *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 Percent)—Total (18–75 Years)* and *Poor HbA1c Control (<8.0 Percent)—Total (18–75 Years)* fell below the 25th percentile, indicating poor control over diabetes **[Quality]**
In the Appropriate Utilization of Services measure group, Care1st ACC-RBHA's performance measure rate for *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total (18–64 Years)* fell below the 25th percentile, indicating that members who were admitted to an acute inpatient and observation stay might have been followed by an unplanned acute readmission for any diagnosis within 30 days.[189] **[Quality]**

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Performance measure recommendations were not included in the CYE 2023 EQR technical report as performance measure activities were not conducted in CYE 2023; therefore, no follow-up was required by Care1st ACC-RBHA.

Validation of Performance Improvement Projects

Preventive Screening PIP

As the Care1st ACC-RBHA contract went into effect on October 1, 2022, and the *Preventive Screening* PIP was already initiated with the existing ACC-RBHA Contractors, Care1st ACC-RBHA was not required to conduct the *Preventive Screening* PIP.

[188] National Committee for Quality Assurance. Cervical Cancer Screening (CCS). Available at: https://www.ncqa.org/hedis/measures/cervical-cancer-screening/. Accessed on: Feb 19, 2025.
[189] National Committee for Quality Assurance. Metabolic Monitoring for Children and Adolescents on Antipsychotics. Available at: https://www.ncqa.org/hedis/measures/plan-all-cause-readmissions/. Accessed on: Feb 12, 2025.

Prenatal and Postpartum Care PIP

Overview

AHCCCS initiated the implementation of the *Prenatal and Postpartum Care* PIP for the ACC population in CYE 2022. The objective of the *Prenatal and Postpartum Care* PIP is to improve health outcomes for members and infants. This PIP focuses on increasing the number and percentage of members with live birth deliveries that 1) received a prenatal care visit, and 2) received a postpartum visit. In CYE 2024, Care1st ACC-RBHA continued to implement interventions to improve these outcomes and provided updates on the status of each intervention to AHCCCS.

Interventions

Table 7-22 presents PIP interventions for Care1st ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 7-22—Care1st ACC-RBHA *Prenatal and Postpartum Care* PIP Interventions

Contractor	Interventions
Care1st ACC-RBHA	New interventions to support the *Prenatal and Postpartum Care* PIP in CYE 2024 include:
	• Utilized Arizona Complete Health Provider Engagement team and deployed new Path to 5 Stars provider resource guide for improving quality measures, including *PPC*. The guide provided practitioners with Medicaid percentile targets, coding advice, and best practices for performance improvement. The team engaged high-volume Medicaid providers with a variety of data and resources, including care gap data, missed opportunities report, month-over-month and year-over-year performance, and educational resources. • Sent NOP reports to strategic partners and FQHCs to begin outreach and engage members timely for prenatal and postpartum care. The report was automated to reduce manual requirements. The NOP can also be accessed through the provider portal. • Utilized new Health Equity Dashboard to provide a method to assess HEDIS measures by race/ethnicity, age, gender, language, county and ZIP Code for specific measures.
	Continued interventions to support the *Prenatal and Postpartum Care* PIP in CYE 2024 include:
	• Attempted to engage all pregnant RBHA members in care management. Care managers outreach to any RBHA member identified as pregnant to educate them on the importance of prenatal and postpartum visits, as well as identify and refer members to resources to address SDOH that may pose barriers to accessing care. • Supported education about the importance of timely prenatal care and postpartum visits through written material and texts. Prenatal text messages are

Contractor	Interventions
	tailored to the member's week of pregnancy and provide information on self-care and content of prenatal visits specific to trimester. • Offer My Health Pays Program incentivized completion of prenatal and postpartum visits using a claims-based incentive payout.

Strengths, Opportunities for Improvement, and Recommendations

HSAG did not conduct validation on the *Prenatal and Postpartum Care* PIP in CYE 2024; therefore, strengths, opportunities for improvement, and recommendations are not provided.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Prenatal and Postpartum Care PIP recommendations were not included in the CYE 2023 EQR technical report as Care1st ACC-RBHA was not required to participate in PIP validation activities during CYE 2023. Therefore, no follow-up was required by Care1st ACC-RBHA.

Compliance Reviews

Results

AHCCCS conducted a compliance review of Care1st ACC-RBHA from December 11, 2023, through December 15, 2023. On March 8, 2024, AHCCCS finalized the report findings, provided Care1st ACC-RBHA with a CAP submission matrix, and required a CAP for any standard with a total score of less than 95 percent. On April 19, 2024, AHCCCS accepted Care1st ACC-RBHA's proposed CAPs and required the Contractor to submit updated policies, manuals, desktop procedures, and other vital documents to provide evidence of CAP completion. On June 4, 2024, AHCCCS reviewed Care1st ACC-RBHA's status and determined that all CAPs have been completed and approved for closure.

Table 7-23—Care1st ACC-RBHA Compliance Review Results

Compliance Focus Areas	CYE 2024 Care1st ACC-RBHA Scores	CYE 2024 Program-Level Average	CYE 2024 Care1st ACC-RBHA CAP Update
CC	93%	95%	Met
CIS	99%	99%	NA
DS	97%	97%	NA
GA	98%	97%	NA
GM	100%	100%	NA
GS	100%	100%	NA
MCH	97%	96%	NA

Compliance Focus Areas	CYE 2024 Care1st ACC-RBHA Scores	CYE 2024 Program-Level Average	CYE 2024 Care1st ACC-RBHA CAP Update
MM	93%	95%	Met
MI	96%	94%	NA
QM	89%	89%	Met
QI	100%	100%	NA
RI	100%	100%	NA
TPL	100%	100%	NA
ISOC	99%	99%	NA

NA = Not applicable. A CAP was not required as the CYE 2024 score was 95% or above.
Met = AHCCCS accepted and closed the Contractor's CAP.

Strengths, Opportunities for Improvement, and Recommendations

Table 7-24 presents strengths, opportunities for improvement, and recommendations for Care1st ACC-RBHA based on compliance activities conducted in CYE 2024, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement. As of October 1, 2024, Care1st ACC-RBHA no longer holds an AHCCCS contract; therefore, the information in this section does not include recommendations.

Table 7-24—Care1st ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
Care1st ACC-RBHA scored at or above 95 percent in the following focus areas: • Claims and Information Standards (CIS) **[Access]** • Delivery Systems (DS) **[Timeliness, Access]** • General Administration (GA) **[Timeliness, Access]** • Grants Management (GM) **[Quality, Access]** • Grievance Systems (GS) **[Timeliness, Access]** • Adult, EPSDT and Maternal Child Health (MCH) **[Quality, Timeliness, Access]** • Member Information (MI) **[Quality]** • Quality Improvement (QI) **[Quality, Access]** • Reinsurance (RI) **[Quality]** • Third-Party Liability (TPL) **[Quality, Timeliness, Access]** • Integrated Systems of Care (ISOC) **[Quality, Access]**

Strengths, Opportunities for Improvement, and Recommendations
Opportunities for Improvement and Recommendations
Care1st ACC-RBHA scored below 95 percent in the following focus areas: • Corporate Compliance (CC) **[Quality, Access]** • Medical Management (MM) **[Timeliness, Access]** • Quality Management (QM) **[Quality]** As a result of its CAP interventions implemented in CYE 2024, Care1st ACC-RBHA, was found to be fully compliant within all focus areas and had no continuing corrective actions or recommendations.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Compliance review recommendations were not included in the CYE 2023 EQR technical report as compliance review activities were not conducted in CYE 2023; therefore, no follow-up was required by Care1st ACC-RBHA.

Network Adequacy Validation

ISCA Results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Care1st ACC-RBHA's interpretation of data was accurate.

Table 7-25 summarizes HSAG's validation ratings for Care1st ACC-RBHA by indicator type.

Table 7-25—Summary of Care1st ACC-RBHA's Validation Ratings by Indicator Type

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

Of the network adequacy indicators assessed, Care1st ACC-RBHA received *High Confidence* for both appointment availability and time/distance indicator types. However, there were identified areas for improvement; please refer to the Contractor-specific Strengths, Opportunities for Improvement, and Recommendations section below for more details.

NAV Results

HSAG evaluated Care1st ACC-RBHA's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents CYE 2024 S1 validation findings specific to the ACC-RBHA Program, with one results table for the following GSA:

- North GSA: Apache, Coconino, Mohave, Navajo, and Yavapai counties

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

Table 7-26—Time/Distance Validation Results for Care1st ACC-RBHA North GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Apache	Coconino	Mohave	Navajo	Yavapai
Behavioral Health Outpatient and Integrated Clinic, Adult	97.9^	99.1^	100.0^	99.4^	100.0^
BHRF	NA	NA	NA	NA	NA
Cardiologist, Adult	99.5^	99.6^	100.0^	99.7^	100.0^
Cardiologist, Pediatric	100.0*^	100.0^	100.0^	100.0*^	100.0^
Crisis Stabilization Facility	97.4	97.2	99.2	99.2	98.9
Dentist, Pediatric	100.0*	100.0	100.0	100.0*	100.0
Hospital	99.5	100.0	100.0	100.0	100.0
OB/GYN	100.0	100.0	100.0	100.0	100.0
Pharmacy	100.0	98.4	99.2	100.0	99.0
PCP, Adult	99.5^	100.0^	99.1^	100.0^	100.0^
PCP, Pediatric	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.

* indicates that fewer than 10 members were included in the denominator of HSAG's results.

^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

Strengths, Opportunities for Improvement, and Recommendations

Table 7-27 presents strengths, opportunities for improvement, and recommendations for Care1st ACC-RBHA related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each

strength and opportunity for improvement. As of October 1, 2024, Care1st ACC-RBHA no longer holds an AHCCCS contract; therefore, the information in this section does not include recommendations.

Table 7-27—Care1st ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • Care1st ACC-RBHA had established processes to research daily and monthly missing or incomplete data from the 834 files that included a Queued Error report that captured any critical data elements determined to be missing. **[Access]** • Care1st ACC-RBHA had established a robust process to maintain data accuracy and completeness by utilizing a reference file and multiple internal reports to compare the provider data loaded into Portico weekly. **[Access]** • Care1st ACC-RBHA met all minimum network requirements for all assigned counties. **[Access]** Note: Care1st ACC-RBHA provides coverage in the following counties: Apache, Coconino, Mohave, Navajo, and Yavapai.
Opportunities for Improvement and Recommendations
HSAG identified no opportunities for improvement for Care1st ACC-RBHA.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 7-28 presents NAV recommendations made to Care1st ACC-RBHA in the CYE 2023 Annual Technical Report[190] and Care1st ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Care1st ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 7-28—Care1st ACC-RBHA Follow-Up to CY 2023 NAV Recommendations

Prior Year's Recommendation From the EQR Technical Report for NAV
HSAG recommended that Care1st ACC-RBHA continue to maintain current compliance with network standards.
Care1st ACC-RBHA's Response:

[190] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for NAV

In CY 2023, Care1st took the following actions to ensure compliance with network standards for the RBHA population:

- Dental Services – Care1st worked with its dental benefit administrator to review the AHCCCS Saturation Analysis report and identified 32 providers at approximately 15 locations to reach out to for contract discussions.
- Outpatient and Integrated Clinics – Care1st used the AHCCCS Saturation Analysis report and identified two potential recruitment opportunities, executing a contract with one clinic, which went into effect Nov. 1, 2023.
- Pharmacy – Care1st increased network compliance for pharmacy as a result of adding two major retail pharmacies to the Care1st network.

Care1st continues to review network adequacy results to determine if there are gaps and opportunities to close gaps. The health plan also ensures that telehealth services are available to provide greater accessibility to care in each of the counties it serves, including:

Provider Types	Apache	Coconino	Mohave	Navajo	Yavapai	Maricopa
Behavioral Health Outpatient Clinic & Integrated Clinic, Adult	X	X	X	X	X	X
Behavioral Health Outpatient Clinic & Integrated Clinic, Pediatric	X	X	X	X	X	X
Cardiologist, Adult	X	X	X	X	X	X
Cardiologist, Pediatric		X			X	X
PCP, Adult	X	X	X	X	X	X
PCP, Pediatric	X	X	X	X	X	X

HSAG's Assessment: HSAG has determined that Care1st ACC-RBHA has satisfactorily addressed these prior year's recommendations.

Mercy Care ACC-RBHA

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2024, HSAG evaluated Mercy Care ACC-RBHA's data system for processing of each data type used for reporting the Contractor's CY 2023 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that Mercy Care ACC-RBHA followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 7-29 displays HSAG's PMV findings for each data type reviewed during CYE 2024 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 7-29—CYE 2024 PMV Findings

Data Type	HSAG Findings
Medical Services Data	*No identified concerns*
Enrollment Data	*No identified concerns*
Provider Data	*No identified concerns*
Medical Record Review Process	*No identified concerns*
Supplemental Data	*No identified concerns*
Data Integration	*No identified concerns*

Results for Performance Measures

Table 7-30 presents the CY 2022 and CY 2023 Mercy Care ACC-RBHA performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and MY 2023. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and/or MY 2023. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 7-30—CY 2022 and CY 2023 Mercy Care ACC-RBHA Performance Measure Results

Performance Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Maternal and Perinatal Care				
Prenatal and Postpartum Care				

Performance Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Timeliness of Prenatal Care[+]	78.6%[+]	NR[#]	—	—
Postpartum Care[+]	73.6%[+]	NR[#]	—	—
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	48.7%	50.6%	→	★
Effective Continuation Phase Treatment—Total (18+ Years)	34.0%	37.5%	↑	★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total (13+ Years)	55.1%	53.2%	→	★★★★★
30-Day Follow-Up—Total (13+ Years)	74.1%	71.1%	→	★★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	69.3%	71.6%	↑	★★★★★
30-Day Follow-Up—Total (6+ Years)	83.6%	86.0%	↑	★★★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	58.5%	55.9%	→	★★★★
30-Day Follow-Up—Total (6+ Years)	72.1%	72.4%	→	★★★★
Use of Opioids at High Dosage				
*18+ Years**	9.7%	8.7%	→	★★
Initiation and Engagement of Substance Use Disorder (SUD) Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	49.3%	54.0%	↑	★★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	12.4%	16.1%	↑	★★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
18+ Years	56.2%	58.9%	↑	★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
18–64 Years	86.3%	87.9%	↑	★★★★★
Care of Acute and Chronic Conditions				
Controlling High Blood Pressure				
18–85 Years[+]	65.0%[+]	68.6%[+]	→	★★★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0 %)—Total (18–75 Years)	65.2%[+]	63.3%[+]	→	★★★★
*Poor HbA1c Control (>9.0 %)—Total (18–75 Years)**	27.0%[+]	27.5%[+]	→	★★★★
Pediatric Health				

Performance Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Oral Evaluation, Dental Services				
Total (0–20 Years)[N]	19.8%	28.6%	↑	—
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	41.1%	44.4%	↑	★
Cervical Cancer Screening				
21–64 Years	49.9%+	44.3%+	→	★
Appropriate Utilization of Services				
Ambulatory Care				
Emergency Department (ED) Visits—Total (0–85+ Years)[F]	1,189.6	1,256.6	—	—
Plan All-Cause Readmissions				
*Observed/Expected (O/E) Ratio—Total (18–64 Years)**	1.3245	1.3712	—	★

* A lower rate indicates better performance for this measure.
+ Indicates the measure was reported using hybrid methodology.
# NR indicates the measure was not reported because the MCO was not required to report the measure.
Cells shaded green indicate that the rate met or exceeded the MY 2022 and/or MY 2023 and/or national Medicaid mean.
— Indicates a 2022–2023 comparison is not presented in the CYE 2024 Annual Technical Report because either the CY 2022 rate was not presented in the CYE 2023 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
[1]Aggregated rates were calculated and compared from CY 2022 to CY 2023, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.
[2] Performance Levels for CY 2023 were based on comparisons of the HEDIS MY 2023 measure rates to national Medicaid Quality Compass HEDIS MY 2023 benchmarks.
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.
[N] Measure has no NCQA Medicaid mean for comparison.
↑ Indicates statistically significant improvement of measure rates.
↓ Indicates statistically significant decline of measure rates.
→ Indicates no statistically significant change in measure rates.
Performance Levels for 2023 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 7-31 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 7-31—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group: • Nine of 13 Mercy Care ACC-RBHA measure rates (69.23 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023: **[Quality, Timeliness, Access]** – *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)* and *30-Day Follow-Up—Total) (13+ Years)* – *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* – *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* – *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* and *Engagement of SUD Treatment—Total—Total (13+ Years)* – *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years* • Mercy Care ACC-RBHA's performance measure rates for the following measures were at or between the 75th and 89th percentile, indicating strength in providing follow-up behavioral health care to members: **[Quality, Timeliness, Access]** – *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* – *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* • Mercy Care ACC-RBHA's performance measure rates for the following measures were at or above the 90th percentile, also indicating strength in providing follow-up behavioral health care to members: **[Quality, Timeliness, Access]** – *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)* and *30-Day Follow-Up—Total (13+ Years)* – *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* – *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years*
In the Care of Acute and Chronic Conditions measure group: • All three of Mercy Care ACC-RBHA's measure rates (100.0 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. **[Quality]**

Strengths, Opportunities for Improvement, and Recommendations
• Mercy Care ACC-RBHA's performance measure rates for *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 %)—Total (18–75 Years)* and *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)* were at or between the 75th and 89th percentile, indicating strength in providing follow-up care of acute and chronic conditions to members. **[Quality]**
Opportunities for Improvement and Recommendations
While Mercy Care ACC-RBHA was successful in reporting valid rates for all AHCCCS-required performance measures, the audit identified some considerations and recommendations for future years' reporting. **[Quality]** Recommendation: HSAG recommends that Mercy Care ACC-RBHA continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes AHCCCS requirements for Contractor-enrolled members who switch product lines or Contractors and members for whom Mercy Care ACC-RBHA does not hold the primary insurance contract. HSAG recommends that Mercy Care ACC-RBHA continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES.
In the Behavioral Health measure group: • Mercy Care ACC-RBHA's performance measure rate for *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total (18+ Years)* also fell below the 25th percentile, suggesting that barriers exist for some members with a diagnosis of major depression to remain on antidepressant medication. Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness, and identifying and managing side effects. Effective medication treatment of major depression can improve a person's daily functioning and well-being and can reduce the risk of suicide.[191] **[Quality]** Recommendation: While Mercy Care ACC-RBHA conducted a root cause analysis and implemented interventions to determine why some members were not managing their antidepressant medication, the rates for *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total (18+ Years)* still fell below the 25th percentile. HSAG recommends that Mercy Care ACC-RBHA monitor and expand on interventions currently in place to improve performance related to these measures. HSAG recommends that Mercy Care ACC-RBHA consider clinical recommendations

[191] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Feb 19, 2025.

Strengths, Opportunities for Improvement, and Recommendations
shown to improve adherence to antidepressants, such as assessing depressive symptoms at baseline and each follow-up, as well as providing psychoeducation to the member and family.[192]
In the Preventive Screening measure group, Mercy Care ACC-RBHA's performance measure rates for *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* remained below the 25th percentile, indicating that not all women were receiving timely screening for breast and cervical cancers. Early detection reduces the risk of dying from these types of cancers and can lead to a greater range of treatment options and lower healthcare costs. **[Quality]** Recommendation: While Mercy Care ACC-RBHA conducted a root cause analysis and implemented interventions specific to the MY 2022 *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* rates, these measure rates remained low in MY 2023. HSAG recommends that Mercy Care ACC-RBHA monitor and expand on interventions currently in place to improve performance related to these measures. HSAG recommends that Mercy Care ACC-RBHA utilize one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve cervical cancer screening rates. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness.
In the Appropriate Utilization of Services measure group, Mercy Care ACC-RBHA's performance measure rates for *Plan All-Cause Readmissions O/E Ratio—Total (18–64 Years)* remains below the 25th percentile. **[Quality]** Recommendation: While Mercy Care ACC-RBHA initiated efforts to identify best practices for reducing the unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay, these rates remained below the 25th percentile for MY 2023. HSAG recommends that Mercy Care ACC-RBHA continue to follow through on these performance improvement strategies to increase provider and member outreach and improve follow-up care after discharge from an acute inpatient admission or observation. HSAG recommends that Mercy Care ACC-RBHA consider reviewing the Re-Engineered Discharge (RED), which has been shown to reduce readmissions and posthospital ED visits.[193] Other interventions that might be effective include technology platforms, including AI or machine learning, that can assist the plan in identifying members more at risk of readmission. HSAG recommends that Mercy Care ACC-RBHA utilize case management strategies that focus on person-centered techniques, addressing barriers and/or SDOH as needed.

[192] Solmi M, Miola A, Croatto G, et al. How can we improve antidepressant adherence in the management of depression? A targeted review and 10 clinical recommendations. *Brazilian Journal of Psychiatry*. 2021;43(2):189–202.
[193] Agency for Healthcare Research and Quality. Re-Engineered Discharge (RED) Toolkit. Available at: https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool1.html. Accessed on Feb 19, 2025.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 7-32 presents performance measure recommendations made to Mercy Care ACC-RBHA in the CYE 2023 Annual Technical Report[194] and Mercy Care ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 7-32—Mercy Care ACC-RBHA Follow-Up to CYE 2023 Performance Measure Recommendations

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Recommendation 1:
• HSAG recommended that Mercy Care ACC-RBHA continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes AHCCCS requirements for Contractor-enrolled members who switch product lines or Contractors and members for whom Mercy Care ACC-RBHA does not hold the primary insurance contract. • HSAG recommended that Mercy Care ACC-RBHA continue to ensure that the mapping of provider specialties to HEDIS provider types is compliant with AHCCCS' requirements for PMV reporting. • HSAG recommended that Mercy Care ACC-RBHA continue to conduct live system validation of data after its vendor's first run of MY 2023 rates, prior to reporting any performance measure data.
Mercy Care ACC-RBHA's Response: AHCCCS required plans to follow the NCQA HEDIS guidelines. As a result, Mercy Care ACC-RBHA is following the current requirements. The National Medicaid Quality Data team ensures that necessary source code changes are made by the software vendor with the release of any changes to event data, and rates are reviewed monthly. Any anomalies/discrepancies/outliers that are found are reviewed, researched, and tested thoroughly before any data are reported to regulatory bodies. Additionally, monthly event checks using vendor resources are compared to any technical specifications to ensure that the vendor is accurately capturing the right reporting elements for all core and non-core activities, as well as higher monitoring of internal back-end system integrations to ensure that all data elements are within scope to be captured for reporting.
HSAG's Assessment: HSAG determined that Mercy Care ACC-RBHA satisfactorily addressed these prior year's recommendations.
Recommendation 2:

[194] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
HSAG recommended that Mercy Care ACC-RBHA continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race and ethnicity data to support performance measure reporting that requires stratification related to race and ethnicity.
Mercy Care ACC-RBHA's Response: Mercy Care ACC-RBHA continues collaboration with the Aetna Medicaid Quality & Report team to update the 834 mapping to include all applicable data. Mercy Care ACC-RBHA is leveraging the CMS enrollment files and case/care management data for capturing additional data for 2024. As part of this additional work, Mercy Care ACC-RBHA and Aetna Medicaid are collaborating with the Health Equity Team to identify if indirect data sources can be captured to supplement the direct data sources. Mercy Care ACC-RBHA has been working with the Health Information Exchange (HIE) on receiving the A08 alerts for Race & Ethnicity data directly.
HSAG's Assessment: HSAG determined that Mercy Care ACC-RBHA satisfactorily addressed these prior year's recommendations.
Recommendation 3:
While Mercy Care ACC-RBHA conducted a root cause analysis and implemented targeted interventions specific to the CY 2020 *Prenatal and Postpartum Care—Postpartum Care* rates, both *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* rates were low in both CY 2021 and CY 2022. HSAG recommended that Mercy Care ACC-RBHA continue to implement appropriate interventions to improve performance relative to both prenatal and postpartum care.
Mercy Care ACC-RBHA's Response: Mercy Care ACC-RBHA completed a fishbone diagram and continued and implemented the following interventions after completion of a root cause analysis. Those interventions include: • "You and Your Baby" magazine for member outreach. • Written outreach explaining the services offered by Women, Infants, and Children (WIC) to new moms. • Educational outreach information is available on the MC website. • Telephonic outreach calls to pregnant members encouraging them to schedule prenatal and postnatal visit and inform them of local community resources. • Perinatal CM and outreach staff offering and assisting members with scheduling transportation to appointments. • Perinatal CMs and outreach staff refer members to community programs including the Phoenix Nurse-Family Partnership, Tucson Family Partnership, Healthy Families in Maricopa and Pima counties, and Teen Outreach Pregnancy Services.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
• Perinatal CM and outreach staff provide members with information on WIC, Supplemental Nutrition Assistance Program (SNAP), Health Start, and the Maricopa Pregnancy and Breastfeeding hotline during outreach calls. • Members under 16 and over 36 years of age and those with high-risk conditions such as diabetes, hypertension, twins, homelessness, and all RBHA members will be flagged and referred to case management for perinatal care coordination. • Mercy Care Perinatal Case Management will work along with contracted facilities to offer childbirth classes to all pregnant members. This information is communicated to members and providers via newsletters and handbooks as well as outreach calls. • Perinatal case management offers an OB incentive program for providers. The OB incentive program rewards providers for submitting American College of Obstetricians and Gynecologists (ACOG) forms to the health plan. This aids the plan in identifying pregnant members and detecting members with high-risk conditions, promotes early intervention of care coordination services, and improves birth outcomes. • Postpartum call follow-up call conducted by outreach staff. Informs member of availability of counseling for postpartum depression, perinatal depression screenings, and other mood and anxiety disorders, their signs and symptoms, and where to get help. • When the health plan has been made aware of members' pregnancy, outreach staff perform a Prenatal Call Follow-Up phone call. Call includes Healthy Pregnancy Measures—Addressing Nutrition, Sexually Transmitted Infections (including HIV and syphilis), Smoking and Alternative Tobacco (including e-cigarettes and vaping), Alcohol, Opioid and Substance Use (including information regarding fetal alcohol spectrum disorders, and neonatal abstinence syndrome [NAS]) and other risky behaviors. • Partner with Gellert Health to arrange additional member care management and outreach for pregnant members identified as under-utilizers of perinatal services provided by MC. Will refer members to community programs, provide members with information on WIC, SNAP, Health Start, and the Maricopa Pregnancy and Breastfeeding hotline, provide moral support, assist with transportation, and encourage to schedule all perinatal appointments. • Creation of a VBS program with the new RBHA BHH ACO, ANP, which includes incentivizing this measure. • Mercy Care Health Assistant Application—Member Web portal to provide educational information regarding gaps in care along with digital and written member outreach. • An incentive is delivered to members who attend 10 prenatal appointments and for members who attend a postnatal visit within 10 weeks of childbirth. The MY 2023 rate of 79.2 percent (prenatal) and 85.8 percent (postpartum) continues to demonstrate year-over-year improvement and exceeds the NCQA Medicaid Mean for the postpartum submeasure.
HSAG's Assessment: While the MY 2023 Prenatal and Postpartum Care rates were not reported, Mercy Care ACC-RBHA implemented interventions to improve performance on these measures;

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
therefore, HSAG determined that Mercy Care ACC-RBHA satisfactorily addressed these prior year's recommendations.
Recommendation 4:
While improvement has been made for the *Postpartum Care* rates, HSAG recommended that Mercy Care ACC-RBHA continue to monitor and expand on interventions currently in place to improve performance related to both the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measures.
Mercy Care ACC-RBHA's Response: Mercy Care ACC-RBHA completed a fishbone diagram and continued and implemented the following interventions after completion of a root cause analysis. Those interventions include: • "You and Your Baby" magazine for member outreach. • Written outreach explaining the services offered by WIC to new moms. • Educational outreach information is available on the MC website. • Telephonic outreach calls to pregnant members encouraging them to schedule prenatal and PN visit and inform them of local community resources. • Perinatal CM and outreach staff offering and assisting members with scheduling transportation to appointments. • Perinatal CMs and outreach staff refer members to community programs including the Phoenix Nurse-Family Partnership, Tucson Family Partnership, Healthy Families in Maricopa and Pima counties, and Teen Outreach Pregnancy Services. • Perinatal CM and outreach staff provide members with information on WIC, SNAP, Health Start, and the Maricopa Pregnancy & Breastfeeding hotline during outreach calls. • Members under 16 and over 36 years of age and those with high-risk conditions such as diabetes, hypertension, twins, homelessness, and all RBHA members will be flagged and referred to case management for perinatal care coordination. • Mercy Care Perinatal Case Management will work along with contracted facilities to offer childbirth classes to all pregnant members. This information is communicated to members and providers via newsletters and handbooks as well as outreach calls. • Perinatal case management offers an OB incentive program for providers. The OB incentive program rewards providers for submitting ACOG forms to the health plan. This aids the plan in identifying pregnant members and detecting members with high-risk conditions, promotes early intervention of care coordination services, and improves birth outcomes. • Postpartum call follow-up call conducted by outreach staff. Informs member of availability of counseling for postpartum depression, perinatal depression screenings, and other mood and anxiety disorders, their signs and symptoms, and where to get help. • When the health plan has been made aware of members' pregnancy, outreach staff perform a Prenatal Call Follow-Up phone call. Call includes Healthy Pregnancy Measures—Addressing Nutrition, Sexually Transmitted Infections (including HIV and syphilis), Smoking and Alternative

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Tobacco (including e-cigarettes and vaping), Alcohol, Opioid and Substance Use (including information regarding fetal alcohol spectrum disorders, and NAS) and other risky behaviors. • Partner with Gellert Health to arrange additional member care management and outreach for pregnant members identified as under-utilizers of perinatal services provided by MC. Will refer members to community programs, provide members with information on WIC, SNAP, Health Start, and the Maricopa Pregnancy and Breastfeeding hotline, provide moral support, assist with transportation, and encourage to make schedule all perinatal appointments. • Creation of a VBS program with the new RBHA BHH ACO, ANP, which includes incentivizing this measure. • Mercy Care Health Assistant Application—Member Web portal to provide educational information regarding gaps in care along with digital and written member outreach. • An incentive is delivered to members who attend 10 prenatal appointments and for members who attend a postnatal visit within 10 weeks of childbirth. The MY 2023 rate of 79.2 percent (prenatal) and 85.8 percent (postpartum) continues to demonstrate year-over-year improvement and exceeds the NCQA Medicaid Mean for the postpartum submeasure.
HSAG's Assessment: While the MY 2023 Prenatal and Postpartum Care rates were not reported, Mercy Care ACC-RBHA implemented interventions to improve performance on these measures; therefore, HSAG determined that Mercy Care ACC-RBHA satisfactorily addressed these prior year's recommendations.
Recommendation 5:
While Mercy Care ACC-RBHA conducted a root cause analysis and implemented interventions to determine why some members were not managing their antidepressant medication, the rates for *Antidepressant Medication Management—Effective Acute Phase Treatment* fell and remained below the 25th percentile, and the performance measure rate for *Effective Continuation Phase Treatment* also fell below the 25th percentile. HSAG recommended that Mercy Care ACC-RBHA continue to implement appropriate interventions to improve performance for both measures and consider the nature and scope of the issues (e.g., the issues are related to barriers such as a lack of patient and provider communication or patient education) when implementing interventions.
Mercy Care ACC-RBHA's Response: Mercy Care ACC-RBHA conducted a root cause analysis utilizing a fishbone diagram. Factors which may impact member compliance with medication adherence, including adherence to antidepressant medications include: • Provider office staff may not understand the importance of sharing information or may think that they are prohibited from sharing information due to HIPAA regulations. • PCPs may be unaware of members who are nonadherent to their antidepressant medications. • Limited staffing resources at the provider offices to research and identify members who are nonadherent to their antidepressant medications.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
• Stigma related to the diagnosis of depression. • Side effects, such as weight gain, or adverse drug reactions. Interventions include: • Pharmacy Advisor Support Adherence. • Additional Retrospective Drug Utilization review to identify any potential major drug interactions which include antidepressant medication. • Monitoring Parameters for Behavioral Health Medications Guide (MC Provider Website). • PMMT Program/Care Manager referral program. • Data Review and Best Practice Identification. • Mercy Care Health Assistant Application—Member Web portal to provide educational information regarding gaps in care along with digital and written member outreach. • Addition of the *AMM* measure to Mercy Care's VBS provider incentive program. • Pharmacy Risk Prevention Report including members at risk for adherence noncompliance and gap in care data (measures: *AMM*, *HDO*, *SAA*, *SPD*, *SPC*, *SSD*, and *UOP*) Mercy Care ACC-RBHA will continue to monitor the plan's performance with this measure through the additional phases of the PDSA cycle and modify existing interventions or implement additional interventions as necessary.
HSAG's Assessment: Mercy Care ACC-RBHA implemented interventions to improve performance on this measure; therefore, HSAG determined that Mercy Care ACC-RBHA satisfactorily addressed these prior year's recommendations.
Recommendation 6:
While Mercy Care ACC-RBHA conducted a root cause analysis and implemented interventions to determine why there is a higher proportion of members receiving prescriptions for opioids, performance remained below the 25th percentile in CY 2022. HSAG therefore recommended that Mercy Care ACC-RBHA continue to implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse. HSAG also recommended that Mercy Care ACC-RBHA monitor and expand on interventions currently in place to improve performance related to the *Use of Opioids at High Dosage (18+ Years)* measure.
Mercy Care ACC-RBHA's Response: Mercy Care ACC-RBHA conducted a root cause analysis utilizing a fishbone diagram. Factors which may impact member compliance with medication adherence, including adherence to antidepressant medications include: • Provider office staff may not understand the importance of sharing information or may think that they are prohibited from sharing information due to HIPAA regulations. • PCPs may be unaware of members who are nonadherent to their antidepressant medications.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
• Limited staffing resources at the provider offices to research and identify members who are nonadherent to their antidepressant medications. • Stigma related to the diagnosis of depression. • Side effects, such as weight gain, or adverse drug reactions. Interventions include: • Pharmacy Advisor Support Adherence. • Additional Retrospective Drug Utilization review to identify any potential major drug interactions which include antidepressant medication. • Monitoring Parameters for Behavioral Health Medications Guide (MC Provider Website). • PMMT Program/Care Manager referral program. • Data Review and Best Practice Identification. • Mercy Care Health Assistant Application—Member Web portal to provide educational information regarding gaps in care along with digital and written member outreach. • Addition of the *AMM* measure to Mercy Care's VBS provider incentive program. • Pharmacy Risk Prevention Report including members at risk for adherence noncompliance and gap in care data (measures: *AMM*, *HDO*, *SAA*, *SPD*, *SPC*, *SSD*, and *UOP*) Mercy Care ACC-RBHA will continue to monitor the plan's performance with this measure through the additional phases of the PDSA cycle and modify existing interventions or implement additional interventions as necessary.
HSAG's Assessment: Mercy Care ACC-RBHA implemented interventions to improve performance on this measure; therefore, HSAG determined that Mercy Care ACC-RBHA satisfactorily addressed these prior year's recommendations.
Recommendation 7:
While Mercy Care ACC-RBHA conducted a root cause analysis and implemented interventions specific to the CY 2020 *Breast Cancer Screening* and *Cervical Cancer Screening* rates, these measure rates remained low in CY 2021 and CY 2022. HSAG therefore recommended that Mercy Care ACC-RBHA continue to implement appropriate interventions to improve performance related to preventive screenings. HSAG also recommended that Mercy Care ACC-RBHA monitor and expand on interventions currently in place to improve performance related to the *Breast Cancer Screening* and *Cervical Cancer Screening* measures.
Mercy Care ACC-RBHA's Response: Mercy Care ACC-RBHA conducted a root cause analysis utilizing a fishbone diagram. Mercy Care continued the interventions that were reported in 2023, after completion of a root cause analysis, and developed and implemented additional interventions to further drive improvement. Those interventions include:

Prior Year's Recommendation From the EQR Technical Report for Performance Measures

- Offer additional provider education for those areas identified as under-utilizers and work with those providers to discuss how we can help utilize a mobile mammogram program to reach their members and promote our incentive program for breast cancer screenings.
- Partner with Mercy Care VBS providers to provide standard supplemental data feeds to improve data capture.
- Mercy Care Health Assistant Application—Member Web portal to provide educational information regarding gaps in care along with digital and written member outreach.
- Increased/improved member incentive.
- Pursue hosting a Mercy Care sponsored health fair where individuals can receive a mobile mammogram.
- Staying Healthy Fall/Winter 2024 Member Newsletter provides the member with information on women's wellness exams, cervical cancer screenings (CCS) and breast cancer screenings (BCS)

Continued interventions:

- Educational outreach to female members ages 40–74 to encourage well woman exams and mammograms (BCS).
- Providers are notified via mail of members who are due for a mammogram. They are given an order form to sign and send into us. We then contact the member and assist with scheduling a mammogram and submitting the order form.
- Outreach staff contact members who still have not had a mammogram to assist with scheduling an appointment.
- Incentive letter mailed to members who still need a mammogram; once they receive a mammogram and the facility signs the form, the member can submit it to us for a gift card if met before deadline.
- Provider outreach educating on breast cancer screening guideline and provide them with a list of members in need of a mammogram.
- Text messaging, email, and IVR outreach to close gaps in care to members with MCA.
- Content that is specific to mammogram disparities was included in provider newsletters and the Mercy Care Provider Conference.
- Offer additional provider education for those areas identified as under-utilizers and work with those providers to discuss how we can help utilize a mobile mammogram program to reach their members and promote our incentive program for breast cancer screenings.
- Partner with Arizona Diagnostics Radiology to outreach members specifically assigned to these providers.
- Addition of *BCS* measure to value-based programs.
- Collaboration with Native Health by providing targeted gap lists of members in need of a mammography screening.
- Collection of nonstandard supplemental data, particularly for members with other primary coverage, to close gaps in data.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
• Partner with Mercy Care VBS providers to provide standard supplemental data feeds to improve data capture. • Healthmine Application—Member Web portal to provide educational information regarding gaps in care along with digital and written member outreach. • Provider "Gaps-in-Care" well-woman mailing includes a list of members who need breast or cervical cancer screening. • Outreach staff contact members who need a Pap [Papanikolaou] test and assist with scheduling an appointment. • Provider outreach to provide education on the *CCS* screening guidelines and furnish a list of members still in need of a Pap test. • Member education utilizing educational videos on the Mercy Care member website. • Creation of a VBS program with the new RBHA BHH ACO, ANP, which includes incentivizing this measure. Mercy Care ACC-RBHA will continue to monitor the plan's performance with these measures through the additional phases of the PDSA cycle and modify existing interventions or implement additional interventions as necessary.
HSAG's Assessment: Mercy Care ACC-RBHA implemented interventions to improve performance on this measure; therefore, HSAG determined that Mercy Care ACC-RBHA satisfactorily addressed these prior year's recommendations.
Recommendation 8:
While Mercy Care ACC-RBHA initiated efforts to identify best practices for reducing the unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay, these rates remained below the 25th percentile for CY 2022. Mercy Care ACC-RBHA also followed the recommendation of conducting a root cause analysis to identify factors contributing to members experiencing unplanned acute readmissions, which should include evaluating whether or not appropriate follow-up care is available to members upon discharge from an acute inpatient admission or observation. HSAG recommends that Mercy Care ACC-RBHA continue to follow through on these performance improvement strategies to increase provider and member outreach and improve follow-up care after discharge from an acute inpatient admission or observation.
Mercy Care ACC-RBHA's Response: Mercy Care ACC-RBHA conducted a root cause analysis utilizing a fishbone diagram. Analysis regarding the *PCR* measure demonstrates that factors which may impact readmissions include: • Poor or incomplete communication between inpatient facilities and outpatient providers/MCOs. • Lack of social planning/SDOH factor support at discharge. • Discharge planning not occurring timely. • Lack of member understanding of discharge instructions/new or revised medications. • Follow-up visits post-discharge not available or not completed timely.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
As a result of this analysis, Mercy Care developed the following interventions aimed at reducing the unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay: • Creation of a VBS program with the new RBHA BHH ACO, ANP, which includes incentivizing this measure. • Creation of a new level of care of case management at RBHA health homes, Intensive Level of Care to help provide more assistance to members who have higher utilization and greater clinical needs. Caseloads' size maximum will be between ACT and supportive and the case manager but be a licensed professional such as an RN, LMSW, LAC, or LMFT. • Behavioral health UM managers and supervisors meet with newly contracted psychiatric hospitals within 90 days of the contract go-live date, and then as needed or requested, to review UM and disposition planning processes, answer questions, provide education, and identify barriers potentially impacting member outcomes. The goal is to establish strong relationships between hospital and Mercy Care leaders, support new providers on how to support best member outcomes through coordination of care, disposition planning, and reducing the potential for hospital readmissions. • SMI Sepsis Readmissions: SMI members with a sepsis discharge diagnosis are referred to a specific CM who then sends a referral to Your Health Connection (YHC) for follow-up outpatient services such as a PCP appointment, filling scripts for antibiotics, continued follow-up care as well as making any referrals for outpatient services including CM collaboration to support members and prevent hospital readmissions. Mercy Care ACC-RBHA will continue to monitor the plan's performance with this measure through the additional phases of the PDSA cycle and modify existing interventions or implement additional interventions as necessary.
HSAG's Assessment: Mercy Care ACC-RBHA implemented interventions to improve performance on this measure; therefore, HSAG determined that Mercy Care ACC-RBHA satisfactorily addressed these prior year's recommendations.

Validation of Performance Improvement Projects

Preventive Screening PIP

In CYE 2024, Mercy Care ACC-RBHA continued the *Preventive Screening* PIP, which was initiated in CYE 2019. As the PIP had progressed through Remeasurement 2, PIP validation activities focused on improvement from the baseline results. Mercy Care ACC-RBHA submitted Remeasurement 2 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes to or possible discontinuation of the intervention.

HSAG conducted an annual validation of the second remeasurement year reflective of CY 2023 (January 1, 2023, through December 31, 2023) using AHCCCS-calculated and validated indicator rates. HSAG evaluated Mercy Care ACC-RBHA's performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

Validation Results

Table 7-33 displays the overall confidence levels for the Mercy Care ACC-RBHA *Preventive Screening* PIP.

Table 7-33—Mercy Care ACC-RBHA *Preventive Screening* PIP Overall Confidence Levels

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]
Mercy Care ACC-RBHA	*High Confidence*	100%	100%	*Moderate Confidence*	33%	100%

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

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

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

Measure Results

Table 7-34 and Table 7-35 provide the *Preventive Screening* PIP baseline, Remeasurement Year 1, and Remeasurement Year 2 rates for each indicator for Mercy Care ACC-RBHA.

Table 7-34—Mercy Care ACC-RBHA *Preventive Screening* PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: *Breast Cancer Screening*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
Mercy Care ACC-RBHA	35.8%	41.1%	44.4%

HSAG rounded percentages to the first decimal place.

Table 7-35—Mercy Care ACC-RBHA *Preventive Screening* PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: *Cervical Cancer Screening*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
Mercy Care ACC-RBHA	43.5%	37.4%	38.2%

HSAG rounded percentages to the first decimal place.

Interventions

Table 7-36 presents PIP interventions for Mercy Care ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 7-36—Mercy Care ACC-RBHA *Preventive Screening* PIP Interventions

Contractor	Intervention
Mercy Care ACC-RBHA	**Mammogram Screening:** • Additional provider education for those areas mentioned that are underutilized: – Worked with those providers to promote our incentive program for breast cancer screenings. – Worked with those providers to discuss how we can help utilize a mobile mammogram program to reach their members. • Partnered with Arizona Diagnostics Radiology to outreach members specifically assigned to these providers. • Developed and implemented a written or multi-channel outreach (text/IVR/email) intervention for newly enrolled female members ages 50–74 years, as well as members ages 52–59 years. • Addition of *BCS* measure to value-based programs. • Surveyed providers that have a high compliance rate/have been successful in working with members with similar profiles to identify best practices and outreach to low-performing providers to share identified best practices; encouraged member outreach to close gaps in care. • ACMO targeted provider outreach for PCPs identified with the largest volume of members in need of screening—share best practices and list of members with a gap in care for outreach and care coordination. **Cervical Cancer Screening:** • Sent out cervical cancer screening mailer biannually. • Provider outreach and education.

Contractor	Intervention
	– Encouraged MD to ask members if they have received a Pap test at their OB; if not, help the member schedule for the provider's office or the member's OB office. – Encouraged MD to offer HPV vaccination to all members ages 11–26. • Provider site visits. Make it a priority for an MCH representative to meet with the MD and office staff, specifically in areas that are in need (Phoenix), at a minimum of once per year to review the provider outreach manual. • Increased community/tribal outreach and education. • Addition of two more tribal specialists (tribal relations positions) to the Mercy Care team who will function similarly to community health workers in that they engaged members who might be difficult to engage or find, provide health information, offer referral, assist with navigation, etc., to assist in addressing these disparities. • Met with Native Health and the Phoenix Indian Medical Center to determine if partnership opportunities exist.

Strengths, Opportunities for Improvement, and Recommendations

Table 7-37 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA related to the *Preventive Screening* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 7-37—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to the *Preventive Screening* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG noted that Mercy Care ACC-RBHA adhered to an acceptable methodology through all phases of the PIP and was able to measure the effectiveness of interventions and perform accurate statistical testing between the baseline rate and the Remeasurement 2 rate. Mercy Care ACC-RBHA was able to achieve statistically significant improvement for Performance Indicator 1 (*BCS*) when comparing the baseline rate to Remeasurement 2 rate. **[Quality, Access]**
Opportunities for Improvement and Recommendations
For Indicator 2, Mercy Care ACC-RBHA had a decline of 5.3 percentage points between the baseline year and Remeasurement Year 2. **[Quality, Access]** Recommendations: To support successful progression of the PIP in the next calendar year, HSAG recommends that Mercy Care ACC-RBHA:

Strengths, Opportunities for Improvement, and Recommendations
• Seek technical assistance from HSAG to understand the PIP submission requirements, if needed. • Revisit the causal/barrier analysis used to develop interventions and adjust the existing interventions or develop new interventions to facilitate improvement for the *CCS* performance indicator. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 7-38 presents PIP recommendations made to Mercy Care ACC-RBHA in the CYE 2023 Annual Technical Report[195] and Mercy Care ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 7-38—Mercy Care ACC-RBHA Follow-Up to CYE 2023 PIP Recommendations

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG recommended that Mercy Care ACC-RBHA: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. • Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.
Mercy Care ACC-RBHA's Response: Mercy Care continues to review the PIP rates at least quarterly, with an annual final measurement year evaluation once the data are finalized. When Mercy Care ACC-RBHA identifies declines in performance, or that the rates are not on track to reach the defined goal, we initiate or follow to the next step in the PDSA cycle. Interventions are assessed for effectiveness, and best practices are identified, documented, and incorporated into the health plan's standard operating procedures. *BCS* interventions: • Additional provider education for those areas mentioned that are underutilized.

[195] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for PIPs
– Work with those providers to discuss how we can help utilize a mobile mammogram program to reach their members. – Work with those providers to promote our incentive program for breast cancer screenings. • Partner with Arizona Diagnostics Radiology to outreach members specifically assigned to these providers. • Develop and implement a written or multi-channel outreach (text/IVR/email) intervention for newly enrolled female members ages 50–74 years, as well as members ages 52–59 years. • Addition of *BCS* measure to value-based programs. • Survey providers that have a high compliance rate/have been successful in working with members with similar profiles to identify best practices and outreach to low-performing providers to share identified best practices; encourage member outreach to close gaps in care. • ACMO targeted provider outreach for PCPs identified with the largest volume of members in need of screening—share best practices and list of members with a gap in care for outreach and care coordination. *CCS* interventions: • Send out cervical cancer screening mailer biannually. • Provider outreach and education. • Encourage MD to ask members if they have received a Pap test at an OB; if not, help the member schedule for their office or the member's OB office. • Encourage MD to offer HPV vaccination to all 11–26-year-olds. • Provider site visits. • Make it a priority for an MCH representative to meet with MD and office staff, specifically in areas that are in need (Phoenix), at a minimum of once per year to review the provider outreach manual. • Increase community/tribal outreach and education. • Addition of two more tribal specialists (tribal relations positions) to the Mercy Care team who will function similarly to community health workers in that they will engage members who might be difficult to engage or find, provide health information, offer referral, assist with navigation, etc., to assist in addressing these disparities. • Meet with Native Health and the Phoenix Indian Medical Center to determine if partnership opportunities exist.
HSAG's Assessment: HSAG determined that Mercy Care ACC-RBHA satisfactorily addressed these prior year's recommendations.

Prenatal and Postpartum Care PIP

Overview

AHCCCS initiated the implementation of the *Prenatal and Postpartum Care* PIP for the ACC population in CYE 2022. The objective of the *Prenatal and Postpartum Care* PIP is to improve health outcomes for members and infants. This PIP focuses on increasing the number and percentage of members with live birth deliveries that 1) received a prenatal care visit, and 2) received a postpartum visit. In CYE 2024, Mercy Care ACC-RBHA continued to implement interventions to improve these outcomes and provided updates on the status of each intervention to AHCCCS.

Interventions

Table 7-39 presents PIP interventions for Mercy Care ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 7-39—Mercy Care ACC-RBHA *Prenatal and Postpartum Care* PIP Interventions

Contractor	Interventions
Mercy Care ACC-RBHA	Continued interventions to support the *Prenatal and Postpartum Care* PIP in CYE 2024 include: • Leveraging the ACOG data submitted to the perinatal ICM team for low-risk pregnancy identification, in addition to use by the perinatal CM team. • Leveraging newborn notifications for identification of postpartum members. • Revising the outreach process so that the postpartum mailing is sent to the member regardless of whether or not the member's PCP or baby's PCP information is available (revised letter template and process). • Written educational information: member handbook, member newsletters, maternity booklets, letters and flyers that focus on the components of prenatal and postpartum visits. • Provider letter is mailed to PCPs and OB/GYNs letting them know they have a newly pregnant member who requires prenatal/postpartum care. • Virtual or face-to-face contacts between the Mercy Care coordinators, PCPs, and OB/GYNs to provide education on the components of prenatal/postpartum visits. • Improving medical record retrieval processes to ensure requested records for all sample members are received. • Add the prenatal care measure to Mercy Care's VBS contracts. • Sharing of gap in care data, which includes identified race and ethnicity, with Mercy Care VBS providers for outreach and care coordination. • Collecting available SDOH data from sources including but not limited to claims, SocialScape and Pyx.

Strengths, Opportunities for Improvement, and Recommendations

HSAG did not conduct validation on the *Prenatal and Postpartum Care* PIP in CYE 2024; therefore, strengths, opportunities for improvement, and recommendations are not provided.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 7-40 presents PIP recommendations made to Mercy Care ACC-RBHA in the CYE 2023 Annual Technical Report[196] and Mercy Care ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 7-40—Mercy Care ACC-RBHA Follow-Up to CYE 2023 PIP Recommendations

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG recommended that Mercy Care ACC-RBHA: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. • Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.
Mercy Care ACC-RBHA's Response: Mercy Care continues to review the PIP rates at least quarterly, with an annual final measurement year evaluation once the data are finalized. When Mercy Care ACC-RBHA identifies declines in performance, or that the rates are not on track to reach the defined goal, we initiate or follow to the next step in the PDSA cycle. Interventions are assessed for effectiveness, and best practices are identified, documented, and incorporated into the health plan's standard operating procedures. Interventions: • Leveraging the ACOG data submitted to the perinatal ICM team for low-risk pregnancy identification, in addition to use by the perinatal CM team. • Leveraging newborn notifications for identification of postpartum members. • Implementing a process to identify pregnant members through positive pregnancy tests in the HIE.

[196] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for PIPs
• Revising the outreach process so that the postpartum mailing is sent to members regardless of whether or not the member's PCP or baby's PCP information is available (revised letter template and process). • Written educational information: member handbook, member newsletters, maternity booklets, letters, and flyers that focus on the components of prenatal and postpartum visits. • Provider letter is mailed to PCPs and OB/GYNs letting them know they have a newly pregnant member who requires prenatal/postpartum care. • Virtual or face-to-face contacts between the Mercy Care coordinators, PCPs, and OB/GYNs to provide education on the components of prenatal/postpartum visits. • MCH outreach call staff assists with setting appointments and provides information on community resources during their outreach calls. • MCH outreach call staff submit referrals to the perinatal ICM team for care management identification discovered during the outreach call. • MCH coordinators assist the care management department by providing outreach to members to verify the need for care management during their pregnancy. During these calls, the coordinators also assist with setting appointments and providing information on community resources. • Improving medical record retrieval processes to ensure requested records for all sample members are received. • Prenatal and Postpartum Member Incentives for all LOBs. • Healthmine Application—Member Web portal. • Add the prenatal care measure to Mercy Care's VBS contracts. • Sharing of gap in care data, which includes identified race and ethnicity, with Mercy Care VBS providers for outreach and care coordination. • Collecting available SDOH data from sources including but not limited to claims, SocialScape, and Pyx.
HSAG's Assessment: HSAG determined that Mercy Care ACC-RBHA satisfactorily addressed these prior year's recommendations.

Compliance Reviews

Results

AHCCCS conducted a compliance review of Mercy Care ACC-RBHA from February 12, 2024, through February 15, 2024. On May 2, 2024, AHCCCS finalized the report findings, provided Mercy Care ACC-RBHA with a CAP submission matrix, and required a CAP for any standard with a total score of less than 95 percent. On June 7, 2024, AHCCCS accepted Mercy Care ACC-RBHA's proposed CAPs and required the Contractor to submit updated policies, manuals, desktop procedures, and other vital

documents to provide evidence of CAP completion. CAP items were under review by AHCCCS at the time this report was written. Results of the CAP update will be included in the CYE 2025 annual technical report.

Table 7-41—Mercy Care ACC-RBHA Compliance Review Results

Compliance Focus Areas	CYE 2024 Mercy Care ACC-RBHA Scores	CYE 2024 Program-Level Average
CC	100%	95%
CIS	99%	99%
DS	97%	97%
GA	96%	97%
GM	100%	100%
GS	100%	100%
MCH	96%	96%
MM	97%	95%
MI	90%	94%
QM	95%	89%
QI	100%	100%
RI	100%	100%
TPL	100%	100%
ISOC	99%	99%

Strengths, Opportunities for Improvement, and Recommendations

Table 7-42 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA based on compliance activities conducted in CYE 2024, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 7-42—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
Mercy Care ACC-RBHA scored at or above 95 percent in the following focus areas: • Claims and Information Standards (CIS) **[Access]** • Delivery Systems (DS) **[Timeliness, Access]** • General Administration (GA) **[Timeliness, Access]** • Grants Management (GM) **[Quality, Access]**

Strengths, Opportunities for Improvement, and Recommendations
• Grievance Systems (GS) **[Timeliness, Access]** • Adult, EPSDT and Maternal Child Health (MCH) **[Quality, Timeliness, Access]** • Medical Management (MM) • Quality Management (QM) **[Quality]** • Quality Improvement (QI) **[Quality, Access]** • Reinsurance (RI) **[Quality]** • Third-Party Liability (TPL) **[Quality, Timeliness, Access]** • Integrated Systems of Care (ISOC) **[Quality, Access]** AHCCCS approved Mercy Care ACC-RBHA's proposed CAPs for all focus areas with scores less than 95 percent. Mercy Care ACC-RBHA provided evidence of CAP completion at the end of CYE 2024.
Opportunities for Improvement and Recommendations
Mercy Care ACC RBHA scored below 95 percent in the following focus areas: • Member Information (MI) **[Quality]** Recommendation: HSAG recommends that Mercy Care ACC-RBHA continue to work with AHCCCS on closing remaining CAPs.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Compliance review recommendations were not included in the CYE 2023 EQR technical report as compliance review activities were not conducted in CYE 2023; therefore, no follow-up was required by Mercy Care ACC-RBHA.

Network Adequacy Validation

ISCA Results

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

Table 7-43 summarizes HSAG's validation ratings for Mercy Care ACC-RBHA by indicator type.

Table 7-43—Summary of Mercy Care ACC-RBHA's Validation Ratings by Indicator Type

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

Of the network adequacy indicators assessed, Mercy Care ACC-RBHA received *High Confidence* for both appointment availability and time/distance indicator types. However, there were identified areas for improvement, please refer to the Strengths, Opportunities for Improvement, and Recommendations section for more details.

NAV Results

HSAG evaluated Mercy Care ACC-RBHA's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents CYE 2024 S1 validation findings specific to the ACC-RBHA Program, with one results table for the following GSA:

- Central GSA: Gila, Maricopa, and Pinal counties

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

Table 7-44—Time/Distance Validation Results for Mercy Care ACC-RBHA Central GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^[1,2]	99.5^[1,2]	100.0^[1,2]
BHRF	NA	99.5[1]	NA
Cardiologist, Adult	100.0^[1]	99.9^[1]	100.0^[1]
Cardiologist, Pediatric	100.0*^[1]	100.0^[1,3]	100.0^[1]
Crisis Stabilization Facility	100.0[1]	99.4[1]	100.0[1]
Dentist, Pediatric	100.0*[1]	99.8[1]	100.0[1]
Hospital	100.0[1,2]	100.0[1,2]	100.0[1,2]
OB/GYN	100.0[1]	100.0[1,3]	100.0[1]
Pharmacy	100.0[1]	99.4[1]	100.0[1]

Minimum Network Requirement	Gila	Maricopa	Pinal
PCP, Adult	100.0^[1]	99.8^[1]	100.0^[1]
PCP, Pediatric	100.0*^[1]	99.8^[1]	100.0^[1]

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

* indicates that fewer than 10 members were included in the denominator of HSAG's results.

^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

[1] Mercy Care's CYE 2024 S1 results for the ACC-RBHA Program are reflective of its ACOM 436 resubmission submitted on December 17, 2024.

[2] In CYE 2024 S1, Mercy Care ACC-RBHA's data included substantially increased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Adult and Hospital. When contacted, Mercy Care ACC-RBHA indicated that it inadvertently included home office addresses in its report of service addresses, raising the number of providers in the count. This potentially influenced the validated compliance for these provider categories.

[3] In CYE 2024 S1, Mercy Care ACC-RBHA's ACOM 436 resubmission for the ACC-RBHA Program may not accurately represent the following standards, when compared to information gathered from the ISCA: Cardiologist, Pediatric and OB/GYN. Please use caution when comparing HSAG-calculated results to Mercy Care ACC-RBHA-submitted results.

Strengths, Opportunities for Improvement, and Recommendations

Table 7-45 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 7-45—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • Mercy Care ACC-RBHA demonstrated its capability for ensuring the accuracy and completeness of its provider network by conducting rigorous quality assurance processes, including monthly provider data reconciliations, maintaining regular provider outreach and communication, and conducting annual audits of provider data. **[Access]** • Mercy Care ACC-RBHA met all minimum network requirements for all assigned counties. **[Access]** Note: Mercy Care ACC-RBHA provides coverage in Gila. Maricopa, and Pinal counties.
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: • Isolated data issues may have contributed to specific instances affecting Mercy Care ACC-RBHA's compliance with time/distance standards. **[Access]**

Strengths, Opportunities for Improvement, and Recommendations
Recommendation: HSAG recommends that AHCCCS support Mercy Care ACC-RBHA in continuing to monitor the Contractor's processes for creating the PAT file and review this file for accuracy prior to submitting to AHCCCS. • HSAG identified an opportunity for Mercy Care ACC-RBHA to improve the results to calculate time/distance indicators. **[Access]** Recommendation: HSAG recommends that Mercy Care ACC-RBHA incorporate additional oversight and monitoring when transferring Quest-generated output to the ACOM Policy 436 template to ensure the most accurate results are being submitted to AHCCCS**.** • Mercy Care ACC-RBHA had a high level of compliance mismatch between its submitted results and HSAG's calculated results. **[Access]** Recommendation: HSAG recommends that Mercy Care ACC-RBHA continue to work with AHCCCS and HSAG to reduce the amount of compliance discrepancies.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 7-46 presents NAV recommendations made to Mercy Care ACC-RBHA in the CYE 2023 Annual Technical Report[197] and Mercy Care ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 7-46—Mercy Care ACC-RBHA Follow-Up to CYE 2023 NAV Recommendations

Prior Year's Recommendation From the EQR Technical Report for NAV
HSAG recommended that Mercy Care ACC-RBHA maintain current compliance with network standards but continue to address network gaps, as applicable.
Mercy Care ACC-RBHA's Response:

[197] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for NAV
Mercy Care continues existing processes to ensure that the plan maintains compliance with the AHCCCS-required network coverage requirements.
HSAG's Assessment: HSAG has determined that Mercy Care ACC-RBHA has satisfactorily addressed these prior year's recommendations.

8. DCS CHP Program Results

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

This section provides, by EQR activity, DCS CHP activity-specific strengths, opportunities for improvement, and HSAG's recommendations for performance improvement. This section also includes information about the extent to which DCS CHP was able to address the prior year's recommendations for each activity. This section also includes CAHPS survey results for the DCS CHP Program. DCS CHP provides services through a subcontracted health plan, Mercy Care DCS CHP. This report uses DCS CHP when referring to the DCS CHP Contractor, and Mercy Care DCS CHP when referring to activities conducted by the DCS CHP subcontracted health plan (Mercy Care).

DCS CHP Program

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2024, HSAG evaluated DCS CHP's data system for processing of each data type used for reporting the Contractor's CY 2023 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that DCS CHP followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 8-1 displays HSAG's PMV findings for each data type reviewed during CYE 2023 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 8-1—CYE 2024 PMV Findings

Data Type	HSAG Findings
Medical Services Data	*No identified concerns*
Enrollment Data	*No identified concerns*
Provider Data	*No identified concerns*
Medical Record Review Process	*No identified concerns*
Supplemental Data	*No identified concerns*
Data Integration	*No identified concerns*

Results for Performance Measures

Table 8-2 presents the CY 2023 performance measure results for DCS CHP. Performance measure rate cells shaded green indicate that DCS CHP met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 8-2—CY 2023 DCS CHP Performance Measure Results

Performance Measure	CY 2023 Performance
Pediatric Health	
Metabolic Monitoring for Children and Adolescents on Antipsychotics	
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	67.6%
Childhood Immunization Status*	
Combination 3	66.7%+
Combination 7	54.5%+
Combination 10	30.2%+
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	95.7%
Combination 2 (Meningococcal, Tdap, HPV)	54.5%
Oral Evaluation, Dental Services	
*Total (0–20 Years)*N	71.9%
Well-Child Visits in the First 30 Months of Life	
First 15 Months—Six or More Well-Child Visits	66.9%
15 Months to 30 Months—Two or More Well-Child Visits	77.9%
Child and Adolescent Well-Care Visits	
Total (3–21 Years)	77.1%

+ Indicates the measure was reported using hybrid methodology.
** Table A-2 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
N Measure has no NCQA Medicaid mean for comparison.
Cells shaded green indicate that the rate met or exceeded the national Medicaid mean for HEDIS MY 2023.

Table 8-3 presents the CY 2022 and CY 2023 DCS CHP performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and MY 2023. Performance measure rate cells shaded green indicate that DCS CHP met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and/or MY 2023. Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 8-3—CY 2022 and CY 2023 Performance Measure Results for DCS CHP

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Pediatric Health				
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	59.0%	67.6%	↑	★★★★★
Childhood Immunization Status*				
Combination 3	71.8%+	66.7%+	→	★★★
Combination 7	59.6%+	54.5%+	→	★★
Combination 10	38.6%+	30.2%+	→	★★★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	97.0%+	95.7%+	→	★★★★★
Combination 2 (Meningococcal, Tdap, HPV)	57.0%+	54.5%+	→	★★★★★
Oral Evaluation, Dental Services				
Total (0–20 Years)[N]	66.0%	71.9%	↑	—
Well-Child Visits in the First 30 Months of Life				
First 15 Months—Six or More Well-Child Visits	—	66.9%	—	★★★★
15 Months to 30 Months—Two or More Well-Child Visits	—	77.9%	—	★★★★
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	71.0%	77.1%	↑	★★★★★

\+ Indicates the measure was reported using hybrid methodology.
** Table A-2 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
Cells shaded green indicate that the rate met or exceeded the MY 2022 and/or MY 2023 national Medicaid mean.
[1] Indicates a 2022–2023 comparison is not presented in the CYE 2024 Annual Technical Report because either there was a break in trending, the CY 2022 rate was not presented in the CYE 2023 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
[2] Performance Levels for CY 2023 were based on comparisons of the HEDIS MY 2023 measure rates to national Medicaid Quality Compass HEDIS MY 2023 benchmarks.
[N] Measure has no NCQA Medicaid mean for comparison.
↑ Indicates statistically significant improvement of measure rates.
↓ Indicates statistically significant decline of measure rates.
→ Indicates no statistically significant change in measure rates.
Performance Levels for 2023 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Table 8-4 highlights DCS CHP's performance for the current year by measure group. The table illustrates the CY 2023 measure rates and performance relative to the NCQA national

Medicaid Quality Compass HEDIS MY 2023 percentiles, where applicable. The performance level star ratings are defined as follows:

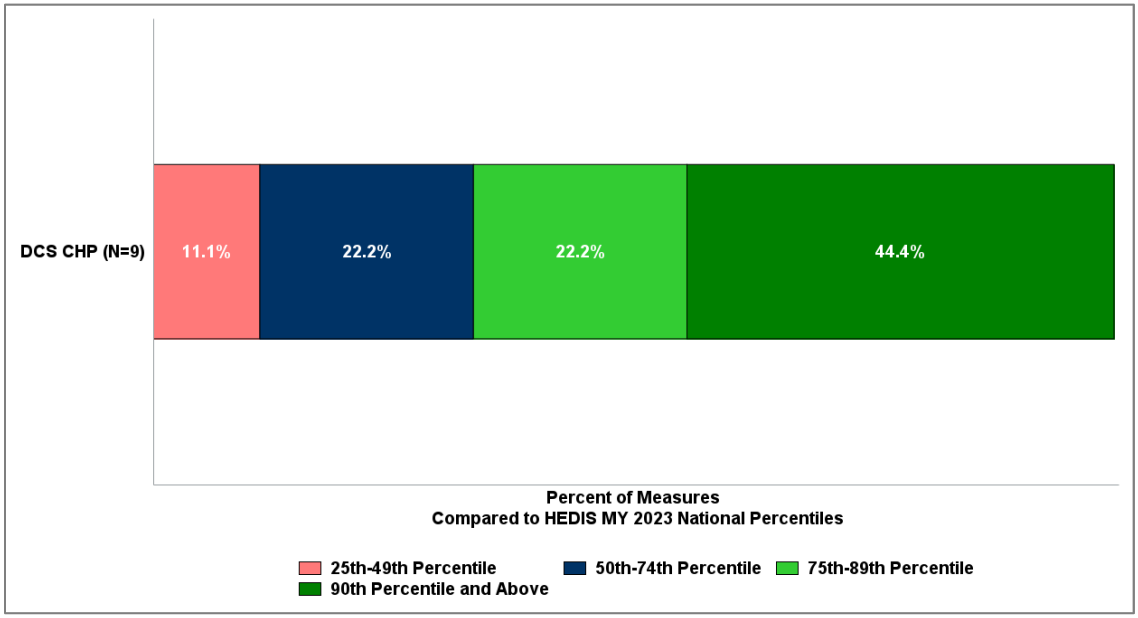
★★★★★ = 90th percentile and above
★★★★ = 75th percentile to 89th percentile
★★★ = 50th percentile to 74th percentile
★★ = 25th percentile to 49th percentile
★ = Below the 25th percentile

Table 8-4—CY 2023 National Percentiles Comparison for DCS CHP

Performance Measure	CY 2023 Performance
Pediatric Health	
Metabolic Monitoring for Children and Adolescents on Antipsychotics	
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	★★★★★
Childhood Immunization Status	
Combination 3	★★★
Combination 7	★★
Combination 10	★★★
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	★★★★★
Combination 2 (Meningococcal, Tdap, HPV)	★★★★★
Well-Child Visits in the First 30 Months of Life	
First 15 Months—Six or More Well-Child Visits	★★★★
15 Months to 30 Months—Two or More Well-Child Visits	★★★★
Child and Adolescent Well-Care Visits	
Total (3–21 Years)	★★★★★

Figure 8-1 displays DCS CHP's HEDIS MY 2023 performance compared to HEDIS MY 2023 National Percentiles. HSAG analyzed results from four performance measures and nine total measure rates for HEDIS MY 2023.

Figure 8-1—Comparison of Measure Indicators to HEDIS Medicaid National Percentiles for DCS CHP



Strengths, Opportunities for Improvement, and Recommendations

Table 8-5 presents strengths, opportunities for improvement, and recommendations for DCS CHP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 8-5—DCS CHP Program Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Pediatric Health measure group: • Eight of 11 DCS CHP rates (72.73 percent) for the following measures met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023: **[Quality, Access]** – *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)* – *Childhood Immunization Status—Combination 3* and *Combination 10* – *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* – *Well-Child Visits in the First 30 Months of Life—First 15 Months—Six or More Well-Child Visits* and *15 Months to 30 Months—Two or More Well-Child Visits* – *Child and Adolescent Well-Care Visits—Total (3–21 Years)*

Strengths, Opportunities for Improvement, and Recommendations
• DCS CHP's rates for these performance measures were at or above the 90th percentile: **[Quality, Access]** – *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)* – *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* – *Child and Adolescent Well-Care Visits—Total (3–21 Years)* • *Well-Child Visits in the First 30 Months of Life—First 15 Months—Six or More Well-Child Visits* and *15 Months to 30 Months—Two or More Well-Child Visits* rates were at or between the 75th and 89th percentile. **[Quality, Access]** • DCS CHP demonstrated strength in providing pediatric care for members. **[Quality]**
Opportunities for Improvement and Recommendations
While DCS CHP generally had appropriate data systems, processes, and oversight, the audit identified the following considerations and recommendations for future years' reporting: **[Quality]** Recommendations: • HSAG recommends that DCS CHP continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. • HSAG recommends that DCS CHP continue to ensure that the mapping of provider specialties to HEDIS provider types is compliant with AHCCCS' requirements for PMV reporting. • DCS CHP has continued to contract with Mercy Care as its subcontracted health plan to produce AHCCCS-required performance measures, and HSAG recommends that DCS CHP continue to maintain this partnership, which allows DCS CHP to appropriately report the AHCCCS PMV measures. • HSAG recommends that DCS CHP continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 8-6 presents performance measure recommendations made to DCS CHP in the CYE 2023 Annual Technical Report[198] and DCS CHP's follow-up to the recommendations, as well as an assessment of the degree to which DCS CHP has effectively addressed the recommendations. Language in this section is

[198] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 8-6—DCS CHP Program Follow-Up to CYE 2023 Performance Measure Recommendations

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Recommendation 1: • HSAG recommended that DCS CHP continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. • HSAG recommended that DCS CHP continue to ensure that the mapping of provider specialties to HEDIS provider types is compliant with AHCCCS' requirements for PMV reporting. • DCS CHP has continued to contract with Mercy Care as its subcontracted health plan to produce AHCCCS-required performance measures, and HSAG recommended that DCS CHP continue to maintain this partnership, which allows DCS CHP to appropriately report the AHCCCS PMV measures.
DCS CHP's Response: DCS CHP continues to ensure compliance with AHCCCS continuous enrolment criteria for PMV reporting and works with MC to ensure PMV measurements are completed. DCS CHP's subcontractor Mercy Care continues to complete provider mapping. DCS CHP continues to work with MC to ensure PMV measurements are completed. DCS CHP's enrollment is primarily children and youth, removed from their families, in the Department of Child Safety's care. As such, biological parents may not be available to provide a comprehensive ethnic/race profile. As part of the department's strategic initiatives to address racial and ethnic disparities, DCS made a concerted effort to ensure data are complete in its child welfare information system, to the greatest extent possible. Work with DCS resulted in the inclusion of the race and ethnicity data in the weekly removal reports produced by DCS' child welfare system. The DCS CHP eligibility and enrollment team then utilizes these removal reports to complete the Health-e-Arizona Plus application for each of the newly removed children/youth in DCS care. The process for including race/ethnicity data during the application process is reliant upon information gathered by DCS child welfare staff, as well as the availability of birth certificates and other data sources. In an effort to enhance future reporting methodologies related to race/ethnicity data for Title XIX-eligible DCS CHP members, the DCS CHP eligibility and enrollment team also revised its enrollment process to include mandatory entry of race/ethnicity data into the Health-e-Arizona Plus system, thereby enhancing the State systems with race and ethnicity data.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
These data are then available for enrollment files generated by AHCCCS to health plans, including DCS CHP, for incorporation into the health plans' claims and enrollment systems and incorporation into data systems that inform performance measures. DCS CHP makes this information available to our partner Mercy Care for utilization in care management and performance improvement efforts to evaluate and address racial and ethnic disparities. As a result, DCS CHP continues to improve the availability of data in terms of completeness and accuracy.
HSAG's Assessment: HSAG determined that DCS CHP satisfactorily addressed the prior year's recommendation.
Recommendation 2:
• For CY 2022 performance measure reporting, race and ethnicity stratifications (RES) was required based on NCQA HEDIS specifications. While HSAG did not identify specific opportunities for DCS CHP to improve RES, DCS CHP could benefit from continuing to focus on refining RES reporting when required according to measure specifications. Therefore, HSAG recommended that DCS CHP explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratifications related to RES. DCS CHP should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information.
DCS CHP's Response: During calendar year 2024, DCS CHP coordinated efforts with DCS to identify race and ethnicity data for the DCS CHP population. DCS CHP's enrollment is primarily children and youth, removed from their families, in DCS care. As such, biological parents may not be available to provide a comprehensive ethnic/race profile. As part of the department's strategic initiatives to address racial and ethnic disparities, DCS made a concerted effort to ensure data are complete in its child welfare information system, to the greatest extent possible. Work with DCS resulted in the inclusion of the race and ethnicity data in the weekly removal reports produced by DCS' child welfare system. The DCS CHP eligibility and enrollment team then utilizes these removal reports to complete the Health-e-Arizona Plus application for each of the newly removed children/youth in DCS care. The process for including race/ethnicity data during the application process is reliant upon information gathered by DCS child welfare staff, as well as the availability of birth certificates and other data sources. In an effort to enhance future reporting methodologies related to race/ethnicity data for TXIX eligible DCS CHP members, the DCS CHP eligibility and enrollment team also revised its enrollment process to include mandatory entry of race/ethnicity data into the Health-e- Arizona Plus system, thereby enhancing the state systems with race and ethnicity data.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
These data are then available for enrollment files generated by AHCCCS to health plans, including DCS CHP, for incorporation into the health plans' claims and enrollment systems and incorporation into data systems that inform performance measures. DCS CHP makes this information available to our partner Mercy Care for utilization in care management, and performance improvement efforts to evaluate and address racial and ethnic disparities. As a result, DCS CHP continues to improve the availability of data in terms of completeness and accuracy.
HSAG's Assessment: HSAG determined that DCS CHP satisfactorily addressed the prior year's recommendation.

Validation of Performance Improvement Projects

In CY 2024, DCS CHP continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 2, PIP validation activities focused on improvement from the baseline results. DCS CHP submitted Remeasurement 2 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes or discontinuation of the interventions.

HSAG conducted an annual validation of the second remeasurement year reflective of CY 2023 (January 1, 2023, through December 31, 2023) using AHCCCS-calculated and validated indicator rates. HSAG evaluated DCS CHP's performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

Validation Results

Table 8-7 displays the overall confidence levels for the DCS CHP *Back to Basics* PIP.

Table 8-7—DCS CHP *Back to Basics* PIP Overall Confidence Levels

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]
DCS CHP	*High Confidence*	100%	100%	*High Confidence*	100%	100%

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

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

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

Measure Results

Table 8-8 provides the *Back to Basics* PIP baseline, Remeasurement Year 1, and Remeasurement Year 2 rates for the indicator for DCS CHP.

Table 8-8—DCS CHP Program *Back to Basics* PIP Rates

Contractor	PIP Indicator: *Child and Adolescent Well-Care Visits (WCV)*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
DCS CHP	72.6%	71.0%	77.1%

HSAG rounded percentages to the first decimal place.

Interventions

Table 8-9 presents PIP interventions for the DCS CHP Program. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 8-9—DCS CHP Program *Back to Basics* PIP Interventions

Contractor	Interventions
DCS CHP	• Integrated care management outreach members focused on the provision of preventive EPSDT services . • HPV educational mailing to members turning 11 years of age. • Mailing to parents/guardians of 1-month-olds that included a well-child magnet listing the ages that children need well visits and a booklet on immunizations and debunking immunization myths. • EPSDT reminder cards, including information consistent with the AHCCCS periodicity schedule. • EPSDT second reminder cards. • Written reminders: member handbook, member newsletters, and newborn booklets to promote well-child visits, EPSDT reminder cards, and well-child reminder letters. • Written provider outreach process which included mailings to PCPs for members in need of an EPSDT visit; members 0–24 months of age in need of immunizations; adolescents in need of immunizations; a reminder on the requirement to conduct a developmental screening at the 9-, 18-, and 24-month visits; and information pertaining to the member's historical dental care and whether or not the member is due for dental care. • Virtual or face-to-face contacts between the Mercy Care coordinators and providers encouraging outreach efforts to members lacking childhood immunizations and/or well-child visits. • Providers pay for performance to VBS groups for improving performance in the measure. • Adolescent immunization reminder card mailed to the parents/guardians of members during the month of the member's 12th birthday, reminding them of the importance of obtaining immunizations. • Mailing to the Native American members in need of a well visit a cover letter and CDC brochure specific to the health of Native Americans. • Follow-up calls to members who were referred for dental screening or services via an EPSDT visit. • Care Management personnel monitor gaps in care for all youth enrolled in Peds Care Management. • Partnership and collaboration with PCCN and EHN to promote EPSDT awareness. • Implement the newly approved TJ modifier [Program group, child and/or adolescent] for all EPSDT codes to increase provider reimbursement for completion of EPSDT visits for DCS CHP members (200 percent for new patients, 150 percent for established patients).

Contractor	Interventions
	• Referred new members to PCCN providers for comprehensive EPSDT services and care. • Resource liaisons outreached to caregivers to ensure understanding of the importance of preventive (EPSDT) visits. • Pilot project to address adolescent well visit adherence. • The total population of adolescents, ages 12–17 in Arizona foster care eligible for the EPSDT. sampled 200 youth for random distribution to control and intervention groups: – Scripted telephonic outreach to caregiver and adolescent dyads. – Outreach of foster caregivers and other placements upon a child's entry into DCS care (Onboarding team). • Written provider outreach process which includes mailings to PCPs for members in need of an EPSDT visit; members 0–24 months of age in need of immunizations; adolescents in need of immunizations; a reminder on the requirement to conduct developmental screenings at the 9-, 18-, and 24-month visits. • Leverage tribal liaisons to engage members who might be difficult to engage or find, provide health information, offer referral, assist with navigation, etc., to assist in addressing health disparities. • Met with Native Health and the Phoenix Indian Medical Center to determine if partnership opportunities exist.

Strengths, Opportunities for Improvement, and Recommendations

Table 8-10 presents strengths, opportunities for improvement, and recommendations for DCS CHP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 8-10—DCS CHP Program Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
DCS CHP adhered to acceptable methodology through all phases of the PIP. The Contractor achieved statistically significant improvement between the baseline rate and the Remeasurement 2 rate for the *WCV* performance indicator. **[Quality, Access]**
Opportunities for Improvement and Recommendations
HSAG identified no opportunities for improvement related to the *Back to Basics* PIP.

Strengths, Opportunities for Improvement, and Recommendations
Recommendation: Although there were no opportunities for improvement identified, as the PIP progresses, HSAG recommends that DCS CHP: • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 8-11 presents PIP recommendations made to DCS CHP in the CYE 2023 Annual Technical Report[199] and DCS CHP's follow-up to the recommendations, as well as an assessment of the degree to which DCS CHP has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 8-11—DCS CHP Program Follow-Up to CYE 2023 PIP Recommendations

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG recommended that DCS CHP: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. • Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.
DCS CHP's Response: Mercy Care continues to monitor rate trends and effectiveness of interventions for the *Back to Basics* PIP which covers the HEDIS measures *Well-Child Visits in the First 30 Months of Life*, *Child and Adolescent Well- Care Visits*, and *Annual Dental Visits*. In CY 2022 and CY 2023, *Well-Child Visits* increased from 53.5 percent to 66.9 percent. *Child and Adolescent Well-Care Visits* increased from 71.0 percent to 77.1 percent. *Annual Dental Visits* increased from 79.1 percent to 84.2 percent respectively. Improvements were seen across all three HEDIS measures from Remeasurement 1 to Remeasurement 2 which indicates current interventions are strong.
HSAG's Assessment: HSAG has determined that Mercy Care ACC-RBHA has satisfactorily addressed these prior year's recommendations.

[199] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

Compliance Reviews

Results

AHCCCS conducted a compliance review of DCS CHP in CYE 2022. On June 27, 2023, AHCCCS accepted DCS CHP's proposed CAPs and required the Contractor to submit updated policies, manuals, desktop procedures, and other vital documents to provide evidence of CAP completion. On April 19, 2024, AHCCCS reviewed DCS CHP's status and determined that not all CAPs had been completed for closure. Remaining CAP items were under review by AHCCCS at the time this report was written. Additional results of the CAP update will be included in the CYE 2025 annual technical report. Table 8-12 presents the compliance review results for DCS CHP.

Table 8-12—DCS CHP Program Compliance Review Results

Focus Areas	CYE 2022 DCS CHP Scores	CYE 2023 DCS CHP CAP Update	CYE 2024 DCS CHP CAP Updated
CC	100%	NA	NA
CIS	99%	NA	NA
DS	7%	Partially Met	Partially Met
GA	60%	Partially Met	Met
GS	100%	NA	NA
MCH	60%	Partially Met	Partially Met
MM	91%	Partially Met	Met
MI	94%	Partially Met	Met
QM	77%	Partially Met	Partially Met
QI	92%	Partially Met	Partially Met
RI	100%	NA	NA
TPL	100%	NA	NA
ISOC	100%	NA	NA

NA = Not applicable. A CAP was not required as the CYE 2022 score was 95% or above or the CAP was closed by AHCCCS in CYE 2023.
Partially Met = AHCCCS approved the Contractor's proposed CAP. The Contractor must submit evidence of compliance.
Met = AHCCCS accepted and closed the Contractor's CAP.

Strengths, Opportunities for Improvement, and Recommendations

Table 8-13 presents strengths, opportunities for improvement, and recommendations for DCS CHP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 8-13—DCS CHP Program Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
DCS CHP successfully closed CAPs in the following focus areas: • General Administration (GA) **[Timeliness, Access]** • Medical Management (MM) **[Timeliness, Access]** • Member Information (MI) **[Quality]**
Opportunities for Improvement and Recommendations
DCS CHP has remaining CAPs in the following focus areas: • Delivery Systems (DS) **[Timeliness, Access]** • Adult, EPSDT and Maternal Child Health (MCH) **[Quality, Timeliness, Access]** • Quality Management (QM) **[Quality]** • Quality Improvement (QI) **[Quality, Access]** Recommendation: HSAG recommends that DCS CHP continue to work on outstanding CAP items and submit to AHCCCS in the approved time frame.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 8-14 presents compliance recommendations made to DCS CHP in the CYE 2023 Annual Technical Report[200] and DCS CHP's follow-up to the recommendations, as well as an assessment of the degree to which DCS CHP has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 8-14—DCS CHP Program Follow-Up to CYE 2023 Compliance Recommendations

Prior Year's Recommendation From the EQR Technical Report for Compliance
HSAG recommended that that DCS CHP continue to work on outstanding CAP items and submit to AHCCCS in the approved time frame.
DCS CHP's Response: DCS CHP continues to work on outstanding CAP items and submitted last updates for Operational Reviews to AHCCCS on 6/27/2024 and is awaiting results.

[200] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for Compliance
HSAG's Assessment: Based on the CAP closure for the GA, MM, and MI focus areas, CAP acceptance and submission of updates for the DS, MCH, QM, and QI focus areas, and the response provided, HSAG determined that DCS CHP has satisfactorily addressed the prior year's recommendations related to compliance.

Network Adequacy Validation

ISCA Results

HSAG completed an ISCA for the DCS CHP subcontracted health plan, Mercy Care, which is contracted to deliver services to Medicaid managed care members in Arizona, and this report presents findings and validation ratings based on Mercy Care DCS CHP's ISCA and live system demonstrations. HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data systems. Additionally, HSAG determined that Mercy Care DCS CHP's data collection procedures were acceptable. Mercy Care DCS CHP used external delegated entities to complete network adequacy indicator reporting during the reporting period, and no issues were identified.

Based on the results of the ISCAs combined with the detailed validation of each NAV indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and whether Mercy Care DCS CHP's interpretation of data was accurate.

Table 8-15 summarizes HSAG's validation ratings for the DCS CHP subcontracted health plan by indicator type.

Table 8-15—Summary of Mercy Care DCS CHP Validation Ratings by Indicator Type

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

Of the network adequacy indicators assessed, Mercy Care DCS CHP received *High Confidence* for both appointment availability and time/distance indicator types. However, there were identified areas for improvement; please refer to the Contractor-specific Strengths, Opportunities for Improvement, and Recommendations section below for more details.

NAV Results

HSAG's validation of Mercy Care DCS CHP's results showed minor discrepancies between its self-reported ACOM 436 results and HSAG's time/distance calculations in each quarter that data could be

compared. While minor differences (i.e., less than 1 percentage point) between HSAG's time/distance calculation results and Mercy Care DCS CHP's time/distance calculation results were common, these findings may be attributable to the timing of the input data or software versions used by Mercy Care DCS CHP, or due to a small number of members eligible for inclusion in time/distance calculations for the standard and county.

Table 8-16 summarizes HSAG's assessment of Mercy Care DCS CHP's compliance with AHCCCS' minimum time/distance network standards. A check mark indicates that Mercy Care DCS CHP met the minimum network standard for all assigned counties during the CYE 2024 S1 assessment, and an "X" indicates that Mercy Care DCS CHP did not meet one or more minimum network standards in any assigned county.

Table 8-16—Summary of CYE 2024 Compliance With Minimum Time/Distance Network Requirements for Mercy Care DCS CHP

Minimum Network Requirement	Mercy Care DCS CHP
Behavioral Health Outpatient and Integrated Clinic, Pediatric	✓
BHRF (Only Maricopa and Pima Counties)	X
Cardiologist, Pediatric	✓
Dentist, Pediatric	X
Hospital	✓
OB/GYN	✓
Pharmacy	X
PCP, Pediatric	✓

Mercy Care DCS CHP consistently met the Behavioral Health Outpatient and Integrated Clinic, Pediatric; Cardiologist, Pediatric; Hospital; OB/GYN; and PCP, Pediatric standards. Overall, Mercy Care DCS CHP met all minimum time/distance network standards in Cochise, Gila, Graham, Maricopa, Mohave, Navajo, Pinal, Santa Cruz, Yavapai, and Yuma counties.

Isolated data issues may have contributed to specific instances affecting DCS CHP's compliance with time/distance standards. Specific examples include the following:

- In CYE 2024 S1, Mercy Care DCS CHP's data included substantially increased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Pediatric and Hospital. When contacted, Mercy Care DCS CHP indicated that it inadvertently included home office addresses in its report of service addresses, raising the number of providers in the count. This potentially influenced the validated compliance for these provider categories.

As part of the NAV, AHCCCS maintained its feedback process for Mercy Care DCS CHP to review and improve the accuracy of its data submissions. Specifically, AHCCCS supplied Mercy Care DCS CHP with copies of HSAG's network adequacy analysis, the PAT file that HSAG used to conduct the

analysis, and HSAG's saturation analysis results. When issues were identified, Mercy Care DCS CHP was expected to research the instances and make corrections for future PAT data and/or ACOM 436 submissions.

Mercy Care DCS CHP should continue to monitor and maintain its existing provider network as of CYE 2024 S1, with specific attention to ensuring the availability of the following provider categories:

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

HSAG evaluated Mercy Care DCS CHP's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents CYE 2024 S1 validation findings specific to the DCS CHP Program, with one results table for each of the following GSAs:

- Central GSA: Gila, Maricopa, and Pinal counties
- North GSA: Apache, Coconino, Mohave, Navajo, and Yavapai counties
- South GSA: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma counties

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

Table 8-17—Time/Distance Validation Results for Mercy Care DCS CHP Central GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0^[1]	99.0^[1]	100.0^[1]
BHRF	NA	98.3	NA
Cardiologist, Pediatric	100.0^	100.0^	100.0^
Dentist, Pediatric	90.8	99.6	100.0
Hospital	100.0[1]	100.0[1]	100.0[1]
OB/GYN	100.0*	100.0	100.0
Pharmacy	100.0	99.1	100.0
PCP, Pediatric	100.0^	99.8^	100.0^

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

* indicates that fewer than 10 members were included in the denominator of HSAG's results.

^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

[1] In CYE 2024 S1, Mercy Care DCS CHP's data included substantially increased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Pediatric and Hospital. When contacted, Mercy Care DCS CHP indicated that it inadvertently included home office addresses in with its report of service addresses, raising the number of providers in the count. This potentially influenced the validated compliance for these provider categories.

Table 8-18—Time/Distance Validation Results for Mercy Care DCS CHP North GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Apache	Coconino	Mohave	Navajo	Yavapai
Behavioral Health Outpatient and Integrated Clinic, Pediatric	96.9^[1]	100.0^[1]	100.0^[1]	92.4^[1]	100.0^[1]
BHRF	NA	NA	NA	NA	NA
Cardiologist, Pediatric	96.9^	100.0^	98.7^	100.0^	100.0^
Dentist, Pediatric	87.5	99.1	95.6	98.9	99.5
Hospital	100.0[1]	100.0[1]	100.0[1]	100.0[1]	100.0[1]
OB/GYN	100.0*	100.0	100.0	100.0*	100.0
Pharmacy	100.0	88.8	95.6	97.8	97.9
PCP, Pediatric	100.0^	99.1^	98.1^	91.3^	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.
* indicates that fewer than 10 members were included in the denominator of HSAG's results.
^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.
[1] In CYE 2024 S1, Mercy Care DCS CHP's data included substantially increased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Pediatric and Hospital. When contacted, Mercy Care DCS CHP indicated that it inadvertently included home office addresses in its report of service addresses, raising the number of providers in the count. This potentially influenced the validated compliance for these provider categories.

Table 8-19—Time/Distance Validation Results for Mercy Care DCS CHP South GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Cochise	Graham	Greenlee	La Paz	Pima	Santa Cruz	Yuma
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0^[1]	100.0^[1]	100.0^[1]	100.0*^[1]	98.0^[1]	100.0^[1]	100.0^[1]
BHRF	NA	NA	NA	NA	86.9	NA	NA
Cardiologist, Pediatric	100.0^	100.0^	100.0^	100.0*^	99.8^	100.0^	100.0^
Dentist, Pediatric	97.6	100.0	89.5	80.0*	98.2	100.0	100.0
Hospital	100.0[1]	100.0[1]	100.0[1]	100.0*[1]	99.9[1]	100.0[1]	100.0[1]

Minimum Network Requirement	Cochise	Graham	Greenlee	La Paz	Pima	Santa Cruz	Yuma
OB/GYN	100.0	100.0*	100.0*	NR*	100.0	100.0*	100.0
Pharmacy	97.6	100.0	100.0	100.0*	97.8	100.0	100.0
PCP, Pediatric	97.6^	100.0^	100.0^	100.0*^	98.9^	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.

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

* indicates that fewer than 10 members were included in the denominator of HSAG's results.

^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

[1] In CYE 2024 S1, Mercy Care DCS CHP's data included substantially increased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Pediatric and Hospital. When contacted, Mercy Care DCS CHP indicated that it inadvertently included home office addresses in its report of service addresses, raising the number of providers in the count. This potentially influenced the validated compliance for these provider categories.

Strengths, Opportunities for Improvement, and Recommendations

Table 8-20 presents strengths, opportunities for improvement, and recommendations for DCS CHP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 8-20—DCS CHP Program Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • Mercy Care DCS CHP received *High Confidence* for both appointment availability and time/distance indicators. **[Access]** • Mercy Care DCS CHP met all minimum network requirements for all assigned counties except Apache, Coconino, Greenlee, La Paz, and Pima counties. **[Access]** • Mercy Care DCS CHP met all minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Pediatric; Cardiologist, Pediatric; Hospital; OB/GYN; and PCP, Pediatric. **[Access]** • Mercy Care DCS CHP demonstrated its capability for ensuring the accuracy and completeness of its provider network by conducting rigorous quality assurance processes, including monthly provider data reconciliations, maintaining regular provider outreach and communication, and conducting annual audits of provider data. **[Access]**.

Strengths, Opportunities for Improvement, and Recommendations
Note: DCS CHP provides coverage statewide in the following counties: Apache, Cochise, Coconino, Gila, Graham, Greenlee, La Paz, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma.
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: • Isolated data issues may have contributed to specific instances affecting Mercy Care DCS CHP's compliance with time/distance standards. **[Access]** Recommendation: HSAG recommends that AHCCCS support Mercy Care DCS CHP in continuing to monitor its processes for creating the PAT file and review this file for accuracy prior to submitting to AHCCCS. • HSAG identified an opportunity for Mercy Care DCS CHP to improve the results to calculate time/distance indicators. **[Access]** Recommendation: HSAG recommends that Mercy Care DCS CHP incorporate additional oversight and monitoring when transferring Quest-generated output to the ACOM Policy 436 template to ensure the most accurate results are being submitted to AHCCCS**.** • Mercy Care DCS CHP had a high level of compliance mismatch between its submitted results and HSAG's calculated results. **[Access]** Recommendation: HSAG recommends that Mercy Care DCS CHP continue to work with AHCCCS and HSAG to reduce the amount of compliance discrepancies**.** • Mercy Care DCS CHP did not meet the minimum network requirements for BHRF; Dentist, Pediatric; and Pharmacy. **[Access]** Recommendation: HSAG recommends that Mercy Care DCS CHP maintain current compliance with network standards and continue to address network gaps, as applicable.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 8-21 presents NAV recommendations made to DCS CHP in the CYE 2023 Annual Technical Report[201] and DCS CHP's follow-up to the recommendations, as well as an assessment of the degree to which DCS CHP has effectively addressed the recommendations. Language in this section is minimally

[201] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 8-21—DCS CHP Program Follow-Up to CY 2023 NAV Recommendations

Prior Year's Recommendation From the EQR Technical Report for NAV
HSAG recommended that Mercy Care DCS CHP maintain current compliance with network standards but continue to address network gaps, as applicable.
DCS CHP's Response: Mercy Care continues existing processes to ensure that the plan maintains compliance with the AHCCCS-required network coverage requirements.
HSAG's Assessment: Based on the CYE 2024 S1 NAV results, HSAG has determined that Mercy Care DCS CHP has partially addressed the prior year's recommendations.

Consumer Assessment of Healthcare Providers and Systems Results

DCS CHP Results

HSAG administered member experience surveys on AHCCCS' behalf to members enrolled in the AHCCCS' DCS CHP. DCS CHP is Arizona's CHIP for eligible children (under age 18 years) who do not qualify for other AHCCCS health insurance. The goal of the CAHPS Health Plan Survey is to provide performance feedback that is actionable and will aid in improving overall member experience.

HSAG calculated results for four global ratings, four composite measures, one individual item measure, and five CCC composites/items (CCC population only).

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

Table 8-22 shows the scores and overall member experience ratings on each CAHPS measure for both the general child and CCC populations.

Table 8-22—National Comparisons

Measure	2024 General Child Medicaid	2024 CCC Medicaid
Global Ratings		
Rating of Health Plan	★★ 68.7%	★ 61.5%
Rating of All Health Care	★★★★ 73.8%	★★★ 65.6%
Rating of Personal Doctor	★★★★ 79.9%	★★★ 75.4%
Rating of Specialist Seen Most Often	★ 66.2%+	★ 62.1%+
Composite Measures		
Getting Needed Care	★★ 82.4%	★ 79.3%+
Getting Care Quickly	★★★★ 89.6%	★ 85.3%+
How Well Doctors Communicate	★★★ 94.3%	★★ 92.7%
Customer Service	★★★★★ 93.3%+	★★★★★ 95.3%+
Individual Item Measure		
Coordination of Care	★★ 83.7%	★ 77.0%+
CCC Composite Measures and Items		
Access to Specialized Services	NA	★ 64.5%+
Family-Centered Care (FCC): Personal Doctor Who Knows Child	NA	★ 81.2%
Coordination of Care for Children with Chronic Conditions	NA	★ 74.2%+
Access to Prescription Medicines	NA	★ 84.5%
FCC: Getting Needed Information	NA	★ 87.7%

Star Assignments Based on Percentiles:
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
NA Indicates that this measure is not applicable for the population.

Table 8-23 shows the results of the trend analysis wherein the 2024 CAHPS results were compared to their corresponding 2023 CAHPS results on each CAHPS measure for both the general child and CCC populations.

Table 8-23—Trend Analysis

Measure	General Child Medicaid			CCC Medicaid		
	2023	2024	Trend Results (2024 Compared to 2023)	2023	2024	Trend Results (2024 Compared to 2023)
Global Ratings						
Rating of Health Plan	61.8%	68.7%	—	52.8%	61.5%	—
Rating of All Health Care	65.4%	73.8%	—	55.4%	65.6%	—
Rating of Personal Doctor	79.0%	79.9%	—	76.4%	75.4%	—
Rating of Specialist Seen Most Often	77.4%	66.2%+	—	75.7%	62.1%+	—
Composite Measures						
Getting Needed Care	82.7%	82.4%	—	79.8%	79.3%+	—
Getting Care Quickly	89.3%	89.6%	—	87.3%	85.3%+	—
How Well Doctors Communicate	98.0%	94.3%	▼	96.9%	92.7%	—
Customer Service	82.0%+	93.3%+	▲	83.3%+	95.3%+	▲
Individual Item Measure						
Coordination of Care	79.3%	83.7%	—	70.9%	77.0%+	—
CCC Composite Measures and Items						
Access to Specialized Services	NA	NA	NA	69.3%+	64.5%+	—
FCC: Personal Doctor Who Knows Child	NA	NA	NA	87.5%	81.2%	—
Coordination of Care for Children with Chronic Conditions	NA	NA	NA	73.5%+	74.2%+	—
Access to Prescription Medicines	NA	NA	NA	85.1%	84.5%	—
FCC: Getting Needed Information	NA	NA	NA	92.9%	87.7%	—

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.
▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.
— Indicates the 2024 score is not statistically significantly higher or lower than the 2023 score.
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
NA Indicates that this measure is not applicable for the population.

Strengths, Opportunities for Improvement, and Recommendations

Table 8-24 presents program-level strengths, opportunities for improvement, and recommendations for DCS CHP related to the 2024 DCS CHP program-level CAHPS results.

Table 8-24—DCS CHP Strengths, Opportunities for Improvement, and Recommendations Related to CAHPS

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths for DCS CHP: • DCS CHP's member experience rating for *Customer Service* was at or above the 90th percentile for the general child and CCC populations. **[Quality]** • DCS CHP's member experience ratings for *Rating of All Health Care*, *Rating of Personal Doctor*, and *Getting Care Quickly* were at or between the 75th and 89th percentile for the general child population. **[Quality, Timeliness]** • DCS CHP's 2024 score for *Customer Service* was statistically significantly higher than the 2023 score for the general child and CCC populations. **[Quality]**
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement for DCS CHP: • DCS CHP's member experience rating for *Rating of Specialist Seen Most Often* was below the 25th percentile for the general child population. **[Quality]** • DCS CHP's member experience ratings for Rating of Health Plan, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, Coordination of Care, Access to Specialized Services, FCC: Personal Doctor Who Knows Child, Coordination of Care for Children with Chronic Conditions, Access to Prescription Medicines, and FCC: Getting Needed Information ere below the 25th percentile for the CCC population. **[Quality, Timeliness, Access]** • DCS CHP's member experience ratings for *Rating of Health Plan*, *Getting Needed Care*, and *Coordination of Care* were at or between the 25th and 49th percentile for the general child population. **[Quality, Access]** • DCS CHP's member experience rating for *How Well Doctors Communicate* was at or between the 25th and 49th percentile for the CCC population. **[Quality]** • DCS CHP's 2024 score for *How Well Doctors Communicate* was statistically significantly lower than the 2023 score for the general child population. **[Quality]** • DCS CHP's 2024 scores were not statistically significantly lower than the 2023 scores; therefore, no substantial weaknesses were identified for trend results for the CCC population. **[Quality]** Recommendation: HSAG recommends that DCS CHP explore what may be driving lower experience scores and develop initiatives designed to improve the quality of and access to care, including a focus on improving parents'/caretakers' overall experiences with the health plan, ,

Strengths, Opportunities for Improvement, and Recommendations
specialist seen most often, getting needed care/information, access to care in a timely manner, access to prescription medicines, and coordination of care for child members.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 8-25 presents CAHPS recommendations made to DCS CHP in the CYE 2023 Annual Technical Report[202] and DCS CHP's follow-up to the recommendations, as well as an assessment of the degree to which DCS CHP effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 8-25—DCS CHP Follow-Up to CY 2023 CAHPS Recommendations

Prior Year's Recommendation From the EQR Technical Report for CAHPS
HSAG recommended that DCS CHP explore what may be driving lower experience scores and develop initiatives designed to improve quality and access to care, including a focus on improving parents'/caretakers' overall experiences with the health plan, healthcare, personal doctor, access to care in a timely manner, access to prescription medicines, coordination of care, and customer service for child members.
DCS CHP's Response: Mercy Care is completing the following activities to address CAHPS: • Healthmine—outreach to member campaigns • MCA concierge team—outreach calls to members • Provider education materials • Provider notices • Member materials • CAHPS training course for staff
HSAG's Assessment: Based on the 2024 results, HSAG has determined that the Contractor has partially addressed the prior year's recommendations.

[202] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

9. ALTCS-EPD Program-Level Comparative Results

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

This section includes ALTCS- EPD program-level comparative results organized by EQR-related activity, strengths, opportunities for improvement, and HSAG's recommendations for program-level performance improvement.

Performance Measure Validation

During CYE 2024, HSAG evaluated each ALTCS-EPD Program Contractor's data system for processing of each data type used for reporting the Contractor's CY 2023 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. A summary of these findings by ALTCS-EPD Program Contractor is provided in Table 9-1. Table 9-1 also displays whether or not each ALTCS-EPD Program Contractor met the assessed IS standards, which demonstrates whether or not the Contractor has effective IS practices and control procedures for data reporting. Additional information about each ALTCS-EPD Program Contractor's general findings for each data type reviewed can be found in Section 10. ALTCS-EPD Program Contractor-Specific Results. Additional information regarding the CMS EQR Protocol 2 audit requirements, including additional information about the levels of scoring, can be found in the Validation of Performance Measures section of Appendix A. Methodology.

Table 9-1—Performance Measures Validation Contractor Comparison: CMS EQR Protocol 2 Validation Results for ALTCS-EPD Program Contractors

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

ALTCS-EPD Program-Level Results

Table 9-2 presents the CY 2023 aggregate performance measure results for the ALTCS-EPD Program Contractors. Performance measure rate cells shaded green indicate that the Contractor met or exceeded

the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the national Medicaid mean are shaded green. Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 9-2—CY 2023 Performance Measure Results for ALTCS-EPD Program Contractors

Measure	BUFC LTC	Mercy Care LTC	UHCCP LTC	Aggregate
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	78.4%	70.3%	88.3%	79.1%
Effective Continuation Phase Treatment—Total (18+ Years)	65.2%	64.7%	77.3%	69.1%
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	NA++	48.1%	26.1%	35.9%
30-Day Follow-Up—Total (6+ Years)	NA++	66.7%	54.3%	57.8%
Use of Opioids at High Dosage				
*18+ Years**	12.7%	10.9%	10.5%	11.1%
Initiation and Engagement of Substance Use Disorder (SUD) Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	51.2%	48.3%	48.7%	49.1%
Engagement of SUD Treatment—Total—Total (13+ Years)	7.2%	6.5%	6.8%	6.8%
Care of Acute and Chronic Conditions				
Controlling High Blood Pressure				
18–85 Years	73.0%+	76.6%+	73.7%+	74.9%+
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0 Percent)—Total (18–75 Years)	68.9%+	70.3%+	70.3%+	70.0%+
*HbA1c Poor Control (>9.0 Percent)—Total (18–75 Years)**	30.2%+	22.1%+	21.9%+	23.9%+
Pediatric Health				
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	NA++	NA++	NA++	NA++
Oral Evaluation, Dental Services				
*Total (0–20 Years)*N	32.3%	46.8%	45.8%	43.1%
Well-Child Visits in the First 30 Months of Life				
First 15 Months—Six or More Well-Child Visits	NA++	NA++	NA++	NA++

Measure	BUFC LTC	Mercy Care LTC	UHCCP LTC	Aggregate
15 Months to 30 Months—Two or More Well-Child Visits	NA++	NA++	NA++	NA++
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	48.7%	46.1%	46.0%	46.7%
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	48.9%	38.4%	37.3%	40.3%
Cervical Cancer Screening				
21–64 Years	22.6%+	30.4%+	34.5%+	29.9%+
Appropriate Utilization of Services				
Ambulatory Care				
Emergency Department (ED) Visits—Total (0–85+ Years)F	16,907.3	721.3	877.3	4,838.3
Plan All-Cause Readmissions				
*Observed/Expected (O/E) Ratio—Total (18–64 Years)**	0.7946	0.7434	0.6666	0.7382

* A lower rate indicates better performance for this measure.
+ Indicates the measure was reported using hybrid methodology.
++ NA indicates the denominator was too small to report a valid rate, based on the applicable measure specification.
N Measure has no NCQA Medicaid mean for comparison.
F NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months.
Cells shaded green indicate that the rate met or exceeded the MY 2023 national Medicaid mean.

Table 9-3 presents the CY 2022 and CY 2023 ALTCS-EPD Program Aggregate for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and MY 2023. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and/or MY 2023. Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*).

Table 9-3—CY 2022 and CY 2023 Performance Measure Aggregate Results for ALTCS-EPD Program Contractors

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	75.6%	79.1%	→	★★★★★

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Effective Continuation Phase Treatment—Total (18+ Years)	66.6%	69.1%	→	★★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	48.0%	35.9%	→	★★
30-Day Follow-Up—Total (6+ Years)	69.7%	57.8%	→	★★
Use of Opioids at High Dosage				
*18+ Years**	11.6%	11.1%	→	★
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	54.8%	49.1%	→	★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	7.1%	6.8%	→	★
Care of Acute and Chronic Conditions				
Controlling High Blood Pressure				
18–85 Years	74.0%+	74.90%+	→	★★★★★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0 %)—Total (18–75 Years)	66.4%+	70.0%+	↑	★★★★★
*HbA1c Poor Control (>9.0 %)—Total (18–75 Years)**	27.5%+	23.9%+	↑	★★★★★
Pediatric Health				
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	NA ++	NA ++	—	—
Oral Evaluation, Dental Services				
Total (0–20 Years)[N]	41.0%	43.1%	→	—
Well-Child Visits in the First 30 Months of Life				
First 15 Months—Six or More Well-Child Visits	NA ++	NA ++	—	—
15 Months to 30 Months—Two or More Well-Child Visits	NA ++	NA ++	—	—
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	—	46.7%	—	★★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	38.5%	40.3%	→	★
Cervical Cancer Screening				
21–64 Years	35.5%+	29.9%+	↓	★
Appropriate Utilization of Services				

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[2]
Ambulatory Care				
Emergency Department (ED) Visits—Total (0–85+ Years)[F]	721.1	4,838.3	—	—
Plan All-Cause Readmissions				
*Observed/Expected (O/E) Ratio—Total (18–64 Years)**	NA [++]	0.7382	—	★★★★★

* A lower rate indicates better performance for this measure.
\+ Indicates the measure was reported using hybrid methodology.
[++] NA indicates that the ALTCS-EPD Program Contractor was not required to report the measure (i.e., small denominator).
Cells shaded green indicate that the rate met or exceeded the MY 2022 and/or MY 2023 national Medicaid mean.
[1] Aggregated rates were calculated and compared from MY 2022 to MY 2023, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.
[2] Performance Levels for CY 2023 were based on comparisons of the HEDIS MY 2023 measure rates to national Medicaid Quality Compass HEDIS MY 2023 benchmarks.
— Indicates a 2022–2023 comparison is not presented in the CYE 2024 Annual Technical Report because either there was a break in trending, the CY 2021 rate was not presented in the CYE 2023 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.
[N] Measure has no NCQA Medicaid mean for comparison.
↑ Indicates statistically significant improvement of measure rates.
↓ Indicates statistically significant decline of measure rates.
→ Indicates no statistically significant change in measure rates.
Performance Levels for 2023 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Table 9-4 highlights the ALTCS-EPD Program Contractors' performance for the current year by measure group. The table illustrates the Contractors' CY 2023 measure rates and their performance relative to the NCQA national Medicaid Quality Compass HEDIS MY 2023 percentiles, where applicable. The performance level star ratings are defined as follows:

★★★★★ = 90th percentile and above
★★★★ = 75th percentile to 89th percentile
★★★ = 50th percentile to 74th percentile
★★ = 25th percentile to 49th percentile
★ = Below the 25th percentile

Table 9-4—CY 2023 National Percentiles Comparison for ALTCS-EPD Program Contractors

Measure	BUFC LTC	Mercy Care LTC	UHCCP LTC	Aggregate
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	★★★★★	★★★★	★★★★★	★★★★★
Effective Continuation Phase Treatment—Total(18+ Years)	★★★★★	★★★★★	★★★★★	★★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	NA++	★★★★	★	★★
30-Day Follow-Up—Total (6+ Years)	NA++	★★★	★★	★★
Use of Opioids at High Dosage				
*18+ Years**	★	★	★	★
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	★★★★	★★★	★★★	★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	★	★	★	★
Care of Acute and Chronic Conditions				
Controlling High Blood Pressure				
18–85 Years	★★★★★	★★★★★	★★★★★	★★★★★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0 Percent)—Total (18–75 Years)	★★★★★	★★★★★	★★★★★	★★★★★
*HbA1c Poor Control (>9.0 Percent)—Total (18–75 Years)**	★★★	★★★★★	★★★★★	★★★★★
Pediatric Health				
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	NA++	NA++	NA++	NA++
Well-Child Visits in the First 30 Months of Life				
First 15 Months—Six or More Well-Child Visits	NA++	NA++	NA++	NA++
15 Months to 30 Months—Two or More Well-Child Visits	NA++	NA++	NA++	NA++
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	★★	★	★	★★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	★★	★	★	★

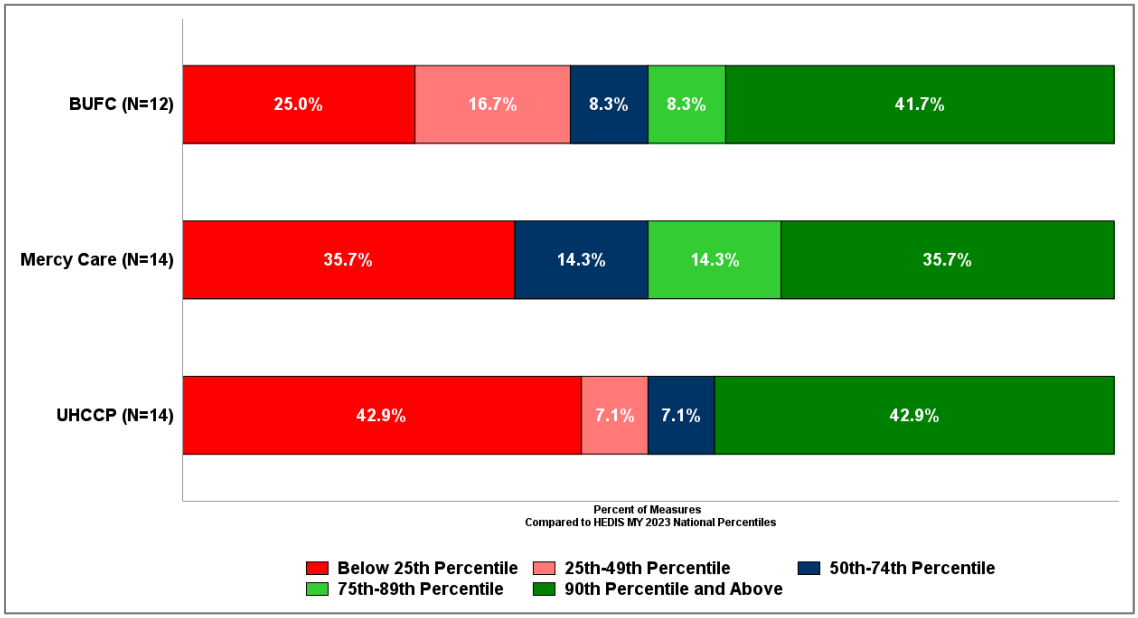
Measure	BUFC LTC	Mercy Care LTC	UHCCP LTC	Aggregate
Cervical Cancer Screening				
21–64 Years	★	★	★	★
Appropriate Utilization of Services				
Plan All-Cause Readmissions				
*Observed/Expected (O/E) Ratio—Total (18–64 Years)**	★★★★★	★★★★★	★★★★★	★★★★★

++ NA indicates that the ALTCS-EPD Program Contractor was not required to report the measure (i.e., small denominator).

* A lower rate indicates better performance for this measure.

Figure 9-1 displays the ALTCS-EPD Program Contractors' HEDIS CY 2023 performance compared to NCQA CY 2023 National Percentiles. HSAG analyzed results from 12 performance measures for HEDIS CY 2023 for a total of 17 measure rates.

Figure 9-1—Comparison of Measure Indicators to HEDIS Medicaid National Percentiles for ALTCS-EPD Contractors



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

Table 9-5 presents program-level strengths, opportunities for improvement, and recommendations (as applicable) for the ALTCS-EPD Program related to performance measures.

Table 9-5—ALTCS-EPD Program Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group: • The *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total (18+ Years)* measure rates for all ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rates met or exceeded the NCQA Quality Compass national Medicaid HMO HEDIS MY 2023 75th percentile. Moreover, *Antidepressant Medication Management—Effective Continuation Phase Treatment—Total (18+ Years)* measure rates for all ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rates met or exceeded the 90th percentile. These results may indicate that members with a diagnosis of major depression who were enrolled with the three ALTCS-EPD Program Contractors may be receiving continuous medication treatment. Effective medication treatment of major depression can improve a person's daily functioning and well-being and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated as well.[203] **[Quality]** • The *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* measure rates for all ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. These results may indicate that members enrolled with the three ALTCS-EPD Program Contractors may be initiating SUD treatment, which, in conjunction with counseling or other behavioral therapies, has been shown to reduce SUD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.[204] **[Quality, Timeliness, Access]**
In the Care of Acute and Chronic Conditions measure group: • The *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 %)—Total (18–75 Years)* and *HbA1c Poor Control (>9.0%)—Total (18–75 Years)* measure rates for all ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023, indicating that members with diabetes enrolled with the three ALTCS-EPD Program Contractors may be able to manage their condition according to evidence-based guidelines through the appropriate use of

[203] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Feb 19, 2025.
[204] National Committee for Quality Assurance. Initiation and Engagement of Substance Use Disorder Treatment (IET). Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-substance-use-disorder-treatment/. Accessed on: Feb 19, 2025.

Strengths, Opportunities for Improvement, and Recommendations
medications, diet and nutrition, or physical activity. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[205] **[Quality]** • The *Controlling High Blood Pressure—18–85 Years* measure rate for all ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO HEDIS MY 2023 90th percentile, indicating that members enrolled with the three ALTCS-EPD Program Contractors who had a hypertension diagnosis may have had controlled blood pressure most of the time. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[206] **[Quality]**
In the Appropriate Utilization of Services measure group, the *Plan All-Cause Readmissions—O/E Ratio—Total—(18–64 Years)* measure rate for all three ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO HEDIS MY 2023 90th percentile, indicating that most members were not experiencing unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay. [**Quality**]
Opportunities for Improvement and Recommendations
In the Behavioral Health measure group: • The rates for all three ALTCS-EPD Program Contractors and the ALTCS-EPD Program Aggregate rate for *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* fell below the NCQA Quality Compass national Medicaid HMO HEDIS MY 2023 25th percentile, indicating that members who initiated SUD treatment may not have had two or more additional SUD treatment services or MAT in the 34 days following their initiation visit. Treatment, including MAT, in conjunction with counseling or other behavioral therapies, has been shown to reduce SUD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.[207] **[Quality, Timeliness, Access]** Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors continue all efforts being made to conduct a root cause analysis or focus study to determine why some members were not accessing SUD services or MAT following their initiation visit. HSAG recommends that the ALTCS-EPD Program Contractors review patient data for any patterns present by ZIP Code and other demographics for case management prioritization. One study suggests that members who are male and have a schizophrenia spectrum disorder diagnosis are

[205] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Feb 19, 2025.
[206] National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Feb 19, 2025.
[207] National Committee for Quality Assurance. Initiation and Engagement of Substance Use Disorder Treatment (IET). Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-substance-use-disorder-treatment/. Accessed on: Feb 19, 2025.

Strengths, Opportunities for Improvement, and Recommendations
less likely to initiate treatment, while current drug dependence and recent arrest were associated with lowered odds of engaging in treatment. Current drug dependence is associated with factors that make scheduling and attending treatment appointments difficult, such as severe symptoms, chaotic living situations, and self-care and life functioning issues.[208] • Rates for all three ALTCS-EPD Program Contractors and the ALTCS-EPD Program Aggregate rate for *Use of Opioids at High Dosage—18+ Years* did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023, and rates remained below the 25th percentile. These results indicate that there is an opportunity for the ALTCS-EPD Program Contractors to better monitor prescribing and utilization data and implement interventions to improve care and services around opioid prescribing. The CDC guidelines on opioid prescribing for chronic, nonmalignant pain recommend the use of "additional precautions" when prescribing dosages ≥50 MED and that providers avoid or "carefully justify" increasing dosages ≥90 mg MED.[209] **[Quality]** Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors continue to evaluate their opioid prescription monitoring efforts to identify opportunities to enhance oversight of prescription opioids at a high dosage. Through this process, each ALTCS-EPD Program Contractor should determine if it is necessary to deploy additional mechanisms to identify members who may be at high risk for opioid overuse and misuse, as literature suggests there is a correlation between high dosages of prescription opioids and the risk of both fatal and nonfatal overdoses.[210] Each ALTCS-EPD Program Contractor should continue to report any completed prescription opioid monitoring effort enhancements to AHCCCS. HSAG also recommends that ALTCS-EPD Program Contractors identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts.
In the Preventive Screening measure group: • The rates for all three ALTCS-EPD Program Contractors and the ALTCS-EPD Program Aggregate rate for *Breast Cancer Screening—Total (50–74 Years)* did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023, and rates for two of the three ALTCS-EPD Program Contractors fell below the 25th percentile, indicating that some women may not be receiving timely screening for breast cancer. Early detection reduces the risk of dying from this type of cancer and can lead to a greater range of treatment options and lower healthcare costs.[211] **[Quality]**

[208] Brown CH, Bennett ME, Li L, Bellack AS. Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders. *Addictive Behaviors.* 2010;36(5):439-47.
[209] National Committee for Quality Assurance. Use of Opioids at High Dosage (HDO). Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/. Accessed on: Feb 19, 2025.
[210] Ibid.
[211] National Committee for Quality Assurance. Breast Cancer Screening. Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Feb 19, 2025.

Strengths, Opportunities for Improvement, and Recommendations
Recommendation: As ALTCS-EPD Program Contractors are currently conducting the *Breast Cancer Screening* PIP, which includes a root cause analysis and interventions to address this measure, HSAG recommends that the ALTCS-EPD Program Contractors continue all efforts being made to conduct a root cause analysis or focus study to determine why some female members were not receiving timely screenings for breast cancer. • Rates for all three ALTCS-EPD Program Contractors and the ALTCS-EPD Program Aggregate rate for *Cervical Cancer Screening—21–64 Years* did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023 and fell below the 25th percentile, indicating that some women may not be receiving timely screening for cervical cancer. Effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate.[212] **[Quality]** Recommendation: HSAG recommends that ALTCS-EPD Program Contractors consider utilizing one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve cervical cancer screening rates. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that ALTCS-EPD Program Contractors provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge.
Starting in CY 2022 performance measure reporting, RES is required based on NCQA HEDIS specifications. While HSAG noted that two of the three ALTCS-EPD Contractors could benefit from improvement in performance measure reporting using RES, all ALTCS-EPD Contractors could benefit from continuing to focus on refining RES reporting where required in keeping with measure specifications. **[Quality]** Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors continue to explore data sources for the capture of race and ethnicity data to support performance measure reporting that requires stratifications related to RES. The ALTCS-EPD Program Contractors should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information.

[212] National Committee for Quality Assurance. Cervical Cancer Screening. Available at: https://www.ncqa.org/hedis/measures/cervical-cancer-screening/. Accessed on: Feb 19, 2025.

Performance Improvement Projects

Breast Cancer Screening PIP

Breast cancer is the most common cancer in women in the United States except for skin cancers and is the second most common cause of cancer death in women.[213] It accounts for about 30 percent (or one in three) of all new female cancers each year.[214] Ensuring that all women receive regular breast cancer screening is critically important in disease prevention, early detection, and treatment. Breast cancer screening for women is aimed at identifying breast abnormalities as early as possible, and ideally before warning signs or symptoms are present, when the chances of survival are the highest. Even if breast cancer incidences cannot be substantially reduced for some women who are at high risk for developing the disease, the risk of death from breast cancer can be reduced by regular screenings.

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Breast Cancer Screening* PIP for the ALTCS-EPD Program. The objective of the *Breast Cancer Screening* PIP is to increase the number and percentage of breast cancer screenings.

ALTCS-EPD Program-Level Validation Results

Table 9-6 presents the ALTCS-EPD program-level overall validation results for each Contractor for the *Breast Cancer Screening* PIP.

Table 9-6—ALTCS-EPD Program Contactors' *Breast Cancer Screening* PIP Overall Confidence Levels

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]
BUFC LTC	*High Confidence*	100%	100%	*High Confidence*	100%	100%

[213] American Cancer Society. Key Statistics for Breast Cancer (2024). Available at: https://www.cancer.org/cancer/types/breast-cancer/about/how-common-is-breast-cancer.html. Accessed on: Feb 19, 2025.
[214] Ibid.

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]
Mercy Care LTC	*High Confidence*	100%	100%	*Moderate Confidence*	67%	100%
UHCCP LTC	*High Confidence*	100%	100%	*High Confidence*	75%	100%

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

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

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

ALTCS-EPD Program-Level Measure Results

Table 9-7 presents the indicator rate for each Contractor during the baseline, Remeasurement Year 1, and Remeasurement Year 2 rates.

Table 9-7—ALTCS-EPD Program Contractors' *Breast Cancer Screening* PIP Comparative Rates

Contractor	PIP Indicator: *Breast Cancer Screening*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
BUFC LTC	38.5%^	41.0%	48.9%
Mercy Care LTC	37.8%	35.2%	38.4%
UHCCP LTC	34.1%	41.6%	37.3%

^In CYE 2019, the BUFC LTC indicator rate had a small denominator, which did not allow for reporting of the measure. As such, the CY 2020 rate of 38.5 percent served as the baseline for BUFC LTC.

HSAG rounded percentages to the first decimal place.

ALTCS-EPD Program-Level Interventions

For the *Breast Cancer Screening* PIP, all Contractors provided lists of interventions that were in place for this validation cycle. These lists detailed the identified population, the intervention(s) in place, and whether or not the intervention(s) will be continued. The most common interventions across the ALTCS-EPD Program Contractors included targeting members and providers for outreach and education related to breast cancer screenings. Outreach methods included IVR, person-to-person, and automated phone calls; text message campaigns; events; mobile units; emails; and letters and other physical mailers. Provider and member incentives were also used as well as provider gap reports. For further descriptions of each Contractor's interventions, see Section 10. ALTCS-EPD Program Contractor-Specific Results.

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

Table 9-8 presents program-level strengths, opportunities for improvement, and recommendations (as applicable) for the ALTCS-EPD Program related to PIPs.

Table 9-8—ALTCS-EPD Program Strengths, Opportunities for Improvement, and Recommendations Related to the *Breast Cancer Screening* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
All ALTCS-EPD Program Contractors adhered to acceptable methodology through all phases of the PIP. All three Contractors were able to achieve improvement when comparing the baseline rate to Remeasurement 2 rate. One Contractor achieved statistically significant improvement at Remeasurement 2 when compared to the baseline rate, sustaining the statistically significant improvement achieved at Remeasurement 1. **[Quality, Access]**
Opportunities for Improvement and Recommendations
Although HSAG did not identify any program-level opportunities for improvement, to support successful progression of the PIP in the next CY, HSAG recommends that the ALTCS-EPD Program Contractors: • Seek technical assistance from HSAG to understand the PIP submission requirements, if needed. • If improvement was not sustained, revisit the causal/barrier analysis used to develop interventions and adjust the interventions or develop new interventions to facilitate improvement. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.

Compliance Reviews

AHCCCS includes the following focus areas in its compliance review activity. For information about compliance activities for the ALTCS-EPD Program, see Section 10. ALTCS-EPD Program Contractor-Specific Results. Table 9-9 presents the focus areas, including each associated acronym, used by AHCCCS during its compliance review.

Table 9-9—Focus Areas and Associated Acronyms

Focus Area	Acronym
Corporate Compliance	CC
Claims and Information Standards	CIS
Case Management	CM
Delivery Systems	DS
General Administration	GA
Grievance Systems	GS
Adult, EPSDT, and Maternal Child Health	MCH
Medical Management	MM
Member Information	MI
Quality Management	QM
Quality Improvement	QI
Reinsurance	RI
Third-Party Liability	TPL
Integrated Systems of Care	ISOC

ALTCS-EPD Program-Level Results

AHCCCS conducts a full compliance review for each Contractor every three years. This current three-year review cycle spans from CYE 2023 to CYE 2025. In CYE 2023, AHCCCS conducted compliance reviews for BUFC LTC, Mercy Care LTC, and UHCCP LTC. In CYE 2024, the ALTCS-EPD Program Contractors continued implementation of CAPs. CAP updates for the ALTCS-EPD Program Contractors are available in Section 10. ALTCS-EPD Program Contractor-Specific Results. Table 9-10 presents program-level and comparative results for the ALTCS-EPD Program for CAP reviews conducted in CYE 2024.

Table 9-10—ALTCS-EPD Program-Level Compliance Review CAP Results

Focus Areas	BUFC LTC	Mercy Care LTC	UHCCP LTC
CC	NA	NA	NA
CIS	NA	NA	NA

Focus Areas	BUFC LTC	Mercy Care LTC	UHCCP LTC
CM	Met	Met	Partially Met
DS	Met	NA	NA
GA	NA	NA	NA
GS	NA	NA	NA
MCH	NA	Met	Met
MM	Met	NA	NA
MI	NA	NA	NA
QM	Met	Partially Met	Partially Met
QI	NA	NA	NA
RI	NA	NA	NA
TPL	NA	NA	NA
ISOC	NA	NA	Met

NA = Not applicable. A CAP was not required as the CYE 2023 score was 95% or above.
Partially Met = AHCCCS approved the Contractor's proposed CAP. The Contractor must submit evidence of compliance.
Met = AHCCCS accepted and closed the Contractor's CAP.

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

Table 9-11 presents program-level strengths, opportunities for improvement, and recommendations (as applicable) for the ALTCS-EPD Program related to compliance.

Table 9-11—ALTCS-EPD Program Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
One of the three ALTCS-EPD Program Contractors that underwent compliance reviews in CYE 2023 successfully completed all remaining CAPs during CYE 2024. **[Quality]**
Opportunities for Improvement and Recommendations
Two ALTCS-EPD Program Contractors has remaining CAPs in the following focus area: • Case Management (CM) **[Quality, Access]** • Quality Management (QM) **[Quality]** Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors continue to work on outstanding CAP items and submit updates to AHCCCS in the approved time frame, as applicable.

Network Adequacy Validation

ALTCS-EPD Program-Level Results

ISCA Results

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

Based on the results of the ISCAs combined with the detailed validation of each NAV indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and whether the ALTCS-EPD Program Contractors' interpretation of data was accurate. All ALTCS-EPD Program Contractors received *High Confidence* for both appointment availability and time/distance indicators. However, there were identified areas for improvement for some of the ALTCS-EPD Program Contractors; please refer to Section 10: ALTCS-EPD Program Contractor-Specific Results.

NAV Results

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

Table 9-12 summarizes HSAG's assessment of each ALTCS-EPD Program Contractor's compliance with AHCCCS' minimum time/distance network standards. A check mark indicates that the ALTCS-EPD Program Contractor met the minimum network standard for all assigned counties during the CYE 2024 S1 assessment, and an "X" indicates that the ALTCS-EPD Program Contractor did not meet one or more minimum network standard in any assigned county. Section 10. ALTCS-EPD Program Contractor-Specific Results contains NAV results specific to each ALTCS-EPD Program Contractor.

Table 9-12—Summary of CYE 2024 Compliance With Minimum Time/Distance Network Requirements for ALTCS-EPD Program Contractors

Minimum Network Requirement	BUFC LTC	Mercy Care LTC	UHCCP LTC
Behavioral Health Outpatient and Integrated Clinic, Adult	✓	✓	✓
Behavioral Health Outpatient and Integrated Clinic, Pediatric	✓	✓	✓
BHRF (Only Maricopa and Pima Counties)	✓	✓	✓
Cardiologist, Adult	✓	✓	✓
Cardiologist, Pediatric	✓	✓	✓
Dentist, Pediatric	✓	✓	✓
Hospital	✓	✓	✓
Nursing Facility	✓	✓	✓
OB/GYN	✓	✓	✓
Pharmacy	✓	✓	✓
PCP, Adult	✓	✓	✓
PCP, Pediatric	✓	✓	✓

The ALTCS-EPD Program Contractors consistently met the Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; BHRF; Cardiologist, Adult and Pediatric; Dentist, Pediatric; Hospital; Nursing Facility; OB/GYN; Pharmacy; and PCP, Adult and Pediatric standards.

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

- In CYE 2024 S1, one ALTCS-EPD Program Contractor's data included substantially increased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; and Hospital. When contacted, the ALTCS-EPD Program Contractor indicated that it inadvertently included home office addresses in its report of service addresses, raising the number of providers in the count. This potentially influenced the validated compliance for these provider categories.

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

Overall, the applicable ALTCS-EPD Program Contractors met all requirements for all standards in each respective county.

ALTCS-EPD Program Conclusions, Opportunities for Improvement, and Recommendations Related to Network Adequacy Validation

Table 9-13 presents program-level strengths, opportunities for improvement, and recommendations (as applicable) for the ALTCS-EPD Program related to NAV.

Table 9-13—ALTCS-EPD Program Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • The ALTCS-EPD Program Contractors received *High Confidence* for both appointment availability and time/distance indicators. **[Access]** • The ALTCS-EPD Program Contractors met all minimum time/distance network standards for all assigned counties. **[Access]**
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: • Isolated data issues may have contributed to specific instances affecting the ALTCS-EPD Program Contractors' compliance with time/distance standards. **[Access]** Recommendation: HSAG recommends that AHCCCS support the ALTCS-EPD Program Contractors in continuing to monitor their processes for creating the PAT file and review this file for accuracy prior to submitting to AHCCCS.

10. ALTCS-EPD Program Contractor-Specific Results

This section provides, by ALTCS-EPD Contractor, activity-specific strengths, opportunities for improvement, and HSAG's recommendations (as applicable) for performance improvement. This section also includes information about the extent to which each Contractor was able to address the prior year's recommendations for each activity.

BUFC LTC

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2024, HSAG evaluated BUFC LTC's data system for processing of each data type used for reporting the Contractor's CY 2023 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that BUFC LTC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 10-1 displays HSAG's PMV findings for each data type reviewed during CYE 2024 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 10-1—CYE 2024 PMV Findings

Data Type	HSAG Findings
Medical Services Data	*No identified concerns*
Enrollment Data	*No identified concerns*
Provider Data	*No identified concerns*
Medical Record Review Process	*HSAG identified several critical errors during the CM MRRV process. A second sample passed for two of the three measure failures, and the third measure required BUFC LTC to remove all noncompliant cases.*
Supplemental Data	*No identified concerns*
Data Integration	*No identified concerns*

Results for Performance Measures

Table 10-2 presents the CY 2022 and CY 2023 BUFC LTC performance measure results that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and MY 2023. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA

Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and/or MY 2023. Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*).

Table 10-2—CY 2022 and CY 2023 BUFC LTC Performance Measure Results

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison	2023 Performance Level[1]
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	74.4%	78.4%	→	★★★★★
Effective Continuation Phase Treatment—Total (18+ Years)	65.6%	65.2%	→	★★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	NA++	NA++	—	—
30-Day Follow-Up—Total (6+ Years)	NA++	NA++	—	—
Use of Opioids at High Dosage				
*18+ Years**	12.2%	12.7%	→	★
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	50.2%	51.2%	→	★★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	4.8%	7.2%	→	★
Care of Acute and Chronic Conditions				
Controlling High Blood Pressure				
18–85 Years+	74.5%+	73.0%+	→	★★★★★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0%)—Total (18–75 Years)+	63.0%+	68.9%+	→	★★★★★
HbA1c Poor Control (>9.0%)—Total (18–75 Years)+*	37.0%+	30.2%+	↑	★★★
Pediatric Health				
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	NA++	NA++	—	—
Oral Evaluation, Dental Services				
Total (0–20 Years)N	31.0%	32.3%	→	—
Well-Child Visits in the First 30 Months of Life				
First 15 Months—Six or More Well-Child Visits	NA++	NA++	—	—

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison	2023 Performance Level[1]
15 Months to 30 Months—Two or More Well-Child Visits	NA++	NA++	—	—
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	—	48.7%	—	★★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	41.0%	48.9%	→	★★
Cervical Cancer Screening				
21–64 Years+	44.8%+	22.6%+	↓	★
Appropriate Utilization of Services				
Ambulatory Care				
Emergency Department (ED) Visits—Total (0–85+ Years)F	688.3	16,907.3	—	—
Plan All-Cause Readmissions				
*Observed/Expected (O/E) Ratio—Total (18–64 Years)**	NA++	0.7946	—	★★★★★

* A lower rate indicates better performance for this measure.
\+ Indicates the measure was reported using hybrid methodology.
++ NA indicates the denominator was too small to report a valid rate, based on the applicable measure specification.
Cells shaded green indicate that the rate met or exceeded the MY 2022 and/or MY 2023 national Medicaid mean.
— Indicates a 2022–2023 comparison is not presented in the CYE 2024 Annual Technical Report because either there was a break in trending, the CY 2021 rate was not presented in the CYE 2023 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
[1] Performance Levels for CY 2023 were based on comparisons of the HEDIS MY 2023 measure rates to national Medicaid Quality Compass HEDIS MY 2023 benchmarks.
F NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.
N Measure has no NCQA Medicaid mean for comparison.
↑ Indicates statistically significant improvement of measure rates.
↓ Indicates statistically significant decline of measure rates.
→ Indicates no statistically significant change in measure rates.
Performance Levels for 2023 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 10-3 presents strengths, opportunities for improvement, and recommendations (as applicable) for BUFC LTC related to performance measures, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-3—BUFC LTC Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group: • BUFC LTC's performance measure rate for *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* was between the 75th and 89th percentile, indicating strength in members initiating SUD treatment. **[Quality, Timeliness, Access]** • BUFC LTC's performance measure rates for *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total (18+ Years)* were at or above the 90th percentile, indicating most members were compliant with antidepressant prescriptions. **[Quality, Timeliness, Access]**
In the Care of Acute and Chronic Conditions measure group: • BUFC LTC's performance measure rate for *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 %)—Total (18–75 Years)* was at or above the 90th percentile, indicating that most members with diabetes had controlled HbA1c levels most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[215] **[Quality]** • BUFC LTC's performance measure rate for *Controlling High Blood Pressure (18–85 Years)* was at or above the 90th percentile, indicating that most members with a diagnosis of hypertension had controlled blood pressure. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[216] **[Quality]**
In the Appropriate Utilization of Services measure group, BUFC LTC's performance measure rate for *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total (18–64 Years)* was at or above the 90th percentile, indicating that most members who were admitted to an acute inpatient and

[215] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Feb 19, 2025.
[216] National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Feb 19, 2025.

Strengths, Opportunities for Improvement, and Recommendations
observation stay might not have been followed by an unplanned acute readmission for any diagnosis within 30 days.[217] **[Quality]**
Opportunities for Improvement and Recommendations
While BUFC LTC was successful in reporting valid rates for nearly all rates for its ALTCS-EPD population, the audit review identified some considerations and recommendations for future years' reporting. **[Quality]** Recommendations: • While BUFC LTC integrated available EHR and HIE data to report the required measure stratifications by race and ethnicity for MY 2023 data reporting, BUFC LTC should work to integrate race data that BUFC LTC noted it is receiving as of April 2024 for future stratification reporting to improve data completeness. BUFC LTC should ensure that it submits all Record of Administration, Data Management, and Processes (Roadmap) and associated attachments as part of its ISCAT submission, including all data inventories and supplemental data documentation to allow for a more streamlined review of documentation, which will reduce the amount of follow-up requests. • The MRRV and CM MRRV processes revealed several criterial errors which impacted BUFC LTC's ability to report the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition* measure indicators using the hybrid methodology. In addition, the LTSS measures required several measures with second samples and revisions to the final medical record compliant case counts. HSAG recommends that BUFC LTC incorporate the feedback provided during this year's validation process into its abstraction process to mitigate these issues in future years.
In the Preventive Screening measure group, BUFC LTC's performance measure rate for *Breast Cancer Screening Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023, indicating that not all women were receiving timely screening for breast or cervical cancer. 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. **[Quality]** Recommendation: HSAG recommends that BUFC LTC identify disparities or SDOH within the plan's populations that contributed to breast cancer and cervical cancer screening rates. Upon identification of a root cause, HSAG recommends that BUFC LTC implement appropriate interventions to reduce barriers to care. Further, HSAG recommends that BUFC LTC provide

[217] National Committee for Quality Assurance. Plan All-Cause Readmissions. Available at: https://www.ncqa.org/hedis/measures/plan-all-cause-readmissions/. Accessed on: Feb 12, 2025.

Strengths, Opportunities for Improvement, and Recommendations
scheduled reminders, messages directly from providers, and utilize personalized outreach for overdue patients. Communication messages should be clear and concise and include information on the procedure time. Some of these interventions might include a mobile clinic to conduct the screening, transportation assistance, and adjusting hours for visits to accommodate those with job/childcare concerns.
In the Behavioral Health measure group, BUFC LTC's performance measure rate for *Use of Opioids at High Dosage (18+ Years)* fell below the 25th percentile. This result provides an opportunity for BUFC LTC to monitor prescribing and utilization data and to implement interventions to improve care and services around opioid prescribing. **[Quality]** Recommendation: HSAG recommends that BUFC LTC follow the CDC guidelines on opioid prescribing for chronic, nonmalignant pain, which recommend the use of "additional precautions" when prescribing dosages ≥50 MED and that providers avoid or "carefully justify" increasing dosages ≥90 mg MED.[218] In 2019, the authors of the 2016 guidelines published commentary that cautioned providers, systems, payers, and states from developing policies and practices that are "inconsistent with and go beyond" the guideline recommendations. The commentary included cautions regarding strict enforcement of dosage and duration thresholds, as well as abrupt tapering of opioids. The opioid dosage assessed in this measure is a reference point for health plans to identify members who may be at high risk for opioid overuse and misuse. HSAG recommends outreach to members who fall within this category to assess and schedule interventions as necessary.[219] HSAG also recommends that BUFC LTC identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 10-4 presents performance measure recommendations made to BUFC LTC in the CYE 2023 Annual Technical Report[220] and BUFC LTC's follow-up to the recommendations, as well as an assessment of the degree to which BUFC LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

[218] National Committee for Quality Assurance. Use of Opioids at High Dosage (HDO). Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/. Accessed on: Feb 1, 2024.
[219] National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/ Accessed on: Feb 19, 2025.
[220] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

Table 10-4—BUFC LTC Follow-Up to CYE 2023 Performance Measure Recommendations

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Recommendation 1:
• While there were no concerns with the processing of practitioner data, the audit found that BUFC LTC could benefit from a practitioner credentialing software solution from the perspective of data processing and resource efficiency. • While BUFC LTC integrated some available EHR data to report the required measure stratifications by race and ethnicity for MY 2022 data reporting, BUFC LTC should work with AHCCCS to clarify race and ethnicity data available on the 834 file and develop a methodology for integrating these data for future reporting to augment EHR data to improve data completeness. • BUFC LTC should work with its performance measure vendor to identify the cause of the incorrect eligible population for the *Screening for Depression and Follow-Up Plan (CDF)* measure to prevent the same issue from impacting future reporting.
BUFC LTC's Response: None.
HSAG's Assessment: BUFC LTC worked with HSAG during the CYE 2024 PMV audit regarding the *CDF* measure. HSAG determined that BUFC LTC satisfactorily addressed the prior year's recommendation.
Recommendation 2:
HSAG recommended that BUFC LTC drill down to race, ethnicity, and age stratifications as well as SDOH to help determine gaps in care and continue to implement appropriate interventions to improve the performance related to these preventive screenings. HSAG also recommended that BUFC LTC monitor and expand on interventions currently in place to improve performance related to the *Breast Cancer Screening* measure. In addition to drilling down into breast cancer screenings, it would also be beneficial to drill down for members who are due for cervical cancer screening to also implement interventions to improve the performance related to preventive cervical cancer screenings. Some of these interventions could include a mobile clinic to conduct the screening, transportation programs, and adjusting hours for visits to accommodate those with job/childcare concerns.
BUFC LTC's Response: *Breast Cancer Screening* Response: Interventions that have been established or continued for implementation with enhancements are listed below: • Gaps in care reports are generated and sent monthly to the ALTCS Case Management team for outreach and follow-up. • Facilitate community-based wellness events that provide on-site screening. • Mobile mammogram program was initiated and closed due to low turnouts. Mobile/community-based imaging program is being reinitiated utilizing a Banner mobile imaging unit. • Member-facing outreach team contacts members who are due for screening and offers education and assistance with scheduling.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
• Targeted outreach attempts to the American Indian/Alaska Native population by a tribal care coordinator are being made providing education, encouragement, and scheduling information. • Provider education on best practices, measure specifications, member barriers and tips on overcoming barriers has been routinely shared through Joint Operating Committees (JOCs), Banner University Health Plan (BUHP) Provider Forums, and provider newsletters. • Billboards have been posted in collaboration with the American Cancer Society in areas reminding of the importance to get screened in various languages in areas with high membership of American Indian/Alaska Native members. • Member education shared through mailers, postcards, and on various social media outlets. • Well-Women's preventive care text message campaign was initiated in July 2024 sending text messages or postcards to women providing education on the importance of routine wellness visits and associated screenings, including breast cancer screenings with resources for additional information. *Cervical Cancer Screening* Response: Interventions that have been established or continued for implementation with enhancements are listed below: • Provider education on best practices, measure specifications, member barriers, and tips on overcoming barriers has been routinely shared through JOCs, BUHP Provider Forums, and provider newsletters. • Well-Women's preventive care text message campaign was initiated in July 2024 sending text messages or postcards to women providing education on the importance of routine wellness visits and associated screenings, including cervical cancer screenings with resources for additional information. • Facilitate community-based wellness events that provide on-site screening. • Gaps in care reports are generated and sent monthly to the ALTCS Case Management team for outreach and follow-up. • Member-facing outreach team contacts members who are due for screening and offers education and assistance with scheduling. • Member education shared through mailers, postcards, and on various social media outlets.
HSAG's Assessment: HSAG determined that BUFC LTC satisfactorily addressed the prior year's recommendation.
Recommendation 3:
HSAG recommends that BUFC LTC conduct a drill-down analysis based on race, ethnicity, and age stratifications to determine why there is a higher proportion of members receiving prescriptions for opioids. Upon identification of a root cause, HSAG recommends that BUFC LTC implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse and potentially implement other treatment options that do not include opioids if possible.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
BUFC LTC's Response: A subpopulation analysis has been conducted to identify any areas of membership or subpopulations that are displaying a disparity. This information will be reviewed with key members of leadership to develop additional interventions to target these populations. Interventions that have been established or continued for implementation with enhancements are listed below: • Established the Opioid Strategic Planning Committee which meets at minimum of quarterly. • Updated the outreach policy and letters to reflect the need for possible QOC actions if necessary. This included clear language about members being on pharmacy restriction programs if necessary. • Education is provided to members and providers on alternative therapies, such as acupuncture, mindfulness, and cognitive behavioral therapy interventions, through newsletters and social media. • Continued pharmacy practices for Opioid-Specific Data Extensive Program for monitoring and intervention: – Members identified with high dose opioid use from pharmacy data are sent letters about the risks. – Providers of members identified with high dose opioid use from pharmacy data are sent letters about the risks. – These identified members are assigned a care manager. – Outcomes are reviewed by the Opioid Strategic Planning Committee. – Identified members with no change to the high rate of use are reviewed by the medical director to determine next steps. o Members may be enrolled in the pharmacy restriction program. o Egregious cases may be sent to AHCCCS' credentialing board. – Care managers coordinate with members to connect them to community pain centers when appropriate. Data analysis has been completed, reviewing trends within providers for additional targeted education.
HSAG's Assessment: HSAG determined that BUFC LTC satisfactorily addressed the prior year's recommendation.
Recommendation 4:
HSAG recommended that BUFC LTC conduct a drill-down analysis based on race, ethnicity, and age stratifications to determine why members were not receiving timely SUD services or MAT following their initiation visit. BUFC LTC should consider the nature and scope of the issues (e.g., the issues are 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. Upon identification of a root cause, BUFC LTC should implement interventions that address the identified root cause of the low rate, targeting the interventions so that BUFC LTC improves performance related to initiating and engaging in timely treatment following a new episode of SUD dependence.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
BUFC LTC's Response: A subpopulation analysis has been conducted to identify any areas of membership or subpopulations that are displaying a disparity. This information will be reviewed with members of leadership and members of the established PIP Workgroup to develop additional interventions to target these populations. Additionally, interventions that have been established or continued for implementation with enhancements are listed below: • The QM Team along with leaders from the behavioral health team and other key members meet, at minimum, quarterly for an internal *IET* PIP Workgroup. • Ongoing utilization of the Pyx application which allows members easier access to appointment information. Enhancements to increase the capabilities of this app are in the planning phases. • Collaborations established with the pharmacy department to better identify members utilizing medications for SUD treatment. • Provider education on best practices, measure specifications, member barriers, and tips on overcoming barriers has been routinely shared through JOCs, BUHP Provider Forums, and provider newsletters. • Gaps in care reports are generated and sent monthly to the ALTCS Case Management team for outreach and follow-up. • Member education shared through mailers, postcards, and on various social media outlets. It is important to note that the BUFC-LTC has an exceptionally low denominator for this measure, with the CY 2023 year-end eligible population being 198 members.
HSAG's Assessment: HSAG determined that BUFC LTC satisfactorily addressed the prior year's recommendation.

Validation of Performance Improvement Projects

In CYE 2024, BUFC LTC continued the *Breast Cancer Screening* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 2, PIP validation activities focused on improvement from the baseline results. BUFC LTC submitted Remeasurement 2 performance indicator results and interventions implemented during this validation cycle along with the status of interventions, focus, and rationale for changes to or discontinuation of the intervention.

HSAG conducted an annual validation of the second remeasurement year reflective of CY 2023 (January 1, 2023, through December 31, 2023) using AHCCCS-calculated and validated indicator rates. HSAG evaluated BUFC LTC's performance indicator rates based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

Validation Results

Table 10-5 displays the overall confidence levels for the BUFC LTC *Breast Cancer Screening* PIP.

Table 10-5—BUFC LTC *Breast Cancer Screening* PIP Overall Confidence Levels

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]
BUFC LTC	*High Confidence*	100%	100%	*High Confidence*	100%	100%

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

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

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

Measure Results

Table 10-6 provides the *Breast Cancer Screening* PIP baseline, Remeasurement Year 1, and Remeasurement Year 2 rates for BUFC LTC.

Table 10-6—BUFC LTC *Breast Cancer Screening* PIP Rates

Contractor	PIP Indicator: *Breast Cancer Screening*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2020*	CY 2022	CY 2023
BUFC LTC	38.5%	41.0%	48.9%

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

HSAG rounded percentages to the first decimal place.

Interventions

Table 10-7 presents PIP interventions for BUFC LTC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 10-7—BUFC LTC *Breast Cancer Screening* PIP Interventions

Contractor	Interventions
BUFC LTC	• ALTCS case managers asked applicable female members if they have had a mammogram completed during the assessment with the member and provide the member with education on the importance of mammograms. • ALTCS case managers identified applicable members who needed a mammogram or will become overdue and attempt outreach calls to offer assistance with scheduling a mammogram appointment. • BUFC imaging collaborated with the ALTCS Care Management department to assist with scheduling members who need a mammogram in Maricopa County. • Quarterly gaps in care lists were generated and sent to the ALTCS case managers for outreach to members still needing a screening. • Initiated discussions for contracting with a mobile mammogram unit. • Annual breast cancer screening mailers and postings on social media in both English and Spanish. • Included educational materials in English and Spanish on the Banner Health website. • Reviewed and collected Non-Standard Supplemental Data (NSSD). • Contracted with mobile mammogram units. • Promoted senior health and wellness fair events. • Utilization of Assurance Wireless outreached members and reminded them of regular screenings. • Planned incentive offering members a gift card for completing a mammogram between June 1, 2023, and September 30, 2023.

Strengths, Opportunities for Improvement, and Recommendations

Table 10-8 presents strengths, opportunities for improvement, and recommendations (as applicable) for BUFC LTC related to the *Breast Cancer Screening* PIP, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-8—BUFC LTC Strengths, Opportunities for Improvement, and Recommendations Related to the *Breast Cancer Screening* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
BUFC LTC adhered to acceptable methodology through all phases of the PIP. The Contractor achieved statistically significant improvement between the baseline rate and the Remeasurement 2 rate for the *BCS* performance indicator. **[Quality, Access]**

Strengths, Opportunities for Improvement, and Recommendations
Opportunities for Improvement and Recommendations
HSAG identified no opportunities for improvement related to the *Breast Cancer Screening* PIP: Recommendation: Although there were no opportunities for improvement identified, as the PIP progresses, HSAG recommends that BUFC LTC: • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 10-9 presents PIP recommendations made to BUFC LTC in the CYE 2023 Annual Technical Report[221] and BUFC LTC's follow-up to the recommendations, as well as an assessment of the degree to which BUFC LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 10-9—BUFC LTC Follow-Up to CYE 2023 PIP Recommendations

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG recommended that BUFC LTC: • Complete statistical testing between the baseline (CY 2020) and all remeasure periods using HSAG's statistical testing reference documents sent to the Contractor on November 27, 2023. • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. • Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.
BUFC LTC's Response: Statistical testing was completed utilizing the Fisher's exact test with the results listed below. • The Fisher's exact test shows an extremely statistically significant association between the Baseline Year and Remeasurement Year 2; the *p* value > 0.0001. • The Fisher's exact test shows an extremely statistically significant association between Intervention Year 1 and Remeasurement Year 2; the *p* value > 0.0001.

[221] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for PIPs

- The Fisher's exact test shows an extremely statistically significant association between Intervention Year 2 and Remeasurement Year 2; the *p* value = 0.0002.
- The Fisher's exact test shows a statistically significant association between Remeasurement Year 1 and Remeasurement Year 2; the *p* value = 0.0212.

A fishbone diagram was utilized for a root cause analysis. The fishbone diagram is reviewed and updated accordingly during the *Breast Cancer Screening* PIP Workgroups which are held, at minimum, quarterly. Based on this review and analysis, some interventions that have been identified and updated to better target those underperforming populations, or better meet the specific needs of members include:

- Targeted outreach to American Indian/Alaska Native members facilitated by a tribal care coordinator.
- Billboards have been posted in collaboration with the American Cancer Society in areas reminding of the importance to get screened in various languages in areas with high membership of American Indian/Alaska Native members.
- Reevaluation of mobile imaging programs to ensure they can adequately serve those members who have physical limitations that may be deterring or preventing them from completing mammograms.
- Additional education shared with providers during BUHP provider forums, advisory councils, and JOCs, along with information shared with both providers and members through newsletters and social media outlets on the imaging locations where additional imaging staff are available to assist members who have mobility challenges or that can offer seated mammograms.

Continued or newly implemented interventions include:

- Gaps in care reports are generated and sent monthly to the ALTCS Case Management team for outreach and follow-up.
- Facilitate community-based wellness events that provide on-site screening.
- Mobile mammogram program was initiated and closed due to low turnouts. Mobile/community-based imaging program is being reinitiated utilizing a Banner mobile imaging unit.
- Member-facing outreach team contacts members who are due for screening and offers education and assistance with scheduling.
- Provider education on best practices, measure specifications, member barriers, and tips on overcoming barriers has been routinely shared through JOCs, BUHP provider forums, and provider newsletters.
- Member education shared through mailers, postcards, and on various social media outlets.
- Well-Women's preventive care text message campaign was initiated in July 2024 sending text messages or postcards to women providing education on the importance of routine wellness visits and associated screenings, including breast cancer screenings with resources for additional information.

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG's Assessment: HSAG has determined that BUFC LTC has satisfactorily addressed these prior year's recommendations.

Compliance Reviews

Results

AHCCCS conducted a compliance review of BUFC LTC in CYE 2023. On July 30, 2024, AHCCCS accepted and closed the remaining four CAPs for BUFC LTC. Table 10-10 presents the updated CYE 2024 compliance review results for BUFC LTC.

Table 10-10—BUFC LTC Compliance Review Results

Focus Areas	CYE 2023 BUFC LTC Scores	CYE 2023 Program-Level Average	CYE 2024 BUFC LTC CAP Update
CC	100%	100%	NA
CIS	99%	98%	NA
CM	93%	86%	Met
DS	88%	94%	Met
GA	100%	100%	NA
GS	98%	99%	NA
MCH	98%	92%	NA
MM	84%	92%	Met
MI	96%	97%	NA
QM	88%	89%	Met
QI	95%	98%	NA
RI	100%	100%	NA
TPL	100%	100%	NA
ISOC	96%	93%	NA

NA = Not applicable. A CAP was not required as the CYE 2023 score was 95% or above.
Met = AHCCCS accepted and closed the Contractor's CAP.

Strengths, Opportunities for Improvement, and Recommendations

Table 10-11 presents strengths, opportunities for improvement, and recommendations (as applicable) for BUFC LTC related to compliance activities, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-11—BUFC LTC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
BUFC LTC has successfully closed out CAPs in the following focus areas: • Case Management (CM) **[Quality, Access]** • Delivery Systems (DS) **[Timeliness, Access]** • Medical Management (MM) **[Timeliness, Access]** • Quality Management (QM) **[Quality]**
Opportunities for Improvement and Recommendations
As a result of its CAP interventions, BUFC LTC was found to be fully compliant within all focus areas and had no continuing corrective actions or recommendations.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 10-12 presents compliance recommendations made to BUFC LTC in the CYE 2023 Annual Technical Report[222] and BUFC LTC's follow-up to the recommendations, as well as an assessment of the degree to which BUFC LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 10-12—BUFC LTC's Follow-Up to CYE 2023 Compliance Recommendations

Prior Year's Recommendation From the EQR Technical Report for Compliance
HSAG recommended that BUFC LTC propose and implement CAPs for the CM, DS, MM, and QM focus areas as approved by AHCCCS.
BUFC LTC's Response: According to the AHCCCS response from the June 2024 CAP Resubmission Matrix, the CAPs for Case Management (CM), Delivery Systems (DS), Medical Management (MM), and Quality Management (QM) have been closed.

[222] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for Compliance
HSAG's Assessment: Based on the CAP closure for the CM, DS, MM, and QM focus areas, and the response provided, HSAG determined that BUFC LTC has satisfactorily addressed the prior year's recommendations related to compliance.

Network Adequacy Validation

ISCA Results

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

Table 10-13 summarizes HSAG's validation ratings for BUFC LTC by indicator type.

Table 10-13—Summary of BUFC LTC's Validation Ratings by Indicator Type

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

Of the network adequacy indicators assessed, BUFC LTC received *High Confidence* for both appointment availability and time/distance indicators. However, there were identified areas for improvement, please refer to the Strengths, Opportunities for Improvement, and Recommendations section for more details.

NAV Results

HSAG evaluated BUFC LTC's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents CYE 2024 S1 validation findings specific to the ALTCS-EPD Program, with one results table for each of the following GSAs:

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

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

Table 10-14—Time/Distance Validation Results for BUFC LTC Central GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^	99.6^	100.0^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR*^	97.7^	100.0*^
BHRF	NA	96.5	NA
Cardiologist, Adult	100.0^	99.9^	100.0^
Cardiologist, Pediatric	NR*^	100.0^	100.0*^
Dentist, Pediatric	NR*	100.0	100.0*
Hospital	100.0	100.0	100.0
Nursing Facility	100.0	99.8	100.0
OB/GYN	100.0*	100.0	100.0
Pharmacy	100.0	99.7	100.0
PCP, Adult	100.0^	99.9^	100.0^
PCP, Pediatric	NR*^	100.0^	100.0*^

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

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

* indicates that fewer than 10 members were included in the denominator of HSAG's results.

^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

Table 10-15—Time/Distance Validation Results for BUFC LTC South GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Cochise	Graham	Greenlee	La Paz	Pima	Santa Cruz	Yuma
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^	100.0^	100.0^	100.0^	98.3^	100.0^	100.0^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0*^	100.0*^	NR*^	NR*^	88.4^	100.0*^	100.0*^
BHRF	NA	NA	NA	NA	91.7	NA	NA
Cardiologist, Adult	100.0^	100.0^	100.0^	100.0^	98.7^	100.0^	100.0^
Cardiologist, Pediatric	100.0*^	100.0*^	NR*	NR*	100.0^	100.0*^	100.0^
Dentist, Pediatric	100.0*	100.0*	NR*	NR*	96.3	100.0*	100.0
Hospital	100.0	100.0	100.0	100.0	99.8	100.0	100.0

Minimum Network Requirement	Cochise	Graham	Greenlee	La Paz	Pima	Santa Cruz	Yuma
Nursing Facility	100.0	100.0	100.0*	100.0	99.7	100.0	100.0
OB/GYN	100.0	NR*	100.0*	100.0*	100.0	100.0*	100.0
Pharmacy	100.0	100.0	100.0	93.3	98.7	100.0	100.0
PCP, Adult	100.0^	100.0^	100.0^	100.0^	99.8^	100.0^	100.0^
PCP, Pediatric	100.0*^	100.0*^	NR*	NR*	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.

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

* indicates that fewer than 10 members were included in the denominator of HSAG's results.

^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

Strengths, Opportunities for Improvement, and Recommendations

Table 10-16 presents strengths, opportunities for improvement, and recommendations (as applicable) for BUFC LTC related to NAV, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-16—BUFC LTC Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • BUFC LTC had processes in place to maintain current provider data, including utilizing the AzAHP forms to track provider data updates. Additionally, BUFC performed a monthly reconciliation process of provider data between its systems to ensure accuracy and completeness. **[Access]** • BUFC LTC met all minimum network requirements for all assigned counties. **[Access]** Note: BUFC LTC provides coverage in the following counties: Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Santa Cruz, and Yuma.
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: • In BUFC LTC's ISCAT responses and supporting documentation, BUFC used multiple naming conventions for its database systems. **[Access]**

Strengths, Opportunities for Improvement, and Recommendations
Recommendation: HSAG recommends that BUFC LTC identify one consistent naming convention for each relevant database system as part of reporting to help ensure clarity in references and mitigate potential confusion. • BUFC LTC manually entered provider data updates from the AzAHP forms and provider rosters into the Provider Manager system. **[Access]** Recommendation: Although BUFC LTC had quality assurance checks and validations in place, HSAG recommends that BUFC LTC explore options to automate data transfer from electronic versions of the AzAHP forms and rosters into the Provider Manager system. • HSAG identified concerns with BUFC LTC's network adequacy indicator reporting processes regarding the lack of data checks conducted on the member data extracts used for network adequacy indicator calculation sent to Quest Analytics and the minimal data checks conducted on the provider data extracts used for network adequacy indicator calculation sent to Quest Analytics. **[Access]** Recommendation: HSAG recommends incorporating additional oversight through data reasonability checks and data quality checks. BUFC LTC may be able to mitigate the downstream impact of incorrect identification of member populations, provider classifications, and the results of network adequacy indicator calculation that would allow for better trending/comparison for additional oversight and monitoring activities. This would allow BUFC LTC to better identify gaps and monitor changes to members' access in its service areas.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 10-17 presents NAV recommendations made to BUFC LTC in the CYE 2023 Annual Technical Report[223] and BUFC LTC's follow-up to the recommendations, as well as an assessment of the degree to which BUFC LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

[223] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

Table 10-17—BUFC LTC Follow-Up to CYE 2023 NAV Recommendations

Prior Year's Recommendation From the EQR Technical Report for NAV
HSAG recommended that BUFC LTC maintain current compliance with network standards but continue to address network gaps, as applicable.
BUFC LTC's Response: BUFC-LTC analyzes the PAT to determine if any noted variances are in line with natural network changes such as provider moves, adds, etc. If there are additional providers in the area to fill the gap, the providers are approached to join the network. If there are no providers in the area, BUFC-LTC is left with a gap and an exception is submitted. Additionally, the following actions have been taken for Greenlee and La Paz counties: • Greenlee—Provider locations were identified within 50 miles of Morenci (Greenlee County). A deeper analysis is being conducted to pinpoint where exactly those members are located who are just over the 30-mile requirement to accurately identify what offices to focus on to close the gap in this county. Additionally, per the GEO from 9/25/24, there are 107 members in Greenlee without access. Access standards in rural areas for BUFC are being reviewed. The GEO report shows 30 miles or 40 minutes for rural areas. While the 30-mile requirement is not being met, the GEO showed that members were within 39 miles, which would be equal to a 40-minute drive, therefore being within the range. • La Paz—Provider relations representative contacted the providers in March and July of this year. Please note that there are not many provider options in La Paz due to how rural the county is, which is why there is an exception made by AHCCCS. Additionally, BUFC's dental benefits administrator has been contacting providers for recruitment attempts.
HSAG's Assessment: HSAG has determined that BUFC LTC has satisfactorily addressed these prior year's recommendations.

Mercy Care LTC

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2024, HSAG evaluated Mercy Care LTC's data system for processing of each data type used for reporting the Contractor's CY 2023 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that Mercy Care LTC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 10-18 displays HSAG's PMV findings for each data type reviewed during CYE 2024 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 10-18—CYE 2024 PMV Findings

Data Type	HSAG Findings
Medical Services Data	*No identified concerns*
Enrollment Data	*No identified concerns*
Provider Data	*No identified concerns*
Medical Record Review Process	*No identified concerns*
Supplemental Data	*No identified concerns*
Data Integration	*No identified concerns*

Results for Performance Measures

Table 10-19 presents the CY 2022 and CY 2023 Mercy Care LTC performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and MY 2023. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and/or MY 2023. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 10-19—CY 2022 and CY 2023 Mercy Care LTC Performance Measure Results

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison	2023 Performance Level[1]
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	68.9%	70.3%	→	★★★★
Effective Continuation Phase Treatment—Total (18+ Years)	59.5%	64.7%	→	★★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	55.6%	48.1%	→	★★★★
30-Day Follow-Up—Total (6+ Years)	72.2%	66.7%	→	★★★
Use of Opioids at High Dosage				
*18+ Years**	12.1%	10.9%	→	★
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	56.7%	48.3%	↓	★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	10.2%	6.5%	→	★
Care of Acute and Chronic Conditions				
Controlling High Blood Pressure				
18–85 Years[+]	74.7%[+]	76.6%[+]	→	★★★★★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0 %)—Total (18–75 Years)[+]	69.6%[+]	70.3%[+]	→	★★★★★
*HbA1c Poor Control (>9.0 %)—Total (18–75 Years)**[+]	23.4%[+]	22.1%[+]	→	★★★★★
Pediatric Health				
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	NA[++]	NA[++]	—	—
Oral Evaluation, Dental Services				
Total (0–20 Years)[N]	44.2%	46.8%	→	—
Well-Child Visits in the First 30 Months of Life				
First 15 Months—Six or More Well-Child Visits	NA[++]	NA[++]	—	—
Months to 30 Months—Two or More Well-Child Visits	NA[++]	NA[++]	—	—
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	44.3%	46.1%	→	★

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison	2023 Performance Level[1]
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	35.2%	38.4%	→	★
Cervical Cancer Screening				
21–64 Years	33.1%+	30.4%+	→	★
Appropriate Utilization of Services				
Ambulatory Care				
Emergency Department (ED) Visits—Total (0–85+ Years)[F]	687.5	721.3	—	—
Plan All-Cause Readmissions				
*Observed/Expected (O/E) Ratio—Total (18–64 Years)**	0.7893	0.7434	—	★★★★★

* A lower rate indicates better performance for this measure.
\+ Indicates the measure was reported using hybrid methodology.
++ NA indicates the denominator was too small to report a valid rate, based on the applicable measure specification.
Cells shaded green indicate that the rate met or exceeded the MY 2022 and/or MY 2023 national Medicaid mean.
— Indicates a 2022–2023 comparison is not presented in the CYE 2024 Annual Technical Report because either there was a break in trending, the CY 2021 rate was not presented in the CYE 2023 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
[1] Performance Levels for CY 2023 were based on comparisons of the HEDIS MY 2023 measure rates to national Medicaid Quality Compass HEDIS MY 2023 benchmarks.
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.
[N] Measure has no NCQA Medicaid mean for comparison.
↑ Indicates statistically significant improvement of measure rates.
↓ Indicates statistically significant decline of measure rates.
→ Indicates no statistically significant change in measure rates.
Performance Levels for 2023 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 10-20 presents strengths, opportunities for improvement, and recommendations (as applicable) for Mercy Care LTC related to performance measure, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-20—Mercy Care LTC Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group: • Mercy Care LTC's performance measure rates for *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* were between the 75th and 89th percentile, indicating strength in providing behavioral health follow-up care to members and indicating most members are compliant with antidepressant prescriptions. **[Quality, Timeliness, Access]** • Mercy Care LTC's performance measure rates for *Antidepressant Medication Management—Effective Continuation Phase Treatment—Total—(18+ Years)* was at or above the 90th percentile, indicating most members are compliant with antidepressant prescriptions. **[Quality, Timeliness, Access]**
In the Care of Acute and Chronic Conditions measure group, all three of Mercy Care LTC's performance measure rates for *Controlling High Blood Pressure (18–85 Years), Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 %)—Total (18–75 Years)* and *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)* met or exceeded the 90th percentile, indicating strength in providing appropriate care of acute and chronic conditions to applicable members. **[Quality]**
In the Appropriate Utilization of Services measure group, Mercy Care LTC's performance measure rate for *Plan All Cause-Readmissions—Observed/Expected (O/E) Ratio—Total (18–64 Years)* met or exceeded the 90th percentile, indicating that most members who were admitted to an acute inpatient and observation stay might not have been followed by an unplanned acute readmission for any diagnosis within 30 days.[224] **[Quality]**
Opportunities for Improvement and Recommendations
While Mercy Care LTC was successful in reporting valid rates for all AHCCCS-required performance measures, the audit review identified some considerations and recommendations for future years' reporting. **[Quality]** Recommendation: HSAG recommends that Mercy Care LTC continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes AHCCCS' requirements for MCO-enrolled members who switch product lines or MCOs and members for whom Mercy Care LTC does not hold the primary insurance contract. In addition, HSAG recommends that Mercy Care LTC continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES.

[224] National Committee for Quality Assurance. Plan All-Cause Readmissions. Available at: https://www.ncqa.org/hedis/measures/plan-all-cause-readmissions/. Accessed on: Feb 12, 2025.

Strengths, Opportunities for Improvement, and Recommendations
In the Preventive Screening measure group, Mercy Care LTC's performance measure rates for *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* fell below the 25th percentile, indicating that not all women were receiving timely screening for breast or cervical cancer. 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. **[Quality]** Recommendation: While Mercy Care LTC conducted a root cause analysis and implemented interventions specific to the *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* measures, these rates remained low in MY 2023. HSAG recommends that Mercy Care LTC identify disparities or SDOH within the plan's populations that contributed to breast cancer and cervical cancer screening rates. Upon identification of a root cause, HSAG recommends that Mercy Care LTC implement appropriate interventions to reduce barriers to care. Further, HSAG recommends that Mercy Care LTC provide scheduled reminders, messages directly from providers, and utilize personalized outreach for overdue patients. Communication messages should be clear and concise and include information on the procedure time. Some of these interventions might include a mobile clinic to conduct the screening, transportation assistance, and adjusting hours for visits to accommodate those with job/childcare concerns.
In the Behavioral Health measure group, Mercy Care LTC's performance measure rate for *Use of Opioids at High Dosage (18+ Years)* fell below the 25th percentile. This result provides an opportunity for Mercy Care LTC to monitor prescribing and utilization data and to implement interventions to improve care and services around opioid prescribing. **[Quality]** Recommendation: HSAG recommends that Mercy Care LTC follow the CDC guidelines on opioid prescribing for chronic, nonmalignant pain, which recommend the use of "additional precautions" when prescribing dosages ≥50 MED and that providers avoid or "carefully justify" increasing dosages ≥90 mg MED.[225] In 2019, the authors of the 2016 guidelines published commentary that cautioned providers, systems, payers, and states from developing policies and practices that are "inconsistent with and go beyond" the guideline recommendations. The commentary included cautions regarding strict enforcement of dosage and duration thresholds, as well as abrupt tapering of opioids. The opioid dosage assessed in this measure is a reference point for health plans to identify members who may be at high risk for opioid overuse and misuse. HSAG recommends outreach to members who fall within this category to assess and schedule interventions as necessary.[226] HSAG also recommends that Mercy Care LTC identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts.

[225] National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/. Accessed on: Feb 19, 2025.
[226] Ibid.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 10-21 presents performance measure recommendations made to Mercy Care LTC in the CYE 2023 Annual Technical Report[227] and Mercy Care LTC's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 10-21—Mercy Care LTC Follow-Up to CYE 2023 Performance Measure Recommendations

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Recommendation 1:
HSAG recommended that Mercy Care LTC continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. Additionally, HSAG recommended that Mercy Care LTC continue to 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.
Mercy Care LTC's Response:
Historically, Mercy Care LTC has followed the NCQA HEDIS guidelines regarding continuous enrollment, which varied from AHCCCS guidance. However, AHCCCS has announced that for MY 2023 forward, AHCCCS will require plans to follow the NCQA HEDIS guidelines. As a result, Mercy Care is in compliance with the current requirements. The National Medicaid Quality Data team ensures that necessary source code changes are made by the software vendor with the release of any changes to event data, and rates are reviewed monthly. Any anomalies/discrepancies/outliers that are found are reviewed, researched, and tested thoroughly before any data are reported to regulatory bodies. Additionally, monthly event checks using vendor resources as compared to any technical specifications to ensure that the vendor is accurately capturing the right reporting elements for all core and non-core activities, as well as higher monitoring of internal back-end system integrations to ensure that all data elements are within scope to be captured for reporting.
HSAG's Assessment: HSAG determined that Mercy Care LTC satisfactorily addressed the prior year's recommendation.
Recommendation 2:
HSAG recommended that Mercy Care LTC explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratification related to RES. Mercy Care LTC should continue to work with AHCCCS on collaborative efforts to improve the

[227] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information.
Mercy Care LTC's Response: Mercy Care LTC worked the Aetna Medicaid Quality & Report team to update the 834 mapping and now includes all applicable data. Additionally, Mercy Care is leveraging the CMS enrollment files and case/care management data for capturing additional data. Mercy Care LTC and Aetna Medicaid have worked with the Health Equity Team to identify if indirect data sources can be captured to supplement the direct data sources.
HSAG's Assessment: HSAG determined that Mercy Care LTC satisfactorily addressed the prior year's recommendation.
Recommendation 3:
While Mercy Care LTC conducted a root cause analysis and implemented interventions specific to the *Breast Cancer Screening—Total (50–74 Years)* measure, this rate remained low in CY 2022. HSAG therefore recommended that Mercy Care LTC drill down to race, ethnicity, and age stratifications as well as SDOH to help determine gaps in care and continue to implement appropriate interventions to improve the performance related to these preventive screenings. HSAG also recommended that Mercy Care LTC monitor and expand on interventions currently in place to improve performance related to the *Breast Cancer Screening—Total (50–74 Years)* measure. In addition to drilling down into breast cancer screenings, it would also be beneficial to drill down for members who are due for cervical cancer screening to also implement interventions to improve the performance related to preventive cervical cancer screenings. Examples of these interventions include a mobile clinic to conduct the screening, transportation programs, and adjusting hours for screenings to accommodate those with job/childcare concerns.
Mercy Care LTC's Response: Mercy Care LTC continued the interventions that were reported in 2023, after completion of a root cause analysis, and also developed and implemented additional interventions to further drive improvement. Subjective analysis regarding the *Breast Cancer Screening* measure demonstrates that factors which may impact compliance with mammograms include: • Incomplete data due to inclusion of members with other primary insurance—those claims may not be sent to Mercy Care as they are paid by the members' primary insurance. • SDOH: low income and lack of socioeconomic resources appear as common barriers to adherence as well as being a foreigner, transportation issues, and unemployment. • Member postponement of many "nonessential" health services. • Limited provider resources to reach out to members to schedule appointments or to those who cancel appointments and assist them with rescheduling as soon as possible. • Member fear of pain or discomfort with the procedure. • Member may have loss of work or reduced work hours due to a mammogram appointment.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Enhanced interventions include: • Offer additional provider education for those areas identified as under-utilizers and work with those providers to discuss how we can help utilize a mobile mammogram program to reach their members and promote our incentive program for breast cancer screenings. • Partner with Mercy Care VBS providers to provide standard supplemental data feeds to improve data capture. • Mercy Care Health Assistant Application—Member Web portal to provide educational information regarding gaps in care along with digital and written member outreach. • Increased/improved member incentive (double the previous amount). • Pursue hosting a Mercy Care sponsored health fair where individuals can receive a mobile mammogram. • Staying Healthy Fall/Winter 2024 Member Newsletter provides the member with information on women's wellness exams, cervical cancer screenings (CCS), and breast cancer screenings (BCS). Existing interventions: • Educational outreach to female members ages 40–74 to encourage well-woman exams and mammograms (BCS). • Providers are notified via mail of members who are due for a mammogram. They are given an order form to sign and send into us. We then contact the member and assist with scheduling a mammogram and submitting the order form. • Outreach staff contact members who still have not had a mammogram to assist with scheduling an appointment. • Incentive letter mailed to members who still need a mammogram; once they receive a mammogram and the facility signs the form, the member can submit to us for a gift card if met before the deadline. • Provider outreach educating on breast cancer screening guideline and provide them with a list of members in need of a mammogram. • Text messaging, email, and IVR outreach to close gaps in care to members with MCA. • Content that is specific to mammogram disparities was included in provider newsletters and the Mercy Care Provider Conference. • This topic was reviewed at the ALTCS Member Council to obtain member feedback to address disparities. • Improved communication to ALTCS case management team and members about the availability of the incentives for mammograms. • Offer additional provider education for those areas identified as under-utilizers and work with those providers to discuss how we can help utilize a mobile mammogram program to reach their members and promote our incentive program for breast cancer screenings.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
• Partner with Arizona Diagnostics Radiology to outreach members specifically assigned to these providers. • Addition of *BCS* measure to value-based programs. • Collaboration with Native Health by providing targeted gap lists of members in need of a mammography screening. • Collection of nonstandard supplemental data, particularly for members with other primary coverage, to close gaps in data. • Improve Value-Based Program incentives to include the *Breast Cancer Screening* measure in the VBS contract for Mercy Care's largest ALTCS PCP. • Pay for Quality (P4Q) program for smaller ALTCS providers and skilled nursing facilities who close gaps in care for members who are in need of a mammogram. • Partner with Mercy Care VBS providers to provide standard supplemental data feeds to improve data capture. • Healthmine Application—Member Web portal to provide educational information regarding gaps in care along with digital and written member outreach. Mercy Care LTC will continue to monitor the plan's performance with this measure through the additional phases of the PDSA cycle and modify existing interventions or implement additional interventions as necessary.
HSAG's Assessment: Since Mercy Care LTC implemented interventions to improve performance on this measure even though performance did not improve in MY 2023, HSAG determined that Mercy Care LTC satisfactorily addressed these prior year's recommendations.
Recommendation 4:
HSAG recommended that Mercy Care LTC conduct a drill-down analysis based on race, ethnicity, and age stratifications to determine why there is a higher proportion of members receiving prescriptions for opioids. Upon identification of a root cause, HSAG recommended that Mercy Care LTC implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse and potentially implement other treatment options that do not include opioids if possible.
Mercy Care LTC's Response: As a result of this analysis, Mercy Care LTC developed the following interventions aimed at reducing the number and percentage of members who are prescribed high dose opioids: • Pharmacy Risk Prevention Report including members at risk for adherence noncompliance and gap in care data (measures: *AMM*, *HDO*, *SAA*, *SPD*, *SPC*, *SSD*, and *UOP*). • Opioid/SUD Best Practices Presentation to Mercy Care VBS providers by MC associate chief medical officer.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
• Educational Outreach Program (EOP) with provider fax including targeted member information for providers identified as having members on > 90MME. This also includes an opioid prescriber report card. • Telephonic one-on-one provider outreach to the top 10 high MME prescribers. • SMS (PBM program): This program targets high-risk drug classes, focusing on controlled substances, and inappropriate use and misuse-related indicators such as polypharmacy, provider shopping, and high-total controlled substance claims volume. On a quarterly basis, clinical pharmacists will evaluate controlled substance claims and any available supporting medical data to identify potential medication misuse and inappropriate claims for appropriate intervention. During subsequent quarters, pharmacists conduct follow-up activities utilizing physician responses and current claim activity. Situations identified as being potentially inappropriate may be referred to the client (plan) for further action. • Creation and distribution of a report of members who are utilizing 50–89 MME for provider awareness and intervention prior to the member reaching 90 MME. • Mercy Care associate chief medical officer outreach to prescribing providers of members who are in the *HDO* measure numerator. • Mercy Care case managers will outreach members in the *HDO* measure for care coordination. Mercy Care LTC will continue to monitor the plan's performance with this measure through the additional phases of the PDSA cycle and modify existing interventions or implement additional interventions as necessary.
HSAG's Assessment: Since Mercy Care LTC implemented interventions to improve performance on this measure even though performance did not improve in MY 2023, HSAG determined that Mercy Care LTC satisfactorily addressed these prior year's recommendations.

Validation of Performance Improvement Projects

In CYE 2024, Mercy Care LTC continued the *Breast Cancer Screening* PIP, which was initiated in CYE 2019. As this PIP has progressed through Remeasurement 2, PIP validation activities focused on improvement from the baseline results. Mercy Care LTC submitted Remeasurement 2 performance indicator results and interventions improvement during this validation cycle along with the status of interventions, focus, and rationale for changes to or discontinuation of the interventions.

HSAG conducted an annual validation of the second remeasurement year reflective of CY 2023 (January 1, 2023, through December 31, 2023) using AHCCCS-calculated and validated indicator rates. HSAG evaluated Mercy Care LTC's performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

Validation Results

Table 10-22 displays the overall confidence levels for the Mercy Care LTC *Breast Cancer Screening* PIP.

Table 10-22—Mercy Care LTC *Breast Cancer Screening* PIP Overall Confidence Levels

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met3	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]
Mercy Care LTC	*High Confidence*	100%	100%	*Moderate Confidence*	67%	100%

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

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

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

Measure Results

Table 10-23 provides the *Breast Cancer Screening* PIP baseline, Remeasurement Year 1, and Remeasurement Year 2 rates for Mercy Care LTC.

Table 10-23—Mercy Care LTC *Breast Cancer Screening* PIP Rates

Contractor	PIP Indicator: *Breast Cancer Screening*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
Mercy Care LTC	37.8%	35.2%	38.4%

HSAG rounded percentages to the first decimal place.

Interventions

Table 10-24 presents PIP interventions for Mercy Care LTC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

Table 10-24—Mercy Care LTC *Breast Cancer Screening* PIP Interventions

Contractor	Intervention
Mercy Care LTC	• Additional provider education for those areas mentioned that are underutilized: – Worked with those providers to discuss how we can help utilize a mobile mammogram program to reach their members. – Worked with those providers to promote our incentive program for breast cancer screenings. • Partnered with Arizona Diagnostics Radiology to outreach members specifically assigned to these providers. • Developed and implemented a written or multi-channel outreach (text/IVR/email) intervention for newly enrolled female members ages 50–74 years, as well as members ages 52–59 years. • Addition of *BCS* measure to value-based programs. • Consideration of partnership with mobile mammography provider in targeted ZIP Codes. • Surveyed providers that have a high compliance rate/have been successful in working with members with similar profiles to identify best practices and outreach to low-performing providers to share identified best practices; encourage member outreach to close gaps in care. • ACMO targeted provider outreach for PCPs identified with the largest volume of members in need of screening—share best practices and list of members with a gap in care for outreach and care coordination.

Strengths, Opportunities for Improvement, and Recommendations

Table 10-25 presents strengths, opportunities for improvement, and recommendations (as applicable) for Mercy Care LTC related to the *Breast Cancer Screening* PIP, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-25—Mercy Care LTC Strengths, Opportunities for Improvement, and Recommendations Related to the *Breast Cancer Screening* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
Mercy Care LTC adhered to acceptable methodology through all phases of the PIP. The Contractor achieved improvement between the baseline rate and the Remeasurement 2 rate for the *BCS* performance indicator. **[Quality, Access]**
Opportunities for Improvement and Recommendations
HSAG identified no opportunities for improvement related to the *Breast Cancer Screening* PIP:

Strengths, Opportunities for Improvement, and Recommendations
Recommendation: Although there were no opportunities for improvement identified, as the PIP progresses, HSAG recommends that Mercy Care LTC: • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 10-26 presents PIP recommendations made to Mercy Care LTC in the CYE 2023 Annual Technical Report[228] and Mercy Care LTC's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 10-26—Mercy Care LTC Follow-Up to CYE 2023 PIP Recommendations

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG recommended that Mercy Care LTC: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. • Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.
Mercy Care LTC's Response: Mercy Care LTC continues to review the PIP rates at least quarterly, with an annual final measurement year evaluation once the data are finalized. When the health plan identifies declines in performance, or that the rates are not on track to reach the defined goal, we initiate or follow to the next step in the PDSA cycle. Interventions are assessed for effectiveness, and best practices are identified, documented, and incorporated into the health plan's standard operating procedures.
HSAG's Assessment: HSAG has determined that Mercy Care LTC has satisfactorily addressed these prior year's recommendations.

[228] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

Compliance Reviews

Results

AHCCCS conducted a compliance review of Mercy Care LTC in CYE 2023. On September 20, 2023, AHCCCS accepted Mercy Care LTC's proposed CAPs and required the Contractor to submit updated policies, manuals, desktop procedures, and other vital documents to provide evidence of CAP completion. On March 20, 2024, AHCCCS reviewed Mercy Care LTC's status and determined that not all CAPs had been completed for closure. The remaining CAP item was under review by AHCCCS at the time this report was written. Additional results of the CAP update will be included in the CYE 2025 annual technical report. Table 10-27 presents the updated CYE 2024 compliance review results for Mercy Care LTC.

Table 10-27—Mercy Care LTC Compliance Results

Focus Areas	CYE 2023 Mercy Care LTC Scores	CYE 2023 Program-Level Average	CYE 2024 Mercy Care LTC CAP Update
CC	100%	100%	NA
CIS	97%	98%	NA
CM	77%	86%	Met
DS	97%	94%	NA
GA	100%	100%	NA
GS	99.7%	99%	NA
MCH	89%	92%	Met
MM	97%	92%	NA
MI	97%	97%	NA
QM	84%	89%	Partially Met
QI	99%	98%	NA
RI	100%	100%	NA
TPL	100%	100%	NA
ISOC	98%	93%	NA

NA = Not applicable. A CAP was not required as the CYE 2023 score was 95% or above.
Partially Met = AHCCCS approved the Contractor's proposed CAP. The Contractor must submit evidence of compliance.
Met = AHCCCS accepted and closed the Contractor's CAP.

Strengths, Opportunities for Improvement, and Recommendations

Table 10-28 presents strengths, opportunities for improvement, and recommendations (as applicable) for Mercy Care LTC related to compliance, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-28—Mercy Care LTC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
Mercy Care LTC has successfully closed out CAPs in the following focus areas: • Case Management (CM) **[Quality, Access]** • Adult, EPSDT and Maternal Child Health (MCH) **[Quality, Timeliness, Access]**
Opportunities for Improvement and Recommendations
Mercy Care LTC has a remaining CAP in the following focus area: • Quality Management (QM) **[Quality]** Recommendation: HSAG recommends that Mercy Care LTC continue to work on the outstanding CAP item and submit updates to AHCCCS in the approved time frame, as applicable.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 10-29 presents compliance recommendations made to Mercy Care LTC in the CYE 2023 Annual Technical Report[229] and Mercy Care LTC's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 10-29—Mercy Care LTC's Follow-Up to CYE 2023 Compliance Recommendations

Prior Year's Recommendation From the EQR Technical Report for Compliance
HSAG recommended that Mercy Care LTC propose and implement CAPs for the CM, MCH, and QM focus areas as approved by AHCCCS.
Mercy Care LTC's Response:

[229] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for Compliance
Mercy Care LTC has completed all CAPs for the operational review. Mercy Care LTC continues to review policies, procedures and processes to ensure compliance with AHCCCS OR standards. Annual and ad hoc reviews are ongoing.
HSAG's Assessment: Based on the CAP closure for the CM and MCH, CAP acceptance for the QM focus area and the response provided, HSAG determined that Mercy Care LTC has satisfactorily addressed the prior year's recommendations related to compliance.

Network Adequacy Validation

ISCA Results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Mercy Care LTC's interpretation of data was accurate.

Table 10-30 summarizes HSAG's validation ratings for Mercy Care LTC by indicator type.

Table 10-30—Summary of Mercy Care LTC's Validation Ratings by Indicator Type

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

Of the network adequacy indicators assessed, Mercy Care LTC received *High Confidence* for both appointment availability and time/distance indicators. However, there were identified areas for improvement; please refer to the Contractor-specific Strengths, Opportunities for Improvement, and Recommendations section below for more details.

NAV Results

HSAG evaluated Mercy Care LTC's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents CYE 2024 S1 validation findings specific to the ALTCS-EPD Program, with one results table for the following GSA:

- Central GSA: Gila, Maricopa, and Pinal counties
- South GSA: Pima County

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

Table 10-31—Time/Distance Validation Results for Mercy Care LTC Central GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^[1]	99.6^[1]	100.0^[1]
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0*^[1]	98.8^[1]	100.0^[1]
BHRF	NA	99.8	NA
Cardiologist, Adult	100.0^	100.0^	100.0^
Cardiologist, Pediatric	100.0*^	100.0^	100.0^
Dentist, Pediatric	100.0*	98.2	100.0
Hospital	100.0[1]	100.0[1]	100.0[1]
Nursing Facility	100.0	99.9	100.0
OB/GYN	100.0*	100.0	100.0
Pharmacy	100.0	99.7	100.0
PCP, Adult	100.0^	99.9^	100.0^
PCP, Pediatric	100.0*^	99.6^	100.0^

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

* indicates that fewer than 10 members were included in the denominator of HSAG's results.

^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

[1] In CYE 2024 S1, Mercy Care LTC's data included substantially increased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; and Hospital. When contacted, Mercy Care LTC indicated that it inadvertently included home office addresses in its report of service addresses, raising the number of providers in the count. This potentially influenced the validated compliance for these provider categories.

Table 10-32—Time/Distance Validation Results for Mercy Care LTC South GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Pima
Behavioral Health Outpatient and Integrated Clinic, Adult	99.5^[1]
Behavioral Health Outpatient and Integrated Clinic, Pediatric	94.1^[1]
BHRF	97.4
Cardiologist, Adult	99.9^
Cardiologist, Pediatric	100.0^
Dentist, Pediatric	100.0
Hospital	99.8[1]
Nursing Facility	99.7
OB/GYN	100.0

Minimum Network Requirement	Pima
Pharmacy	99.4
PCP, Adult	99.6^
PCP, Pediatric	100.0^

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
[1] In CYE 2024 S1, Mercy Care LTC's data included substantially increased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; and Hospital. When contacted, Mercy Care LTC indicated that it inadvertently included home office addresses in its report of service addresses, raising the number of providers in the count. This potentially influenced the validated compliance for these provider categories.

Strengths, Opportunities for Improvement, and Recommendations

Table 10-33 presents strengths, opportunities for improvement, and recommendations (as applicable) for Mercy Care LTC related to NAV, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-33—Mercy Care LTC Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • Mercy Care LTC demonstrated its capability for ensuring the accuracy and completeness of its provider network by conducting rigorous quality assurance processes, including monthly provider data reconciliations, maintaining regular provider outreach and communication, and conducting annual audits of provider data. **[Access]** • Mercy Care LTC met all the minimum network requirements for all assigned counties. **[Access]** Note: Mercy Care LTC provides coverage in the following counties: Gila, Maricopa, Pima, and Pinal.
Opportunities for Improvement and Recommendations
HSAG identified the following opportunity for improvement: • HSAG identified an opportunity for Mercy Care LTC to improve the results to calculate time/distance indicators. **[Access]** Recommendation: HSAG recommends that Mercy Care LTC incorporate additional oversight and monitoring when transferring Quest-generated output to the ACOM Policy 436 template to ensure the most accurate results are being submitted to AHCCCS**.**

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 10-34 presents NAV recommendations made to Mercy Care LTC in the CYE 2023 Annual Technical Report[230] and Mercy Care LTC's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 10-34—Mercy Care LTC Follow-Up to CYE 2023 NAV Recommendations

Prior Year's Recommendation From the EQR Technical Report for NAV
While HSAG did not have any recommendations specific to Mercy Care LTC's existing provider network coverage, Mercy Care LTC should continue to maintain current compliance with network standards.
Mercy Care LTC's Response: Mercy Care LTC continues existing processes to ensure that the plan maintains compliance with the AHCCCS-required network coverage requirements.
HSAG's Assessment: HSAG has determined that Mercy Care LTC has satisfactorily addressed this prior year's recommendation.

[230] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

UHCCP LTC

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2024, HSAG evaluated UHCCP LTC's data system for processing of each data type used for reporting the Contractor's CY 2023 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that UHCCP LTC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 10-35 displays HSAG's PMV findings for each data type reviewed during CYE 2024 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 10-35—CYE 2024 PMV Findings

Data Type	HSAG Findings
Medical Services Data	*No identified concerns*
Enrollment Data	*No identified concerns*
Provider Data	*No identified concerns*
Medical Record Review Process	*No identified concerns*
Supplemental Data	*No identified concerns*
Data Integration	*No identified concerns*

Results for Performance Measures

Table 10-36 presents the CY 2022 and CY 2023 UHCCP LTC performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and MY 2023. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and/or MY 2023. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 10-36—CY 2021 and CY 2023 UHCCP LTC Performance Measure Results

Performance Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[1]
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	83.0%	88.3%	↑	★★★★★
Effective Continuation Phase Treatment—Total (18+ Years)	74.3%	77.3%	→	★★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	39.6%	26.1%	→	★
30-Day Follow-Up—Total (6+ Years)	66.0%	54.3%	→	★★
Use of Opioids at High Dosage				
*18+ Years**	10.8%	10.5%	→	★
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	55.8%	48.7%	↓	★★★
Engagement of SUD Treatment—Total—Total (13+ Years)	5.3%	6.8%	→	★
Care of Acute and Chronic Conditions				
Controlling High Blood Pressure				
18–85 Years[+]	72.5%[+]	73.7%[+]	→	★★★★★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0 Percent)—Total (18–75 Years)[+]	64.0%[+]	70.3%[+]	→	★★★★★
*HbA1c Poor Control (>9.0 Percent)—Total (18–75 Years)**[+]	27.0%[+]	21.9%[+]	→	★★★★★
Pediatric Health				
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	NA[++]	NA[++]	—	—
Oral Evaluation, Dental Services				
Total (0–20 Years)[N]	42.7%	45.8%	→	—
Well-Child Visits in the First 30 Months of Life				
First 15 Months—Six or More Well-Child Visits	NA[++]	NA[++]	—	—
15 Months to 30 Months—Two or More Well-Child Visits	NA[++]	NA[++]	—	—
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	44.8%	46.0%	→	★
Preventive Screening				

Performance Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison[1]	2023 Performance Level[1]
Breast Cancer Screening				
Total (50–74 Years)	41.6%	37.3%	→	★
Cervical Cancer Screening				
21–64 Years[+]	32.6%[+]	34.5%[+]	→	★
Appropriate Utilization of Services				
Ambulatory Care				
Emergency Department (ED) Visits—Total (0–85+ Years)[F]	787.6	877.3	—	—
Plan All-Cause Readmissions				
*Observed/Expected (O/E) Ratio—Total (18–64 Years)**	0.6241	0.6666	—	★★★★★

* A lower rate indicates better performance for this measure.
+ Indicates the measure was reported using hybrid methodology.
[++] NA indicates the denominator was too small to report a valid rate, based on the applicable measure specification.
Cells shaded green indicate that the rate met or exceeded the MY 2022 and/or MY 2023 national Medicaid mean.
— Indicates a 2022–2023 comparison is not presented in the CYE 2024 Annual Technical Report because either there was a break in trending, the CY 2021 rate was not presented in the CYE 2023 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
[1] Performance Levels for CY 2023 were based on comparisons of the HEDIS MY 2023 measure rates to national Medicaid Quality Compass HEDIS MY 2023 benchmarks.
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.
[N] Measure has no NCQA Medicaid mean for comparison.
↑ Indicates statistically significant improvement of measure rates.
↓ Indicates statistically significant decline of measure rates.
→ Indicates no statistically significant change in measure rates.
Performance Levels for 2023 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 10-37 presents strengths, opportunities for improvement, and recommendations (as applicable) for UHCCP LTC related to performance measures, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-37—UHCCP LTC Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group, three out of the seven measure indicators (42.86 percent) met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023, indicating strength in providing behavioral health treatment care to members. **[Quality, Timeliness, Access]** • *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total (18+ Years)* • *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* UHCCP LTC's performance measure rates for *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total (18+ Years)* met or exceeded the 90th percentile, indicating a strength in members starting and continuing antidepressant medication. **[Quality, Timeliness, Access]**
In the Care of Acute and Chronic Conditions measure group: • UHCCP LTC's performance measure rates for *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)—Total (18–75 Years)* and *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 %)—Total (18–75 Years)* were at or above the 90th percentile, indicating that most members with diabetes had controlled HbA1c levels most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[231] **[Quality]** • UHCCP LTC's performance measure rate for *Controlling High Blood Pressure—18–85 Years* was at or above the 90th percentile, indicating that most members with a diagnosis of hypertension had controlled blood pressure. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[232] **[Quality]**
In the Appropriate Utilization of Services measure group, UHCCP LTC's *Plan All-Cause Readmissions—O/E Ratio—Total (18–64 Years)* measure rate was at or above the 90th percentile, indicating that members were generally not experiencing unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay. **[Quality]**

[231] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Feb 19, 2025.
[232] National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Feb 19, 2025.

Strengths, Opportunities for Improvement, and Recommendations
Opportunities for Improvement and Recommendations
In the Preventive Screening measure group, UHCCP LTC's performance measure rates for *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* fell below the 25th percentile, indicating that women were not always receiving timely screening for breast and cervical cancer. Early detection reduces the risk of dying from cancer and can lead to a greater range of treatment options and lower healthcare costs. **[Quality]** Recommendation: While UHCCP LTC conducted a root cause analysis and implemented interventions specific to the *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* measures, these rates remained low in MY 2023. HSAG recommends that UHCCP LTC identify disparities or SDOH within the plan's populations that contributed to breast cancer and cervical cancer screening rates. Upon identification of a root cause, HSAG recommends that UHCCP LTC implement appropriate interventions to reduce barriers to care. Further, HSAG recommends that UHCCP LTC provide scheduled reminders, messages directly from providers, and utilize personalized outreach for overdue patients. Communication messages should be clear and concise and include information on the procedure time. Some of these interventions might include a mobile clinic to conduct the screening, transportation assistance, and adjusting hours for visits to accommodate those with job/childcare concerns.
In the Behavioral Health measure group, UHCCP LTC's performance measure rates for *Use of Opioids at High Dosage—18+ Years, Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Engagement of SUD Treatment—Total—Total (13+ Years), and Follow-Up After Hospitalization for Mental Illness 7-Day Follow-Up—Total (6+ Years)* fell below the 25th percentile. This result provides an opportunity for UHCCP LTC to monitor prescribing and utilization data and to implement interventions to improve care and services around opioid prescribing. **[Quality]** Recommendations: • Regarding the *Use of Opioids at High Dosage—18+ Years* measure, HSAG recommends that UHCCP LTC follow the CDC guidelines on opioid prescribing for chronic, nonmalignant pain, which recommend the use of "additional precautions" when prescribing dosages ≥50 MED and that providers avoid or "carefully justify" increasing dosages ≥90 mg MED.[233] In 2019, the authors of the 2016 guidelines published commentary that cautioned providers, systems, payers, and states from developing policies and practices that are "inconsistent with and go beyond" the guideline recommendations. The commentary included cautions regarding strict enforcement of dosage and duration thresholds, as well as abrupt tapering of opioids. The opioid dosage assessed in this measure is a reference point for health plans to identify members who may be at high risk for opioid overuse and misuse. HSAG recommends outreach to members who fall within this category to assess and schedule interventions as

[233] National Committee for Quality Assurance. Use of Opioids at High Dosage (HDO). Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/. Accessed on: Feb 19, 2025.

Strengths, Opportunities for Improvement, and Recommendations
necessary.[234] HSAG also recommends that UHCCP LTC identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts. • Regarding the *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Engagement of SUD Treatment—Total—Total (13+ Years) measure,* HSAG recommends UHCCP LTC review patient data for any patterns present by zip code and other demographics for case management prioritization. One study suggests that members who are male and have a schizophrenia spectrum disorder diagnosis are less likely to initiate treatment, while current drug dependence and recent arrest were associated with lowered odds of engaging in treatment. Current drug dependence is associated with factors that make scheduling and attending treatment appointments difficult, such as severe symptoms, chaotic living situations, and self-care and life functioning issues.[235] • Regarding the *Follow-Up After Hospitalization for Mental Illness 7-Day Follow-Up—Total (6+ Years)* measure, HSAG recommends that UHCCP LTC consider utilizing effective interventions to reduce repeat hospitalizations for people with mental illness, such as Critical Time Intervention (CTI), Assertive Community Treatment (ACT), case management, and focusing on co-occurring substance abuse disorders.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 10-38 presents performance measure recommendations made to UHCCP LTC in the CYE 2023 Annual Technical Report[236] and UHCCP LTC's follow-up to the recommendations, as well as an assessment of the degree to which UHCCP LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 10-38—UHCCP LTC Follow-Up to CYE 2023 Performance Measure Recommendations

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Recommendation 1:
While UHCCP LTC conducted a root cause analysis and implemented interventions specific to the *Breast Cancer Screening* measure, this rate remained low in CY 2022. HSAG therefore recommended that UHCCP LTC drill down into age, race, and ethnicity data as well as SDOH to assist in identifying

[234] National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/ Accessed on: Jan 19, 2025.
[235] Brown CH, Bennett ME, Li L, Bellack AS. Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders. *Addictive Behaviors.* 2010;36(5):439-47.
[236] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
any gaps in preventive care for both breast and cervical cancer screenings and continue to implement appropriate interventions to improve performance related to members' access to timely screenings for breast cancer. HSAG also recommended that UHCCP LTC monitor and expand on interventions currently in place to improve performance related to the *Breast Cancer Screening* measure and implement interventions for cervical cancer screening.

UHCCP LTC's Response:

The MY 2022 LTC *BCS* measure achieved its PIP goal of a statistically significant improvement from baseline, and the PIP workgroup and LTC team continued to work for rate improvement during MY 2023. The LTC population will likely never meet the NCQA Medicaid National Average rate and is probably an unrealistic metric based on limitations for this population.

- A new intervention was developed and implemented during late Q3 and Q4 MY 2023 (PDSA Cycle 1). UHCCP LTC identified members who should be excluded from the *BCS* measure based on their advanced illness and frailty (identified during return calls from ALFs/SNFs [assisted living facilities/skilled nursing facilities).UHCCP LTC developed and implemented provider education on the topic that included appropriate codes for claim submissions so that the exclusions could be obtained through claims data. The clinical practice consultants (CPCs) educated providers during Monthly Talking Points on this topic. The document was also posted to the UHC provider website for easy access. Additionally, verbiage on this topic was added to the annual BCS letter to the ALFs/SNFs which provides them a list of members who still need BCS and reminds and encourages them to get their patients' BCS completed.
- MY 2023 Effectiveness Analysis (PDSA Cycle 1 Study): Quantitative data were not available to measure outcomes; however, qualitative feedback was available. Calls were received from ALFs and SNFs regarding the letters that UHCCP LTC sent them reminding them of their residents still needing BCS and which provided information on the advanced illness and frailty exclusion. Three of the calls were from physician assistants (PAs) and a director of nursing (DON). All were appreciative of the advanced illness and frailty exclusion information and said it was helpful. One PA said that the provider was "coming in next week and I will be sure to address this with him," i.e., making sure the provider documents corresponding advanced illness and frailty codes on their claim submission it least annually to ensure the member is appropriately excluded from some HEDIS measures (*BCS*, *CBP*, and *HBD*). The LTC team agreed that when ALF/SNF facilitators are calling in now, they are asking about the advanced illness and frailty exclusion information (instead of just stating how the resident is on a ventilator, they now have actionable information).

The PIP workgroup also improved their effectiveness analysis on other interventions, and this allowed them to develop priorities based on top trends. For example, UHCCP's LTC high risk nurse manager performs annual live call outreach to members with BCS gaps in care in the Home and Community-Based Services (HCBS). PDSA Cycle 3 Study/Effectiveness Analysis (MY 2023) showed that there were 437 members listed in the HCBS category for LTC with BCS gaps in care. In total, 15.6 percent (68/437) of the members obtained a BCS and closed their quality care gap. A third of members were dropped from the measure (146/437) denoted as #N/A. For these members dropped from the measure, many were contacted, and here are some of the member or family member

Prior Year's Recommendation From the EQR Technical Report for Performance Measures

responses: Advanced illness, bedbound, unable to tolerate, hospice, deceased, hospitalized, and double mastectomy. The PIP workgroup concluded the advanced illness and frailty education helped to remove some members from the measure. Of the 437 members, 269 were contacted, but only 94 committed to obtaining a BCS during their phone outreach. Of those 94, 26 (27.7 percent) completed a BCS in MY 2023, 52 (55.3 percent) still have open gaps in care, and the high-risk nurse manager is going to focus on these members first/next.

For the 2023 LTC BCS Member Rewards Program, PDSA Cycle 3 Study/Effectiveness Analysis (MY 2023): Letters/emails were sent to 416 LTC members (with BCS open gaps in care) educating members on BCS and informing them of their eligibility for a gift card for completion of their BCS. During 2023, the PIP workgroup and LTC team increased outreach to members to assist them with understanding the information contained in the member rewards letters and helped some members with the attestation/redemption process in MY 2023. The redemption report showed that 1.4 percent LTC members redeemed their reward, which is better than the previous year (0.0 percent), and likely due to the increased CM member outreach and assistance regarding the rewards program. Further effectiveness analysis showed of the 416 LTC members sent BCS reward information, 57 members (13.7 percent) obtained BCS (closed care gaps), 89 (21.4 percent) dropped from the measure (no longer met criteria to be in the measure), while 270 (64.9 percent) still had open gaps in care as of February 2024 when the effectiveness analysis was completed. The PIP workgroup agreed to continue this intervention in MY 2024 (PDSA Cycle 4).

During 2023, UHCCP LTC began a collaborative project with the American Cancer Society (ACS) and recently finalized a co-branded BCS letter for members. The intent of the letter is to educate members on the importance of their BCS with the strength and backing of the ACS (co-branded letter with the ACS logo) and therefore remind and encourage members to get their BCS. UHCCP LTC anticipates intervention implementation (PDSA Cycle 1: Do) during MY 2025.

The MY 2023 final BCS rate did not achieve the PIP goal of a statistically significant improvement in spite of increased efforts of the LTC team/CMs, CPCs, QM outreach team, PIP workgroup, and the measure becoming an Electronic Clinical Data Systems (ECDS) measure. The LTC BCS MY 2023 final rate was lower than expected. The only thing that changed was the measure became an ECDS only measure. UHCCP LTC is working to improve data exchange with provider groups, including the use of data aggregators and provider education.

Cervical Cancer Screening (CCS)

Currently, UHCCP LTC conducts member outreach for the *CCS* performance measure for any member with an open care gap via the QM team with letters and live phone calls educating members on the importance of CCS and assisting them with scheduling appointments.

UHCCP LTC is implementing a CCS PIP Q42024 and will be conducting a root cause analysis (RCA), identifying barriers to achieving CCS, and developing interventions. One intervention already

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
in development is the ACS co-branded member material which includes both BCS and CCS member letters co-branded with ACS. Both *CCS* and *BCS* measures were part of the 2022 and 2023 UHCCP Health Disparities Summary & Evaluation Annual Report submitted to AHCCCS. For this report, member data have been analyzed by several different sub-populations, including race and ethnicity. Root cause and barriers were investigated and identified, and interventions developed and implemented to address the findings. Although, no significant health disparities were identified for the MY 2022 BCS analysis, an annual follow-up analysis was completed during MY 2023. Findings: Black or African American members had a better *BCS* compliance rate (28.6 percent) compared to the White *BCS* compliance rate (25.2 percent); however, no statistical significance was identified (*p* value 0.6803). The analysis by ethnicity revealed that the Hispanic or Latina ethnic group had a much better *BCS* rate (69.2 percent) compared to the Not Hispanic or Latina ethnic group (36.7 percent). This finding was statistically significant (*p* value 0.0015). Based on literature review which identified that Black or African Americans have disproportionate *BCS* and *CCS*, UHCCP LTC performed member outreach via reminder letters in July and follow-up letters in October for Black or African American women for both *CCS* and *BCS*. UHCCP LTC also conducted member outreach via live calls to Black or African American members in need of BCS and CCS. Other interventions already in place were reviewed to ensure all sub-populations are receiving interventional information.
HSAG's Assessment: UHCCP LTC implemented interventions to improve performance on this measure even though performance did not improve in MY 2023; therefore, HSAG determined that Mercy Care LTC satisfactorily addressed these prior year's recommendations.
Recommendation 2:
HSAG recommended that UHCCP LTC conduct a drill-down analysis or focus study of age, race, and ethnicity and SDOH to determine why there is a higher proportion of members receiving prescriptions for opioids. Upon identification of a root cause, HSAG recommended that UHCCP LTC implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse and potentially implement other treatment options.
UHCCP LTC's Response: UHCCP LTC completed a drill down to assess why members were not receiving timely SUD services or MAT following their initiation visit. The data did not reveal any insight into significant factors that could be affecting this measure. UHCCP LTC will continue to work with providers and provide guidance based on best practices and education from the CDC. UHCCP LTC encourages prescribers to follow the CDC guidelines on opioid prescribing for chronic, nonmalignant pain. UHCCP LTC provides provider education through various platforms including the UHCCP Provider Manual, uhcprovider.com website, Network Bulletins, mailings, and direct outreach. Education includes directing prescribers to the current "CDC Guidelines for Prescribing

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Opioid for Chronic Pain," "CDC Opioid Overdose Guidelines Resources," as well as the "Arizona Department of Health Services Opioid Prescribing guidelines" webpages. UHCCP LTC implements multiple utilization management (UM) strategies as required by federal and state legislation as well as AHCCCS policy including federal opioid legislation (42 U.S.C. 1396A[OO]) monitoring requirements, Federal Opioid safety edits at the Point-of-Sale, Arizona Revised Statute 32-3248.01 requirements for when a healthcare professional may write for a prescription that is more than 90 MME per day, AHCCCS prior authorization requirement for all long-acting opioid prescription medications unless the member meets certain diagnosis exceptions, AHCCCS 5-Day supply limit of prescription short acting opioid medications with exceptions for certain conditions and care instances. Per the HSAG recommendation: "HSAG recommends outreach to members who fall within this category to assess and schedule interventions as necessary," UHCCP LTC reviewed and considered this recommendation and who would be best suitable to impact member interventions. Upon that consideration, UHCCP LTC will outreach to member's prescribers where the member is in the performance measure *Use of Opioids at High Dosage—18+ Years* to provide additional education to the prescriber and to request that the prescriber assess the member's use of opioids and schedule additional interventions as necessary.
HSAG's Assessment: UHCCP LTC implemented interventions to improve performance on this measure even though performance did not improve in MY 2023; therefore, HSAG determined that Mercy Care LTC satisfactorily addressed these prior year's recommendations.
Recommendation 3:
HSAG recommends that UHCCP LTC conduct a drill-down analysis based on race, ethnicity, and age stratifications to determine why members were not receiving timely SUD services or MAT following their initiation visit. UHCCP LTC should consider the nature and scope of the issues (e.g., the issues are 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. Upon identification of a root cause, UHCCP LTC should implement interventions that address the identified root cause of the low rate, targeting the interventions so that UHCCP LTC improves performance related to initiating and engaging in timely treatment following a new episode of SUD dependence.
UHCCP LTC's Response: Based on a thorough analysis of age, race, ethnicity, and LTC placement type, UHCCP LTC has found no significant correlations between race or ethnicity and the identified trends. However, age trends show that members ages 61 years and above make up 66 percent of the LTC population diagnosed with substance use disorders, and 10 percent of this cohort is aged 80 and above. Members ages 51–60 were the next largest group by age, and members ages 50 and below comprised just 0.2

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
percent of the total. The ages of this largest, 61-years-and-above cohort indicate a population that is generally less ambulatory than the younger groups and potentially less able to obtain their own substances. In the ages 61 years and above population, opioids and alcohol are the primary types of substance use diagnoses; opioid use disorders at 51 percent and alcohol use disorders at 32 percent. Thirty-seven percent of the members ages 61 and above (111), or 25 percent of the total cohort, live in care facilities where access to alcohol or non-prescribed substances would likely be less available. This placement trend and the limited ambulatory abilities of the cohort raise concerns about appropriate diagnosing of current or active substance use disorders. To address the findings of this root cause analysis, interventions include outreach and education, including: • Increasing awareness in adult care facilities of the potential misdiagnosis of substance use in residents. • Training and support for LTC assigned UHCCP case managers to gather information on members' current use and actual access to alcohol and non-prescription substances, and to advocate with members' medical providers to ensure members' SUD diagnoses are based on current information. • Educating medical providers about diagnosing substance use disorders and the proper use of SUD remission codes. At 41 percent, outpatient treatment is the second most frequent setting that diagnoses members with substance use disorders, though inpatient hospitals are slightly higher at 43 percent. Medical outpatient treatment comprises 87 percent of the outpatient SUD diagnoses given to LTC members. The medical outpatient engagement rate is 1.3 percent compared with a 20.8 percent engagement rate in the outpatient mental health setting. This additional root cause reinforces the need for information and education to medical providers on diagnosing substance use disorders, proper use of SUD remission codes, and how to refer for outpatient SUD treatment.
HSAG's Assessment: UHCCP LTC implemented interventions to improve performance on this measure even though performance did not improve in MY 2023; therefore, HSAG determined that UHCCP LTC satisfactorily addressed these prior year's recommendations.

Validation of Performance Improvement Projects

In CY 2024, UHCCP LTC continued the *Breast Cancer Screening* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 2, PIP validation activities focused on improvement from the baseline results. UHCCP LTC submitted Remeasurement 2 performance indicator results and interventions implemented during this validation year along with the status of interventions, focus, and rationale for changes to or discontinuation of the interventions.

HSAG conducted an annual validation of the second remeasurement year reflective of CY 2023 (January 1, 2023, through December 31, 2023) using AHCCCS-calculated and validated indicator rates. HSAG evaluated UHCCP LTC's performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

Validation Results

Table 10-39 displays the overall confidence levels for the UHCCP LTC *Breast Cancer Screening* PIP.

Table 10-39—UHCCP LTC *Breast Cancer Screening* PIP Overall Confidence Levels

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]
UHCCP LTC	*High Confidence*	100%	100%	*High Confidence*	75%	100%

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

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

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

Measure Results

Table 10-40 provides the *Breast Cancer Screening* PIP baseline, Remeasurement Year 1, and Remeasurement Year 2 rates for UHCCP LTC.

Table 10-40—UHCCP LTC *Breast Cancer Screening* PIP Rates

Contractor	PIP Indicator: *Breast Cancer Screening*		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
UHCCP LTC	34.1%	41.6%	37.3%

HSAG rounded percentages to the first decimal place.

Interventions

Table 10-41 presents PIP interventions for UHCCP LTC. Language in the PIP interventions section is minimally edited and generally reflective of the language provided by the Contractor.

Table 10-41—UHCCP LTC *Breast Cancer Screening* PIP Interventions

Contractor	Intervention
UHCCP LTC	• Letter to SNFs and ALFs. The letter identified members with a BCS gap and provided BCS education information. • High risk nurse manager call outreach and survey to members with gaps in care in the HCBS to provide BCS education. • Case managers provided BCS education to members with gaps in care during their assessments. • AZ Medicaid Savings Aggregation Letter "Earn bonuses through the UnitedHealthcare Community Plan Shared Savings Program." • CPCs Monthly Talking Points and Provider Care Opportunities Report (PCOR). • Community Plan Primary Care Professional Incentive (CP-PCPi). • Case managers authorized additional time for direct care workers to assist in coordinating trips to preventive screenings and physician offices. • Member gift card incentive/reward letter mailed to members with gaps in care. • mPulse OmniChannel Member Outreach: IVR, email, and SMS. • CM Education: BCS Education Series annually. • LTC member newsletter with BCS education. • TTEC member live calls. • QM mailings: BCS reminder letters (July) and follow-up letters (October) to Black or African American members with BCS gaps in care. • QM Calls: Health Disparities: BCS Black/African American members. • Advanced illness and frailty exclusion.

Strengths, Opportunities for Improvement, and Recommendations

Table 10-42 presents strengths, opportunities for improvement, and recommendations (as applicable) for UHCCP LTC related to the *Breast Cancer Screening* PIP, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-42—UHCCP LTC Strengths, Opportunities for Improvement, and Recommendations Related to the *Breast Cancer Screening* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
UHCCP LTC adhered to acceptable methodology through all phases of the PIP. The Contractor achieved improvement between the baseline rate and the Remeasurement 2 rate for the *BCS* performance indicator. **[Quality, Access]**
Opportunities for Improvement and Recommendations
HSAG identified no opportunities for improvement related to the *Breast Cancer Screening* PIP: Recommendation: Although there were no opportunities for improvement identified, as the PIP progresses, HSAG recommends that UHCCP LTC: • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 10-43 presents PIP recommendations made to UHCCP LTC in the CYE 2023 Annual Technical Report[237] and UHCCP LTC's follow-up to the recommendations, as well as an assessment of the degree to which UHCCP LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 10-43—UHCCP LTC Follow-Up to CYE 2023 PIP Recommendations

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG recommended that UHCCP LTC: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions as necessary to sustain improvement. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. • Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.
UHCCP LTC's Response:

[237] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for PIPs

The MY 2022 LTC *BCS* measure achieved its PIP goal of a statistically significant improvement from baseline, and the PIP workgroup and LTC team continued to work for rate improvement during MY 2023. The LTC population will likely never meet the NCQA Medicaid National Average rate and is probably an unrealistic metric based on limitations for this population.

The PIP workgroup and LTC team identified that there were members in the measure who should not be due to their eligibility for the NCQA HEDIS advanced illness and frailty exclusion. They reviewed their root cause analysis, updated the Ishakawa fish diagram, and collaborated to identify interventions to address this newly identified barrier.

- A new intervention was developed and implemented during late Q3 and Q4 MY 2023 (PDSA Cycle 1). UHCCP LTC identified members who should be excluded from the *BCS* measure based on their advanced illness and frailty (identified during return calls from ALFs/SNFs). UHCCP LTC developed and implemented provider education on the topic that included appropriate codes for claim submissions so that the exclusions could be obtained through claims data. The CPCs educated providers during monthly talking points on this topic. The document was also posted to the UHC provider website for easy access. Additionally, verbiage on this topic was added to the annual BCS letter to the ALFs/SNFs which provides them a list of members who still need BCS and reminds and encourages them to get their patients' BCS completed.
- MY 2023 Effectiveness Analysis (PDSA Cycle 1 Study): Quantitative data were not available to measure outcomes; however, qualitative feedback was available. Calls were received from ALFs and SNFs regarding the letters that UHCCP LTC sent them reminding them of their residents still needing BCS and which provided information on the advanced illness and frailty exclusion. Three of the calls were from PAs and a DON. All were appreciative of the advanced illness and frailty exclusion information and said it was helpful. One PA said that the provider was "coming in next week and I will be sure to address this with him," i.e., making sure the provider documents corresponding advanced illness and frailty codes on their claim submission it least annually to ensure the member is appropriately excluded from some HEDIS measures (*BCS*, *CBP*, and *HBD*). The LTC team agreed that when ALF/SNF facilitators are calling in now, they are asking about the advanced illness and frailty exclusion information (instead of just stating how the resident is on a ventilator, they now have actionable information).
- The PIP workgroup also improved their effectiveness analysis on other interventions, and this allowed them to develop priorities based on top trends. For example, UHCCP's LTC high risk nurse manager performs annual live call outreach to members with BCS gaps in care in the HCBS. PDSA Cycle 3 Study/Effectiveness Analysis (MY 2023) showed that there were 437 members listed in the HCBS category for LTC with BCS gaps in care. In total, 15.6 percent (68/437) of the members obtained a BCS and closed their quality care gap. A third of members were dropped from the measure (146/437) denoted as #N/A. For these members dropped from the measure, many were contacted, and here are some of the member or family member responses: advanced illness, bedbound, unable to tolerate, hospice, deceased, hospitalized, and double mastectomy. The PIP workgroup concluded the advanced illness and frailty education helped to remove some members from the measure. Of the 437 members, 269 were contacted, but only 94 committed to obtaining a BCS during their phone outreach. Of those 94, 26 (27.7 percent) completed a BCS in

Prior Year's Recommendation From the EQR Technical Report for PIPs
MY 2023; 52 (55.3 percent) still have open gaps in care; and the high risk nurse manager is going to focus on these members first/next. • For the 2023 LTC BCS Member Rewards Program, PDSA Cycle 3 Study/Effectiveness Analysis (MY 2023): Letters/emails were sent to 416 LTC members (with BCS open gaps in care), educating members on BCS and informing them of their eligibility for a gift card for completion of their BCS. During 2023, the PIP workgroup and LTC team increased outreach to members to assist them with understanding the information contained in the member rewards letters and helped some members with the attestation/redemption process in MY 2023. The redemption report showed that 1.4 percent LTC members redeemed their reward, which is better than the previous year (0.0 percent), and likely due to the increased CM member outreach and assistance regarding the rewards program. Further effectiveness analysis showed of the 416 LTC members sent BCS reward information, 57 members (13.7 percent) obtained BCS (closed care gaps), 89 (21.4 percent) dropped from the measure (no longer met criteria to be in the measure), while 270 (64.9 percent) still had open gaps in care as of February 2024 when the effectiveness analysis was completed. The PIP workgroup agreed to continue this intervention in MY 2024 (PDSA Cycle 4). • During 2023, UHCCP LTC began a collaborative project with the American Cancer Society (ACS) and recently finalized a co-branded BCS letter for members. The intent of the letter is to educate members on the importance of their BCS with the strength and backing of the ACS (co-branded letter with the ACS logo) and therefore remind and encourage members to get their BCS. UHCCP LTC anticipates intervention implementation (PDSA Cycle 1: Do) during MY 2025. • The MY 2023 final BCS rate did not achieve the PIP goal of a statistically significant improvement in spite of increased efforts of the LTC team/CMs, CPCs, QM outreach team, PIP workgroup, and the measure becoming an ECDS measure. The LTC BCS MY 2023 final rate was lower than expected. The only thing that changed was the measure became an ECDS only measure. UHCCP LTC is working to improve data exchange with provider groups, including the use of data aggregators and provider education. **Cervical Cancer Screening (CCS)** • Currently, UHCCP LTC conducts member outreach for the CCS performance measure for any member with an open care gap via the QM team with letters and live phone calls educating members on the importance of CCS and assisting them with scheduling appointments. UHCCP is implementing a CCS PIP Q4 2024 and will be conducting RCA, identifying barriers to achieving CCS, and developing interventions. One intervention already in development is the ACS co-branded member material which includes both BCS and CCS member letters co-branded with ACS. • Both CCS and BCS measures were part of the 2022 and 2023 UHCCP Health Disparities Summary & Evaluation Annual Report submitted to AHCCCS. For this report, member data have been analyzed by several different subpopulations, including race and ethnicity. Root cause and barriers were investigated and identified, and interventions developed and implemented to address the findings. Although, no significant health disparities were identified for the MY 2022 BCS

Prior Year's Recommendation From the EQR Technical Report for PIPs
analysis, an annual follow-up analysis was completed during MY 2023. Findings: Black or African American members had a better BCS compliance rate (28.6 percent) compared to the White BCS compliance rate (25.2 percent); however, no statistical significance was identified (*p* value 0.6803). The analysis by ethnicity revealed that the Hispanic or Latina ethnic group had a much better BCS rate (69.2 percent) compared to the Not Hispanic or Latina ethnic group (36.7 percent). This finding was statistically significant (*p* value 0.0015). Based on literature review which identified that Black or African Americans have disproportionate BCS and CCS, UHCCP LTC performed member outreach via reminder letters in July and follow-up letters in October for Black or African American women for both CCS and BCS. UHCCP LTC also conducted member outreach via live calls to Black or African American members in need of BCS and CCS. Other interventions already in place were reviewed to ensure all subpopulations are receiving interventional information.
HSAG's Assessment: HSAG has determined that UHCCP LTC has satisfactorily addressed these prior year's recommendations.

Compliance Reviews

Results

AHCCCS conducted a compliance review of UHCCP LTC in CYE 2023. On May 17, 2023, AHCCCS accepted UHCCP LTC's proposed CAPs and required the Contractor to submit updated policies, manuals, desktop procedures, and other vital documents to provide evidence of CAP completion. On June 3, 2024, UHCCP LTC submitted updated CAP documentation to AHCCCS for review. The remaining CAP items were under review by AHCCCS at the time this report was written. Additional results of the CAP update will be included in the CYE 2025 annual technical report. Table 10-44 presents the updated CYE 2024 compliance review results for UHCCP LTC.

Table 10-44—UHCCP LTC Compliance Review Results

Focus Areas	CYE 2023 UHCCP LTC Scores	CYE 2023 Program-Level Average	CYE 2024 UHCCP LTC CAP Update
CC	100%	100%	NA
CIS	99%	98%	NA
CM	87%	86%	Partially Met
DS	98%	94%	NA
GA	100%	100%	NA
GS	100%	99%	NA
MCH	90%	92%	Met

Focus Areas	CYE 2023 UHCCP LTC Scores	CYE 2023 Program-Level Average	CYE 2024 UHCCP LTC CAP Update
MM	96%	92%	NA
MI	97%	97%	NA
QM	95%	89%	Partially Met
QI	100%	98%	NA
RI	100%	100%	NA
TPL	100%	100%	NA
ISOC	85%	93%	Met

NA = Not applicable. A CAP was not required as the CYE 2023 score was 95% or above.
Partially Met = AHCCCS approved the Contractor's proposed CAP. The Contractor must submit evidence of compliance.
Met = AHCCCS accepted and closed the Contractor's CAP.

Strengths, Opportunities for Improvement, and Recommendations

Table 10-45 presents strengths, opportunities for improvement, and recommendations (as applicable) for UHCCP LTC related to compliance, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-45—UHCCP LTC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
UHCCP LTC has successfully closed out CAPs in the following focus areas: • Adult, EPSDT and Maternal Child Health (MCH) **[Quality, Timeliness, Access]** • Integrated Systems of Care (ISOC) **[Quality, Access]**
Opportunities for Improvement and Recommendations
UHCCP LTC has remaining CAPs in the following focus areas: • Case Management (CM) **[Quality, Access]** • Quality Management (QM) **[Quality]** Recommendation: HSAG recommends that UHCCP LTC continue to work on the outstanding CAP items and submit updates to AHCCCS in the approved time frame, as applicable.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 10-46 presents compliance recommendations made to UHCCP LTC in the CYE 2023 Annual Technical Report[238] and UHCCP LTC's follow-up to the recommendations, as well as an assessment of the degree to which UHCCP LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 10-46—UHCCP LTC's Follow-Up to CYE 2023 Compliance Recommendations

Prior Year's Recommendation From the EQR Technical Report for Compliance
HSAG recommended that UHCCP LTC propose and implement CAPs for the CM, MCH, and ISOC focus areas as approved by AHCCCS.
UHCCP LTC's Response: UHCCP LTC implemented and remediated CAPs for the CM, MCH, and ISOC focus areas that were listed under HSAG recommendations. All LTC CAPs were approved and closed by AHCCCS on October 10, 2024.
HSAG's Assessment: Based on the CAP closure for the CM, MCH, QM, and ISOC focus areas, and the response provided, HSAG determined that UHCCP LTC has satisfactorily addressed the prior year's recommendations related to compliance.

Network Adequacy Validation

ISCA Results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and whether UHCCP LTC's interpretation of data was accurate.

Table 10-47 summarizes HSAG's validation ratings for UHCCP LTC by indicator type.

Table 10-47—Summary of UHCCP LTC's Validation Ratings by Indicator Type

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

[238] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

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

Of the network adequacy indicators assessed, UHCCP LTC received *High Confidence* for both appointment availability and time/distance indicators. However, there were identified areas for improvement; please refer to the Contractor-specific Strengths, Opportunities for Improvement, and Recommendations section below for more details.

NAV Results

HSAG evaluated UHCCP LTC's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents CYE 2024 S1 validation findings specific to the ALTCS-EPD Program, with one results table for each of the following GSAs:

- Central GSA: Gila, Maricopa, and Pinal counties
- North GSA: Apache, Coconino, Mohave, Navajo, and Yavapai counties

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

Table 10-48—Time/Distance Validation Results for UHCCP LTC Central GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^	98.3^	100.0^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR*^	98.7^	100.0*^
BHRF	NA	96.5	NA
Cardiologist, Adult	100.0^	99.9^	100.0^
Cardiologist, Pediatric	NR*^	100.0^	100.0*^
Dentist, Pediatric	NR*	99.0	100.0*
Hospital	100.0	99.9	100.0
Nursing Facility	100.0	99.7	100.0
OB/GYN	100.0*	100.0	100.0
Pharmacy	100.0	99.5	100.0
PCP, Adult	100.0^	99.8^	100.0^
PCP, Pediatric	NR*^	100.0^	100.0*^

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

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

* indicates that fewer than 10 members were included in the denominator of HSAG's results.

^indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

Table 10-49—Time/Distance Validation Results for UHCCP LTC North GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Apache	Coconino	Mohave	Navajo	Yavapai
Behavioral Health Outpatient and Integrated Clinic, Adult	94.2^	93.9^	98.7^	99.2^	100.0^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0*^	100.0*^	100.0*^	100.0*^	100.0^
BHRF	NA	NA	NA	NA	NA
Cardiologist, Adult	94.2^	100.0^	100.0^	99.6^	100.0^
Cardiologist, Pediatric	100.0*^	100.0*^	100.0*^	100.0*^	100.0^
Dentist, Pediatric	100.0*	100.0*	100.0*	100.0*	100.0
Hospital	100.0	100.0	99.9	100.0	100.0
Nursing Facility	95.5	90.3	97.2	98.5	99.8
OB/GYN	100.0*	100.0*	100.0	100.0	100.0
Pharmacy	98.6	100.0	99.8	99.6	99.8
PCP, Adult	94.2^	100.0^	99.8^	100.0^	100.0^
PCP, Pediatric	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.

* indicates that fewer than 10 members were included in the denominator of HSAG's results.

^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

Strengths, Opportunities for Improvement, and Recommendations

Table 10-50 presents strengths, opportunities for improvement, and recommendations (as applicable) for UHCCP LTC related to NAV, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 10-50—UHCCP LTC Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • UHCCP LTC had processes in place to maintain accurate and complete provider data, including a quarterly attestation process, secret shopper campaigns, and quality assurance reviews. **[Access]** • UHCCP LTC met all minimum network requirements for all assigned counties. **[Access]** Note: UHCCP LTC provides coverage in the following counties: Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal, and Yavapai.
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: • UHCCP LTC had a high level of compliance mismatch between its submitted results and HSAG's calculated results. **[Access]** Recommendation: HSAG recommends that UHCCP continue to work with AHCCCS and HSAG to reduce the amount of compliance discrepancies**.** • HSAG identified an opportunity to improve the results to calculate time/distance indicators for UHCCP LTC. **[Access]** Recommendation: HSAG recommends that UHCCP LTC incorporate additional oversight and monitoring when transferring Quest-generated output to the ACOM Policy 436 template to ensure the most accurate results are being submitted to AHCCCS.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 10-51 presents NAV recommendations made to UHCCP LTC in the CYE 2023 Annual Technical Report[239] and UHCCP LTC's follow-up to the recommendations, as well as an assessment of the degree to which UHCCP LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

[239] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

Table 10-51—UHCCP LTC Follow-Up to CYE 2023 NAV Recommendations

Prior Year's Recommendation From the EQR Technical Report for NAV
HSAG recommended the following to UHCCP LTC: • Maintain current compliance with network standards but continue to address network gaps, as applicable.
UHCCP LTC's Response: UHCCP LTC evaluates the contracted network quarterly via the quarterly PAT File monitoring and review process. When gaps in the network are identified, UHCCP LTC conducts a review of the area and category that has underperformed. A thorough audit of the provider community is conducted and includes noncontracted providers, and any new providers who enter the county. UHCCP LTC will continue to monitor and review the PAT file for any opportunities to our network quarterly.
HSAG's Assessment: HSAG has determined that UHCCP LTC has satisfactorily addressed these prior year's recommendations.

11. ALTCS-DD Program Results

The **ALTCS-DD Program** Contractor, DES/DDD, provides integrated physical health and behavioral health services through two subcontracted health plans, Mercy Care DD and UHCCP DD.

This section provides, by EQR activity, ALTCS-DD activity-specific strengths, opportunities for improvement, and HSAG's recommendations for performance improvement. This section also includes information about the extent to which DES/DDD was able to address the prior's year recommendations for each activity.

ALTCS-DD Program

Validation of Performance Measures

Results for Information Systems Standards Review

During CYE 2024, HSAG evaluated DES/DDD's data system for processing of each data type used for reporting the Contractor's CY 2023 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that DES/DDD followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 11-1 displays HSAG's PMV findings for each data type reviewed during CYE 2024 in alignment with the CMS EQR Protocol 2 audit requirements.

Table 11-1—CYE 2024 PMV Findings

Data Type	HSAG Findings
Medical Services Data	*No identified concerns*
Enrollment Data	*No identified concerns*
Provider Data	*No identified concerns*
Medical Record Review Process	*No identified concerns*
Supplemental Data	*No identified concerns*
Data Integration	*No identified concerns*

Results for Performance Measures

Table 11-2 presents the CY 2023 performance measure results for ALTCS-DD. Performance measure rate cells shaded green indicate that DES/DDD met or exceeded the NCQA Quality Compass national

Medicaid HMO mean for HEDIS MY 2023. Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 11-2—CY 2023 DES/DDD Performance Measure Results

Measure	CY 2023 Performance
Behavioral Health	
Antidepressant Medication Management	
Effective Acute Phase Treatment—Total (18+ Years)	65.1%
Effective Continuation Phase Treatment—Total (18+ Years)	53.3%
Follow-Up After Hospitalization for Mental Illness	
7-Day Follow-Up—Total (6+ Years)	69.9%
30-Day Follow-Up—Total (6+ Years)	87.1%
Use of Opioids at High Dosage	
*18+ Years**	4.5%
Initiation and Engagement of Substance Use Disorder Treatment	
Initiation of SUD Treatment—Total—Total (13+ Years)	41.0%
Engagement of SUD Treatment—Total—Total (13+ Years)	10.1%
Care of Acute and Chronic Conditions	
Controlling High Blood Pressure	
18–85 Years	78.8%+
Hemoglobin A1c Control for Patients With Diabetes	
HbA1c Control (<8.0 Percent)—Total (18–75 Years)	75.5%+
*Poor HbA1c Control (>9.0 Percent)—Total (18–75 Years)**	19.0%+
Pediatric Health	
Metabolic Monitoring for Children and Adolescents on Antipsychotics	
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	47.9%
Childhood Immunization Status**	
Combination 3	66.7%+
Combination 7	33.3%+
Combination 10	24.8%+
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	83.9%+
Combination 2 (Meningococcal, Tdap, HPV)	30.2%+
Oral Evaluation, Dental Services	
Total (0–20 Years)^{N}	50.9%
Well-Child Visits in the First 30 Months of Life	
First 15 Months—Six or More Well-Child Visits	NA++
15 Months to 30 Months—Two or More Well-Child Visits	69.9%
Child and Adolescent Well-Care Visits	
Total (3–21 Years)	57.1%

Measure	CY 2023 Performance
Preventive Screening	
Breast Cancer Screening	
Total (50–74 Years)	50.8%
Cervical Cancer Screening	
21–64 Years	23.8%+
Appropriate Utilization of Services	
Ambulatory Care	
*Emergency Department (ED) Visits—Total (0–85+ Years)*F	423.2
Plan All-Cause Readmissions	
*Observed/Expected (O/E) Ratio—Total (18–64 Years)**	1.0067

* A lower rate indicates better performance for this measure.
** Table A-2 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
+ Indicates the measure was reported using hybrid methodology.
++ NA indicates the denominator was too small to report a valid rate, based on the applicable measure specification.
F NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months.
N Measure has no NCQA Medicaid mean for comparison.
Cells shaded green indicate that the rate met or exceeded the MY 2023 national Medicaid mean.

Table 11-3 presents the CY 2022 and CY 2023 DES/DDD results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2023. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 11-3—CY 2022 and CY 2023 DES/DDD Performance Measure Results

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison	2023 Performance Level[1]
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total (18+ Years)	67.5%	65.1%	→	★★★
Effective Continuation Phase Treatment—Total (18+ Years)	55.8%	53.3%	→	★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total (6+ Years)	69.7%	69.9%	→	★★★★★
30-Day Follow-Up—Total (6+ Years)	85.0%	87.1%	→	★★★★★
Use of Opioids at High Dosage				
*18+ Years**	3.6%	4.5%	→	★★

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison	2023 Performance Level[1]
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation of SUD Treatment—Total—Total (13+ Years)	41.3%	41.0%	→	★★
Engagement of SUD Treatment—Total—Total (13+ Years)	8.7%	10.1%	→	★★
Care of Acute and Chronic Conditions				
Controlling High Blood Pressure				
18–85 Years^{+}	78.0%$^{+}$	78.8%$^{+}$	→	★★★★★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0 Percent)—Total (18–75 Years)$^{+}$	72.3%$^{+}$	75.5%$^{+}$	→	★★★★★
HbA1c Poor Control (>9.0 Percent)—Total (18–75 Years)$^{+}$*	20.6%$^{+}$	19.0%$^{+}$	→	★★★★★
Pediatric Health				
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	50.4%	47.9%	→	★★★★
Childhood Immunization Status**				
Combination 3^{+}	62.0%$^{+}$	66.7%$^{+}$	→	★★★
Combination 7^{+}	30.0%$^{+}$	33.3%$^{+}$	→	★
Combination 10^{+}	22.0%$^{+}$	24.8%$^{+}$	→	★★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)$^{+}$	80.5%$^{+}$	83.9%$^{+}$	→	★★★
Combination 2 (Meningococcal, Tdap, HPV)$^{+}$	32.8%$^{+}$	30.2%$^{+}$	→	★★
Oral Evaluation, Dental Services				
Total (0–20 Years)^{N}	49.9%	50.9%	→	—
Well-Child Visits in the First 30 Months of Life				
First 15 Months—Six or More Well-Child Visits	NA^{++}	NA^{++}	—	—
15 Months to 30 Months—Two or More Well-Child Visits	63.8%	69.9%	→	★★★
Child and Adolescent Well-Care Visits				
Total (3–21 Years)	54.4%	57.1%	↑	★★★
Preventive Screening				
Breast Cancer Screening				
Total (50–74 Years)	51.4%	50.8%	→	★★
Cervical Cancer Screening				
21–64 Years^{+}	20.7%$^{+}$	23.8%$^{+}$	→	★

Measure	CY 2022 Performance	CY 2023 Performance	CY 2022–2023 Comparison	2023 Performance Level[1]
Appropriate Utilization of Services				
Ambulatory Care				
Emergency Department (ED) Visits —Total (0–85+ Years)[F]	412.1	423.2	—	—
Plan All-Cause Readmissions				
*Observed/Expected (O/E) Ratio—Total (18–64 Years)**	0.8769	1.0067	—	★★

* A lower rate indicates better performance for this measure.
** Table A-2 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
+ Indicates the measure was reported using hybrid methodology.
[++] NA indicates the denominator was too small to report a valid rate, based on the applicable measure
Cells shaded green indicate that the rate met or exceeded the MY 2022 and/or MY 2023 national Medicaid mean.
— Indicates a 2022–2023 comparison is not presented in the CYE 2024 Annual Technical Report because either there was a break in trending, the CY 2022 rate was not presented in the CYE 2023 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
[1] Performance Levels for CY 2023 were based on comparisons of the HEDIS MY 2023 measure rates to national Medicaid Quality Compass HEDIS MY 2023 benchmarks.
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.
[N] Measure has no NCQA Medicaid mean for comparison.
↑ Indicates statistically significant improvement of measure rates.
↓ Indicates statistically significant decline of measure rates.
→ Indicates no statistically significant change in measure rates.
Performance Levels for 2022 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Table 11-4 highlights DES/DDD's performance for the current year by measure group. The table illustrates the Contractor's CY 2023 measure rates and their performance relative to the NCQA national Medicaid Quality Compass HEDIS MY 2023 percentiles, where applicable. The performance level star ratings are defined as follows:

★★★★★ = 90th percentile and above
★★★★ = 75th percentile to 89th percentile
★★★ = 50th percentile to 74th percentile
★★ = 25th percentile to 49th percentile
★ = Below the 25th percentile

Table 11-4—CY 2023 National Percentiles Comparison for DES/DDD

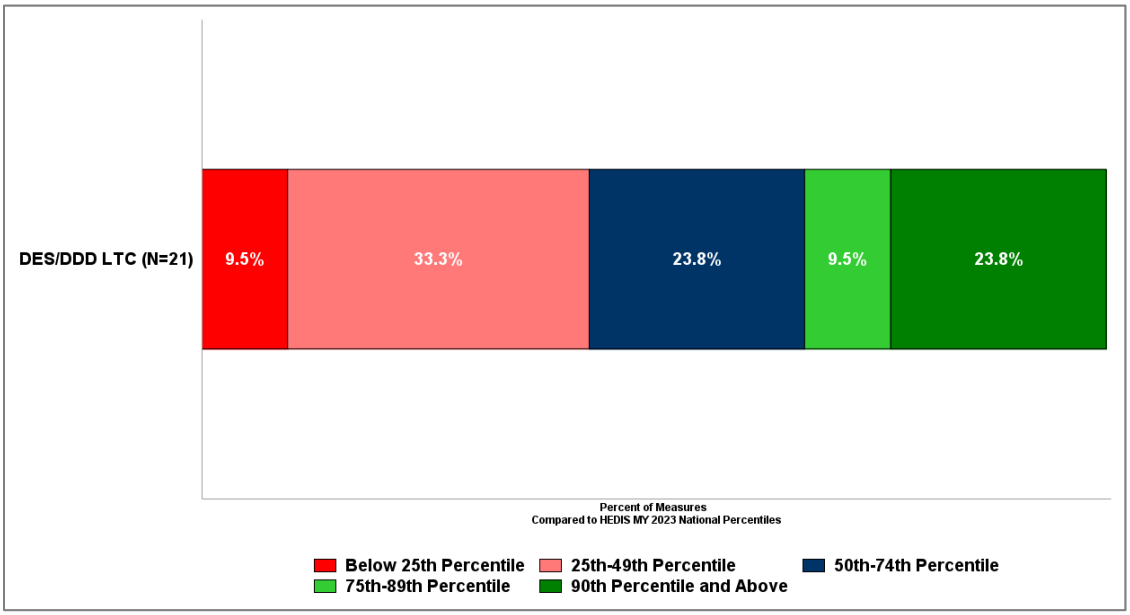
Performance Measure	CY 2023 Performance
Behavioral Health	
Antidepressant Medication Management	
Effective Acute Phase Treatment—Total (18+ Years)	★★★
Effective Continuation Phase Treatment—Total (18+ Years)	★★★★
Follow-Up After Hospitalization for Mental Illness	
7-Day Follow-Up—Total (6+ Years)	★★★★★
30-Day Follow-Up—Total (6+ Years)	★★★★★
Use of Opioids at High Dosage	
18+ Years	★★
Initiation and Engagement of Substance Use Disorder Treatment	
Initiation of SUD Treatment—Total—Total (13+ Years)	★★
Engagement of SUD Treatment—Total—Total (13+ Years)	★★
Care of Acute and Chronic Conditions	
Controlling High Blood Pressure	
18–85 Years	★★★★★
Hemoglobin A1c Control for Patients With Diabetes	
HbA1c Control (<8.0 Percent)—Total (18–75 Years)	★★★★★
HbA1c Poor Control (>9.0 Percent)—Total (18–75 Years)	★★★★★
Pediatric Health	
Metabolic Monitoring for Children and Adolescents on Antipsychotics	
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	★★★★
Childhood Immunization Status	
Combination 3	★★★
Combination 7	★
Combination 10	★★
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	★★★
Combination 2 (Meningococcal, Tdap, HPV)	★★
Well-Child Visits in the First 30 Months of Life	
First 15 Months—Six or More Well-Child Visits	NA++
15 Months to 30 Months—Two or More Well-Child Visits	★★★
Child and Adolescent Well-Care Visits	
Total (3–21 Years)	★★★
Preventive Screening	
Breast Cancer Screening	
Total (50–74 Years)	★★

Performance Measure	CY 2023 Performance
Cervical Cancer Screening	
21–64 Years	★
Appropriate Utilization of Services	
Plan All-Cause Readmissions	
Observed/Expected (O/E) Ratio—Total (18–64 Years)	★★

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

Figure 11-1 displays DES/DDD's HEDIS MY 2023 performance compared to benchmarks. HSAG analyzed results from 15 performance measures for HEDIS MY 2023 for a total of 23 measure rates.

Figure 11-1—Comparison of Measure Indicators to HEDIS Medicaid National Percentiles for DES/DDD



Strengths, Opportunities for Improvement, and Recommendations

Table 11-5 presents strengths, opportunities for improvement, and recommendations for DES/DDD, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 11-5—DES/DDD Strengths, Opportunities for Improvement, and Recommendations for Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health measure group, DES/DDD's performance measure rates for *Antidepressant Medication Management—Effective Continuation Phase Treatment—Total (18+ Years)* was at or

Strengths, Opportunities for Improvement, and Recommendations
between the 75th and 89th percentile, and *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* were at or above the 90th percentile, indicating strength in providing behavioral health follow-up care to members. **[Quality, Timeliness, Access]**
In the Care of Acute and Chronic Conditions measure group: • DES/DDD's performance measure rates for *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 %)—Total (18–75 Years)* and *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)* were at or above the 90th percentile, indicating that most members with diabetes had controlled HbA1c levels most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[240] **[Quality]** • DES/DDD's performance measure rate for *Controlling High Blood Pressure—18–85 Years* was at or above the 90th percentile, indicating that most members with a diagnosis of hypertension had controlled blood pressure. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[241] **[Quality]**
In the Pediatric Health measure group, DES/DDD's performance measure rates for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)* was at or between the 75th and 89th percentile, indicating that most members with antipsychotics had metabolic monitoring most of the time. Proper diabetes monitoring is essential to identify blood glucose concerns, reduce risks for complications, and prolong life.[242] **[Quality]**
Opportunities for Improvement and Recommendations
While DES/DDD was successful in reporting valid rates for all AHCCCS-required performance measures for its ALTCS-DD population, and HSAG did not identify specific opportunities for DES/DDD to improve RES, DES/DDD could benefit from continuing to focus on refining RES reporting where required in keeping with measure specifications. **[Quality]** Recommendation: HSAG recommends that DES DDD work with AHCCCS on collaborative efforts to improve the completion and accuracy of race/ethnicity data and explore other methods to augment enrollment data information. HSAG also recommends that DES DDD explore other potential data sources for the capture of race/ethnicity data to support future performance measure reporting that may require stratification related to RES. To ensure data reporting accuracy, HSAG recommends that DES DDD investigate conducting sample reviews on the

[240] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Feb 19, 2025.
[241] National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Feb 19, 2025.
[242] National Committee for Quality Assurance. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM). Available at: https://www.ncqa.org/hedis/measures/metabolic-monitoring-for-children-and-adolescents-on-antipsychotics/. Accessed on: Feb 19, 2025.

Strengths, Opportunities for Improvement, and Recommendations
subcontractor's reported rates prior to submission as a component of its ongoing quality review process, along with benchmark reviews of the individual subcontractor rates.
In the Preventive Screening measure group, DES/DDD's performance measure rate for *Cervical Cancer Screening—21–64 Years* fell below the 25th percentile, suggesting that female members were not always receiving timely access to screening for cervical cancer. **[Quality]** Recommendation: HSAG recommends that DES/DDD consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended cancer screenings and make appropriate health decisions. HSAG recommends that DES/DDD consider utilizing one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve cervical cancer screening rates. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that DES/DDD provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge. In addition, HSAG recommends that DES/DDD work with its subcontracted health plans to analyze their data and consider if there are disparities within DES/DDD's populations that contributed to lower screening rates.
In the Pediatric Health measure group, DES/DDD's performance measure rate for *Childhood Immunization Status—Combination 7* fell below the 25th percentile, suggesting that some children were not receiving these immunizations, which are a critical aspect of preventive care for children. Childhood vaccines protect children from many serious and potentially life-threatening diseases, such as diphtheria, measles, meningitis, polio, tetanus, and whooping cough, at a time in their lives when they are most vulnerable to disease.[243] Continued coordinated efforts between healthcare providers and public health officials at the local, state, and federal levels will be necessary to achieve rapid catch-up vaccination.[244] **[Quality]** Recommendation: HSAG continues to recommend that DES/DDD identify best practices to support children in receiving preventive vaccinations according to recommended schedules. HSAG recommends that DES/DDD provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.

[243] National Committee for Quality Assurance. Childhood Immunization Status. Available at: https://www.ncqa.org/hedis/measures/childhood-immunization-status/. Accessed on: Feb 19, 2025.
[244] The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Feb 19, 2025.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 11-6 presents performance measure recommendations made to DES/DDD in the CYE 2023 Annual Technical Report[245] and DES/DDD's follow-up to the recommendations, as well as an assessment of the degree to which DES/DDD has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 11-6—DES/DDD Follow-Up to CYE 2023 Performance Measure Recommendations

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Recommendation 1:
HSAG recommended that DES/DDD explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratifications related to RES. DES/DDD should continue working with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information.
DES/DDD's Response:
The Division is actively engaged in multiple initiatives in preparation for the NCQA CM-LTSS accreditation survey in early 2025. Several critical workgroups were developed to identify opportunities and promote enhancements in data collection in the areas of race, ethnicity, language accessibility, and sexual orientation and gender identity. The Division continues to focus on system enhancements to capture data to improve program and service access for people of different races, ethnicities, geographic areas, and different languages; and to address disparities in care. In 2024, the Division was able to reduce the volume of "blank" or "null" values in preferred language by approximately 56 percent. UHCCP reports race and ethnicity data on all NCQA HEDIS performance measures requiring race and ethnicity stratification. UHCCP pulls data from the PMMIS system via screen scrape in cases where data are available in PMMIS but not on existing data feeds. Through that process, member data are validated during member contacts, and UHCCP communicates any changes in selection of race to the State as the system of record. This process is ongoing for any data changes needed to member records based on interactions. For member-reported changes, UHCCP completes the member demographics maintenance process with AHCCCS. AHCCCS will then verify the information we have with the member and update accordingly.

[245] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
HSAG's Assessment: DES/DDD implemented interventions to improve performance on this measure; therefore, HSAG determined that DES/DDD satisfactorily addressed these prior year's recommendations.
Recommendation 2:
HSAG recommended that DES/DDD conduct a drill-down analysis based on race, ethnicity, and age stratifications to determine why members were not receiving timely SUD services or MAT following their initiation visit. DES/DDD should consider the nature and scope of the issues (e.g., the issues are 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. Upon identification of a root cause, DES/DDD should implement interventions that address the identified root cause of the low rate, targeting the interventions so that DES/DDD improves performance related to initiating and engaging in timely treatment following a new episode of SUD dependence.
DES/DDD's Response: The Division is continually assessing current processes and identifying opportunities to improve the collaboration and oversight of the subcontracted health plans. The Division is enhancing the reach of the Performance Improvement and Monitoring Subcommittee (PIM) in establishment of dedicated subcontracted health plan workgroup(s), designed to initiate a focused discussion on development of interventions for performance measures not meeting performance expectations. The workgroups are scheduled to begin in early 2025 to include the Division's behavioral health administrator, Maternal Child Health & EPSDT coordinator, cultural competency manager or designee, system and practice improvement administrator, and other key division staff as applicable. <u>UHCCP:</u> Based on an analysis of race, ethnicity, and age stratifications, UHCCP has found no significant correlations between race or ethnicity and the identified trends. Members ages 18–25 and 31–40 combined make up the largest percentage (52 percent) of the DDD population diagnosed with substance use disorders. However, since the numerator for the total population is low (82), the following analyses looked at trends across the total DDD cohort. Cannabis (28 percent) and alcohol (22 percent) use disorders were the most frequently diagnosed substances for the DDD members, followed by sedatives (16 percent) and opioids (15 percent). The younger members ages 14 to 30 tended toward more frequent diagnoses of cannabis and alcohol given by inpatient hospitals and outpatient mental health providers. The older members ages 41 and above were more often diagnosed with sedative and opioid use disorders by outpatient medical providers. At 51 percent, outpatient treatment is the most frequent setting that diagnoses members with SUD. At 72 percent, medical practitioners comprise most of the outpatient settings that diagnose SUD for DDD members. The medical setting has an initial appointment follow-up rate of 13 percent and a further treatment engagement rate of 0.0 percent. Outpatient behavioral health settings made up the remaining

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
27 percent of outpatient settings, with an initial appointment follow-up rate of 33 percent and further treatment engagement rate of 17 percent. Inpatient behavioral health hospital settings contributed 33 percent of members' initial SUD diagnoses. The rate of treatment engagement post-discharge was 0.0 percent. Emergency departments contributed 16 percent of members' initial SUD diagnoses. There were no DDD members who received SUD treatment appointments within 14 days of discharge from the emergency departments. Based on this analysis, UHCCP addresses the issue using the following outreach and education interventions: • Educating medical providers on diagnosing substance use disorders and proper use of SUD remission codes, motivational interviewing and referral resources for substance use disorder treatment providers, including telehealth. • Providing outreach and education on diagnosing substance use disorders, using SUD remission codes and treatment resources, including telehealth, to a primary care practice seeing 20 percent of DDD members in the outpatient medical cohort. • Providing information on post-discharge referrals for substance use disorders to a key hospital system that diagnosed 50 percent of DDD members in the inpatient hospital cohort as well as DDD members diagnosed by their emergency departments. <u>Mercy Care:</u> Mercy Care continued the interventions that were reported in 2023, after completion of a root cause analysis. Those interventions include: • Referral (as needed) to behavioral health provider and coordination with behavioral health provider after discharge. • Access Points offering 24/7 intake availability for those with an OUD. • Healthmine Application—Member Web portal to provide educational information regarding gaps in care along with digital and written member outreach. • Intensive Treatment Systems, a 24/7 access point for MAT services, as a Health Home (HH) for members with SMI. • Survey of the contracted Health Homes completed for central GSA; workgroups with the HHs being hosted by MC SOC to identify additional barriers to members accessing timely AOD services or MAT, as well as successes that may be implemented more broadly. • Addition of medication-assisted treatment (MAT) to each of our existing HH provider locations. • Report created to assist with identifying providers for DDD members who are non-verbal and experiencing substance abuse issues, so that Mercy Care can funnel members to them as appropriate. The report may also can be used to identify network deficiencies/needs.
HSAG's Assessment: HSAG has determined that DES/DDD satisfactorily addressed these prior year's recommendations.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Recommendation 3:
HSAG recommended that DES/DDD consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended cancer screenings and make appropriate health decisions. In addition, HSAG recommends that DES/DDD work with its subcontracted health plans to analyze their data and consider whether there are disparities within DES/DDD's populations that contributed to lower screening rates. Upon identification of a root cause, HSAG recommended that DES/DDD implement appropriate interventions to improve access to and timeliness of cancer screenings.
DES/DDD's Response: In early 2025, the Division will establish a dedicated subcontracted health plan workgroup intended to improve collaboration promoting focused discussions on performance measure data and identification of population-specific disparities. Workgroups will have appropriate representation from internal and external stakeholders to identify interventions specifically designed for the DD population. UHCCP: Both *CCS* and *BCS* measures are part of the UHCCP Health Disparities Summary & Evaluation Annual Report submitted to AHCCCS in July. For this report, member data have been analyzed by several different subpopulations, including race and ethnicity. Root cause and barriers were investigated, identified, and interventions developed and implemented to address the findings. For MY 2023, the DD MY2023 *CCS* rate of 25.4 percent for Black or African American members was 7.9 percentage points improved/higher than the MY 2020 rate of 17.5 percent. The MY 2023 DD *CCS* overall rate (20.3 percent) improved by 2.3 percentage points from MY 2020. Based on literature review which identified that Black or African American have disproportionate BCS and CCS, UHCCP performed and continues to perform member outreach via reminder letters in July and follow-up letters in October for Black or African American women for both CCS and BCS. UHCCP also conducts member outreach via live calls to Black or African American members in need of BCS and CCS. Other interventions already in place were reviewed to ensure all subpopulations are receiving interventional action and information. Currently, UHCCP conducts member outreach for the *CCS* performance measure for any member with an open care gap via the QM team with letters and live phone calls educating members on the importance of CCS and assisting them with scheduling appointments. UHCCP is implementing a CCS self-selected PIP for all LOBs December 2024 and will be conducting RCA, identifying barriers to achieving CCS, and developing interventions by LOB and subpopulations also. One intervention already in development is the American Cancer Society (ACS) co-branded member material (previously mentioned) which includes both BCS and CCS member letters co- branded with ACS. For the PIP, race, ethnicity, and language will be analyzed again, and results reviewed for potential improvement opportunities.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Mercy Care: In comparing the rate of mammograms to screen for breast cancer in the DDD population to that of the Mercy Care ACC population, the DDD membership demonstrated a statistically lower rate of screening. DDD members (48.4 percent) when compared to ACC members (54.3 percent). Additionally, MC identified a statistically significant disparity in the rate of mammograms to screen for breast cancer for Alaska/American Indian/Native American members as compared to Caucasian members. Mercy Care implemented the following interventions to address the identified disparities: • Member incentives • Collaboration with Native Health • Care manager outreach • *BCS* measure added to VBS contracts • Provider education via the Mercy Care Provider Conference
HSAG's Assessment: DES/DDD implemented interventions to improve performance on this measure even though performance did not improve in MY 2023; therefore, HSAG determined that Mercy Care LTC satisfactorily addressed these prior year's recommendations.
Recommendation 4:
HSAG continues to recommend that DES/DDD identify best practices to support children in receiving preventive vaccinations according to recommended schedules. HSAG also recommends that DES/DDD consider conducting a root cause analysis to identify barriers that members are experiencing in accessing care and services in order to implement appropriate interventions to improve the performance related to the Pediatric Health measure group.
DES/DDD's Response: The Division's Performance Improvement and Monitoring Committee's workgroup will establish a dedicated venue for focused performance measure analysis and discussion. The workgroup will provide an opportunity for the Division to engage in a candid and open dialogue with each subcontracted health plan specific to its performance, analysis, and implementation of plan-specific interventions. The Division's Maternal and Child Health manager (EPSDT coordinator) and Maternal Health Care nurse are pivotal workgroup contributors focused on educating and directing population-specific interventions. UHCCP: A root cause analysis was performed to identify potential barriers, as recommended. It was noted that possible barriers may exist with the provider, member, or UHCCP. Provider barriers may be related to coding or claim submission. When a claim needs to be sent to the member's secondary insurance, does the clinic or billing department send secondary claims for the vaccination to the secondary plan?

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
Or is the provider group submitting the claim accurately with the appropriate code that would identify the service was performed and close the care opportunity? Is the provider ensuring that the vaccination was entered into the Arizona State Immunization Information System (ASIIS) for the State of Arizona records? Another provider barrier may be lack of resources for outreach efforts when a child is due for immunizations. Are immunizations being encouraged during a well visit or is there a separate initiative for the preventive care? Influenza vaccinations are identified as having a lower rate, and are providers educating the parents/guardian on the importance of preventive care with influenza prevalence in the community? Member barriers may exist and influence the low immunization rates. Is the member's parent or guardian providing secondary insurance information to the primary care providers? There could be a possible mistrust by the parent/guardian with the healthcare system, government, or healthcare providers. Mistrust may lead to disbelief of the principle or education behind the importance of the vaccination. The media or historical and contemporary factors may contribute to mistrust. There may be systemic inequalities or a past unethical event that took place that may influence the parent/guardians' decision for the member to receive the vaccination. Additionally, social determinants of health may contribute to the untimeliness or decision to not receive the immunization. These could include transportation, access to care with schedules, or working parents may have a difficult time arranging the appointment for the vaccinations. Additional member barriers that may contribute to the low immunization rate may be the misconception that vaccinations may cause autism. There could also be a misconception that the adolescent needs to be identified as sexually active to receive the HPV vaccinations. Another identified barrier is that after the first HPV dose is provided, the member does not return for the second of the series. Education outside of the clinics needs to be provided. There is material from the CDC that can assist with education; perhaps an email campaign would be helpful. Notification of immunization clinics or back-to-school events may assist in the accessibility of receiving the immunizations. Also, more education to providers for entering the immunization into ASIIS and current audits to be sure the process is taking place. The second component would be for UHCCP to retrieve the data from claims or data aggregation. Monthly talking points to provider groups, implemented by the clinical practice consultants, provide education in a slide deck and identification of barriers. Are the member materials and resources sufficient to educate the importance of immunizations? UHCCP has a goal to train and educate employees of where the subpopulation trends may be a barrier. Subpopulation trends may include race/ethnicity, gender, cultural and linguistic. UHCCP is invested and striving to have more knowledge of AI/AN cultural barriers and customs. UHCCP does rate analysis on the BIPOC population. Goal is to train a dedicated community health worker (CHW) or tribal RN coordinator to assist with populations where education is needed and adding more of a relationship component with similar values.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
UHCCP has planned interventions, to include implementing a process for sending educational materials related to immunizations. The source of information may be extracted from the CDC site. UHCCP 2025 emails are to be sent to parents/guardians to include CDC information and "myths" of immunizations. UHCCP plans to continue to attend the Arizona Partnership for Immunizations (TAPI) meetings. UHCCP conducts vaccination clinics, and the Phoenix Fire Department conducted member vaccinations as well. Information in ASIIS would be reviewed to ensure the care opportunity was closed. UHCCP will continue to identify and implement best practices to share with our team and our members. Mercy Care: Mercy Care conducted a root cause analysis using a fishbone diagram. As a result of this analysis, Mercy Care developed the following interventions aimed at increasing the number and percentage of children who receive preventive vaccinations according to recommended schedules: • HEDIS Gaps in Care Report for Providers—Comprehensive list of members needing care. • Continue to work with ASIIS to obtain additional vaccine data and incorporate into the performance measure tracking database to improve the process to track performance throughout the year. • Healthmine Application—Member Web portal to provide educational information regarding gaps in care along with digital and written member outreach. • Distribution of the latest AHCCCS Periodicity schedule to MC care managers to remind caregivers of the required visit intervals. • Partnership and collaboration with PCCN and EHN to promote EPSDT "awareness." • Member incentives to complete well-child visits (members will be eligible for each EPSDT visit between 0–14 months, up to six and for each EPSDT visit between 15–30 months up to two). • Outreach calls to parents/guardians/caregivers of all 6-, 9-, 11-, and 18-month-old members. If the member does not have a well visit scheduled, a 3-way call with the provider's office is initiated. Immunizations are discussed and the parent is advised what shots their child should be receiving during the visit. • Written communication to parents/guardians/caregivers of 1-month-old members including but not limited to, a well-child visit magnet listing the well-child schedule and a comprehensive booklet on immunizations, as well as mailing of a CDC shot schedule to parents of 18-month-old members. • Written provider outreach process which includes mailings to PCPs for members in need of an EPSDT visit; members 0–24 months of age in need of immunizations; adolescents in need of immunizations; a reminder on the requirement to conduct developmental screenings at the 9-, 18-, and 24-month visits; information pertaining to the members' historical dental care and whether or not the member is due for dental care.

Prior Year's Recommendation From the EQR Technical Report for Performance Measures
• Virtual visits with the Mercy Care EPSDT coordinator to discuss the immunization and EPSDT periodicity schedules and advise the provider of members who are not up to date. Childhood Immunization Status (Combo 3) MY 2023 final rate: 67.57 percent (a 16.3 percentage point improvement over the 2022 rate) Childhood Immunization Status (Combo 7) MY 2023 final rate: 32.43 percent (a 9.8 percentage point improvement over the 2022 rate) Childhood Immunization Status (Combo 10) MY 2023 final rate: 27.03 percent (an 8 percentage point improvement over the 2022 rate)
HSAG's Assessment: HSAG has determined that DES/DDD satisfactorily addressed these prior year's recommendations.

Validation of Performance Improvement Projects

Well-care visits for children and adolescents aim to promote optimal health and development. Ensuring that children and adolescents receive regular well-care visits is critical in disease prevention, early detection, and treatment. There are many benefits of well-child/well-care visits, including disease prevention, tracking growth and development, raising concerns, and establishing a team approach to assist with the development of optimal physical, mental, and social health of a child.[246] Adolescence is a critical stage of development during which physical, intellectual, emotional, and psychological changes occur.[247] Adolescent well-care visits assist with promoting healthy choices and behaviors, preventing risky behaviors, and detecting early the conditions that can inhibit an adolescent's development.

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Back to Basics* PIP for the ALTCS-DD population. The objective of the *Back to Basics* PIP is to increase the number of child and adolescent well-child/well-care visits.

As this PIP had progressed through Remeasurement 2, PIP validation activities focused on improvement from the baseline results. DES/DDD submitted Remeasurement 2 performance indicator results and interventions implemented during this validation cycle along with the status of interventions, focus, and rationale for changes to or discontinuation of the interventions. HSAG conducted an annual validation of

[246] American Academy of Pediatrics. AAP Schedule of Well-Child Care Visits. Available at: https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx. Accessed on: Feb 19, 2025.

[247] Centers for Disease Control and Prevention. Adolescence: Preparing for Lifelong Health and Wellness. Available at: https://archive.cdc.gov/#/details?url=https://www.cdc.gov/grand-rounds/pp/2015/20150818-adolescent-wellness.html. Accessed on: Feb 23, 2025.

the first remeasurement year reflective of CY 2023 (January 1, 2023, through December 31, 2023) using AHCCCS-calculated and validated indicator rates. HSAG evaluated DES/DDD's performance indicator rates based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

Validation Results

Table 11-7 displays the overall confidence levels for the DES/DDD *Back to Basics* PIP.

Table 11-7—DES/DDD *Back to Basics* PIP Overall Confidence Levels

Contractor	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]	Confidence Level[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]
DES/DDD	*Low Confidence*	87%	89%	*High Confidence*	100%	100%

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

Measure Results

Table 11-8 provides the *Back to Basics* PIP baseline, Remeasurement 1, and Remeasurement 2 rates for DES/DDD.

Table 11-8—DES/DDD *Back to Basics* PIP Rates

Contractor	PIP Indicator: *Child and Adolescent Well-Care Visits* (*WCV*)		
	Baseline Year	Remeasurement 1	Remeasurement 2
	CYE 2019	CY 2022	CY 2023
DES/DDD	50.7%	54.4%	57.1%

HSAG rounded percentages to the first decimal place.

Interventions

Table 11-9 presents PIP interventions for DES/DDD. Language in the PIP interventions section is minimally edited and generally reflective of the language provided by the Contractor.

Table 11-9—DES/DDD Program *Back to Basics* PIP Interventions

Contractor	Intervention
DES/DDD	• Collaborated with health plans to ensure best practices and continue member engagement outreach. • QMPI committee addressed health plan issues, questions, and concerns. • Initiated a new DDD Performance Improvement and Monitoring Workgroup. • Initiated a process for health plans to send target lists of members with gaps in care to DDD. • Initiated a process of distributing gap target lists provided by health plans to support coordinators in order to engage members and their families/healthcare decision makers in receipt of recommended services. • Initiated and coordinated member newsletter articles with health plans to increase member awareness of preventive services to optimize impact.

Strengths, Opportunities for Improvement, and Recommendations

Table 11-10 presents strengths, opportunities for improvement, and recommendations for DES/DDD, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 11-10—DES/DDD Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG noted that DES/DDD achieved statistically significant improvement between the baseline rate and the Remeasurement 2 rate, sustaining the statistically significant improvement achieved at Remeasurement 1. **[Quality, Access]**
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement for DES/DDD. The Contractor deleted subcontractor Mercy Care's baseline data from this year's submissions. The issue was identified in the initial submission and not corrected in the resubmission. **[Quality]** Recommendations: To address the issues identified during this year's validation, HSAG recommends that DES/DDD:

Strengths, Opportunities for Improvement, and Recommendations
• Seek technical assistance from HSAG to understand the requirements for the PIP submission. • Include baseline data for the subcontractor Mercy Care.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 11-11 presents PIP recommendations made to DES/DDD in the CYE 2023 Annual Technical Report[248] and DES/DDD's follow-up to the recommendations, as well as an assessment of the degree to which DES/DDD has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 11-11—DES/DDD Follow-Up to CYE 2023 PIP Recommendations

Prior Year's Recommendation From the EQR Technical Report for PIPs
HSAG recommended that DES/DDD: • Revisit the causal/barrier analysis used to develop interventions and adjust the interventions as necessary to sustain improvement. • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. • Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.
DES/DDD's Response: The Division's Performance Improvement and Monitoring Committee is responsible for the oversight and monitoring of the performance improvement plan. PIP progress, data analysis, root causes, barriers, and other critical details are provided to committee members for additional insight and recommendations to help the projects reach their goals. The creation of the PIM Subcommittee workgroup added a venue for coordination with the subcontracted health plan(s) on their progress and a more focused review and analysis of PIP data. UHCCP: UHCCP reviewed the RCA during MY 2023 with the intent to identify other barriers and opportunities for improvement. The B2B PIP Work Group and Clinical Practice Consultants (CPC) Team identified there were root cause issues with provider billing and claims submissions that affect most providers for all indicators/measures and closing quality gaps in care. The Ishikawa fishbone diagram was updated, and additional work is in progress to understand this better. Provider and

[248] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for PIPs
UHCCP collaboration on these barriers has already begun, and CPCs have reviewed best practices of one provider (submitting secondary claims), followed by encouraging and educating other providers to do the same. The barriers included: • Coordination of Benefit (COB) issues when a member has secondary insurance with UHCCP and the provider does not submit a secondary claim. • Provider billing system that does not allow secondary billing with $0.0 billed, mostly due to Provider Clearinghouse and Business Rules setup. • EMRs not allowing flow of supplemental data and working with the UHCCP data aggregators. As part of the interventions' PDSA cycles, UHCCP modified some interventions during 2023 to increase member and provider outreach with the intent of improved member health outcomes and rate performance. Additionally, increased effectiveness analysis was performed and reviewed during PIP workgroup meetings to identify intervention status and any need for improvement: • The provider tip sheet. MY 2022 effectiveness analysis (PDSA Cycle 3: Study): Approximately 150 provider groups received the document tip sheet. Qualitative feedback from many provider groups was positive and supported continuation of this intervention in MY 2023 (PDSA Cycle 4). For 2023, the provider tip sheet was refreshed by the UHC Community & State Provider Marketing Team for improved readability and posted on uhcprovider.com for easier and increased access by providers. Effectiveness analysis is planned for January 2025. • The myth vs fact letter and flyer. An effectiveness analysis was completed by comparing the September 2022 Missed Opportunities Report and Member Address List to the CYE 2022 gaps in care report. On February 1, 2023, administrative data showed 451/897 (50.3 percent) of the DD members who were sent the myth vs fact letters are now compliant as of CYE 2022 (PDSA Cycle 2: Study). The PIP workgroup determined to continue this intervention and PDSA Cycle 3 for MY 2023. UHCCP developed a separate letter and flyer for ages 18–21 years. Unfortunately, this took longer than expected to finalize and was not ready for MY 2023 implementation. However, they were implemented for PDSA Cycle 4/September 2024. A letter and flyer for ages 3–17 years were distributed during MY 2023 as planned. Effectiveness analysis for MY 2024 is planned for Q1 2025 (PDSA Cycle 4: Study). • AHCCCS Back to School Gift Card Campaign. As part of a statewide Medicaid campaign to increase well-child visits, UHCCP participated in the AHCCCS Back to School Campaign. Members with WCV open care gaps were notified of their eligibility for a gift card after completing their visit for dates of service (DOS) starting June 5 through September 5, 2023. Important to note: UHCCP extended member eligibility DOS from September 5 to December 31, 2023, due to calls from parents/guardians stating they were unable to get an appointment before the original due date of September 5. Members were notified of their eligibility via mailed offer letters, AHCCCS and UHCCP website landing page information, and community events. Additionally, provider groups were notified via CPC monthly talking points, flyers, member eligibility lists, and a Microsoft PowerPoint presentation. To further increase member awareness of the campaign and encourage participation, UHCCP added QM member outreach calls to 2,000

Prior Year's Recommendation From the EQR Technical Report for PIPs
members. MY 2023 effectiveness analysis for UHCCP resulted in a 2.8 percent redemption rate which was improved by 2.0 percentage points compared to the previous year (MY 2022) redemption rate of 0.82 percent. For DD, 492/10,700 (4.6 percent) members redeemed AHCCCS Back to School Rewards. Again, DD MY 2023 final rates for the B2B PIP measure (WCV) exceeded the NCQA National Average, performed better than last year, and achieved its PIP goal. UHCCP is awaiting recommendation from HSAG/AHCCCS to close this PIP. Mercy Care: Mercy Care continues to review the PIP rates at least quarterly, with an annual final measurement year evaluation once the data are finalized. When the health plan identifies declines in performance, or that the rates are not on track to reach the defined goal, Mercy Care will initiate or follow to the next step in the PDSA cycle. Best practices are identified and documented and incorporated into the health plan's standard operating procedures. *WCV* MY 2023 final rate: 61.2 percent showing improvement.
HSAG's Assessment: HSAG has determined that DES/DDD has satisfactorily addressed these prior year's recommendations.

Compliance Reviews

Results

AHCCCS conducts a full compliance review for DES/DDD every three years. This current three-year review cycle spans from CYE 2024 to CYE 2027. AHCCCS conducted a compliance review of DES/DDD during CYE 2024, and the final results will be reported in the CYE 2025 EQR Technical Report.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

DES/DDD successfully closed all CAPs during CYE 2023, therefore, no recommendations were provided.

Network Adequacy Validation

ISCA Results

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

Based on the results of the ISCAs combined with the detailed validation of each NAV indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and whether the DES/DDD subcontracted health plans' interpretation of data was accurate.

Table 11-12 and Table 11-13 summarize HSAG's validation ratings for each DES/DDD subcontracted health plan by indicator type.

Table 11-12—Summary of Mercy Care DD Validation Ratings by Indicator Type

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

Table 11-13—Summary of UHCCP DD Validation Ratings by Indicator Type

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

Of the network adequacy indicators assessed, the DES/DDD subcontracted health plans received *High Confidence* for both appointment availability and time/distance indicator types. However, there were identified areas for improvement for some of the DES/DDD subcontracted health plans; please refer to the Contractor-specific Strengths, Opportunities for Improvement, and Recommendations section below for more details.

NAV Results

HSAG's validation of the DES/DDD subcontracted health plans' results showed minor discrepancies between the DES/DDD subcontracted health plans' self-reported ACOM 436 results and HSAG's time/distance calculations for which data could be compared. While minor differences (i.e., less than 1 percentage point) between HSAG's time/distance calculation results and each DES/DDD subcontracted health plan's time/distance calculation results were common, these findings are most likely attributable to the timing of the input data or software versions used by each DES/DDD subcontracted health plan, or due to a small number of members eligible for inclusion in time/distance calculations for the standard and county.

Table 11-14 summarizes HSAG's assessment of each DES/DDD subcontracted health plan's compliance with AHCCCS' minimum time/distance network standards. A check mark indicates that the DES/DDD subcontracted health plan met the minimum network standard for all assigned counties during the CYE 2024 S1 assessment, and an "X" indicates that the DES/DDD subcontracted health plan did not meet one or more minimum network standards in any assigned county.

Table 11-14—Summary of CYE 2024 Compliance With Minimum Time/Distance Network Requirements for DES/DDD Subcontracted Health Plans

Minimum Network Requirement	Mercy Care DD	UHCCP DD
Behavioral Health Outpatient and Integrated Clinic, Adult	X	X
Behavioral Health Outpatient and Integrated Clinic, Pediatric	✓	X
BHRF (Only Maricopa and Pima Counties)	✓	X
Cardiologist, Adult	X	X
Cardiologist, Pediatric	✓	✓
Dentist, Pediatric	X	X
Hospital	✓	✓
OB/GYN	✓	✓
Pharmacy	✓	X
PCP, Adult	✓	X
PCP, Pediatric	✓	X

The DES/DDD subcontracted health plans consistently met the Cardiologist, Pediatric; Hospital; and OB/GYN standards.

Isolated data issues may have contributed to specific instances affecting DES/DDD subcontracted health plans' compliance with time/distance standards. Specific examples include the following:

- In CYE 2024 S1, the data for one of the DES/DDD subcontracted health plans included substantially increased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; and Hospital. When contacted, the DES/DDD subcontracted health plan indicated that it inadvertently included home office addresses in its report of service addresses, raising the number of providers in the count. This potentially influenced the validated compliance for these provider categories.

As part of the NAV, AHCCCS maintained its feedback process for the DES/DDD subcontracted health plans to review and improve the accuracy of their data submissions. Specifically, AHCCCS supplied the DES/DDD subcontracted health plans with copies of HSAG's network adequacy analysis, the PAT file that HSAG used to conduct the analysis, and HSAG's saturation analysis results. When issues were identified, the DES/DDD subcontracted health plans were expected to research the instances and make corrections for future PAT data and/or ACOM 436 submissions.

Overall, the DES/DDD subcontracted health plans met all minimum time/distance network standards in Cochise, Coconino, Graham, Maricopa, Mohave, Navajo, Pinal, Santa Cruz, Yavapai, and Yuma counties. Based on the CYE 2024 S1 NAV results, the DES/DDD subcontracted health plans did not meet all requirements for all standards in the applicable counties.

The DES/DDD subcontracted health plans should continue to monitor and maintain their existing provider network as of CYE 2024 S1 with specific attention to ensuring the availability of the following provider categories where both DES/DDD subcontracted health plans did not meet the network requirement:

- Behavioral Health Outpatient and Integrated Clinic, Adult in Apache County
- Cardiologist, Adult in Apache County
- Dentist, Pediatric in Apache, Gila, Greenlee, and La Paz counties

HSAG evaluated the DES/DDD subcontracted health plans' compliance results with AHCCCS' time/distance standards by GSA and county. This section presents CYE 2024 S1 validation findings specific to the DES/DDD Program, with one results table for each of the following GSAs:

- Central GSA: Gila, Maricopa, and Pinal counties
- North GSA: Apache, Coconino, Mohave, Navajo, and Yavapai counties
- South GSA: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma counties

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

Table 11-15—Time/Distance Validation Results for Mercy Care DD Central GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^[1]	98.5^[1]	100.0^[1]
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0^[1]	98.7^[1]	100.0^[1]
BHRF	NA	99.2	NA
Cardiologist, Adult	100.0^	100.0^	100.0^
Cardiologist, Pediatric	100.0^	100.0^	100.0^
Dentist, Pediatric	91.7	99.5	100.0
Hospital	100.0[1]	99.9[1]	100.0[1]
OB/GYN	100.0	100.0	100.0
Pharmacy	100.0	99.1	100.0
PCP, Adult	99.0^	99.7^	100.0^
PCP, Pediatric	100.0^	99.8^	100.0^

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

^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

[1] In CYE 2024 S1, Mercy Care DD's data included substantially increased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; and Hospital. When contacted, Mercy Care DD indicated that it inadvertently included home office addresses in its report of service addresses, raising the number of providers in the count. This potentially influenced the validated compliance for these provider categories.

Table 11-16—Time/Distance Validation Results for Mercy Care DD North GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Apache	Coconino	Mohave	Navajo	Yavapai
Behavioral Health Outpatient and Integrated Clinic, Adult	71.4*^[1]	100.0^[1]	100.0^[1]	100.0*^[1]	100.0^[1]
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0*^[1]	100.0^[1]	100.0^[1]	90.9^[1]	100.0^[1]
BHRF	NA	NA	NA	NA	NA
Cardiologist, Adult	50.0*^	100.0^	100.0^	100.0*^	100.0^
Cardiologist, Pediatric	100.0*^	100.0^	100.0^	100.0^	100.0^
Dentist, Pediatric	100.0*	100.0	96.9	100.0	98.6
Hospital	100.0[1]	100.0[1]	100.0[1]	100.0[1]	100.0[1]
OB/GYN	100.0*	100.0*	100.0	100.0*	100.0*

Minimum Network Requirement	Apache	Coconino	Mohave	Navajo	Yavapai
Pharmacy	100.0	98.4	98.7	94.7	100.0
PCP, Adult	83.3*^	92.9^	100.0^	100.0*^	100.0^
PCP, Pediatric	100.0*^	100.0^	98.4^	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.
* indicates that fewer than 10 members were included in the denominator of HSAG's results.
^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.
[1] In CYE 2024 S1, Mercy Care DD's data included substantially increased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; and Hospital. When contacted, Mercy Care DD indicated that it inadvertently included home office addresses in its report of service addresses, raising the number of providers in the count. This potentially influenced the validated compliance for these provider categories.

Table 11-17—Time/Distance Validation Results for Mercy Care DD South GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Cochise	Graham	Greenlee	La Paz	Pima	Santa Cruz	Yuma
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^[1]	100.0^[1]	100.0^[1]	100.0*^[1]	98.0^[1]	100.0^[1]	100.0^[1]
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0^[1]	100.0^[1]	100.0*^[1]	100.0*^[1]	98.5^[1]	100.0^[1]	100.0^[1]
BHRF	NA	NA	NA	NA	92.3	NA	NA
Cardiologist, Adult	100.0^	100.0^	100.0^	100.0*^	100.0^	100.0^	100.0^
Cardiologist, Pediatric	100.0^	100.0^	100.0*^	100.0*^	100.0^	100.0^	100.0^
Dentist, Pediatric	100.0	100.0	85.7*	42.9*	98.5	100.0	100.0
Hospital	100.0[1]	100.0[1]	100.0[1]	100.0[1]	99.5[1]	100.0[1]	100.0[1]
OB/GYN	100.0	100.0	100.0*	100.0*	99.6	100.0	100.0
Pharmacy	100.0	98.8	100.0	100.0	98.2	100.0	100.0
PCP, Adult	100.0^	100.0^	100.0^	100.0*^	99.1^	100.0^	100.0^
PCP, Pediatric	100.0^	97.4^	100.0*^	100.0*^	99.3^	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.
* indicates that fewer than 10 members were included in the denominator of HSAG's results.
^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.

[1] In CYE 2024 S1, Mercy Care DD's data included substantially increased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; and Hospital. When contacted, Mercy Care DD indicated that it inadvertently included home office addresses in with its report of service addresses, raising the number of providers in the count. This potentially influenced the validated compliance for these provider categories.

Table 11-18—Time/Distance Validation Results for UHCCP DD Central GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Gila	Maricopa	Pinal
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^	99.1^	100.0^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0^	99.4^	100.0^
BHRF	NA	97.8	NA
Cardiologist, Adult	100.0^	99.8^	100.0^
Cardiologist, Pediatric	100.0^	100.0^	100.0^
Dentist, Pediatric	51.3	99.4	100.0
Hospital	100.0	99.9	100.0
OB/GYN	100.0	99.9	100.0
Pharmacy	96.7	99.2	100.0
PCP, Adult	100.0^	99.6^	100.0^
PCP, Pediatric	94.9^	99.8^	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.
^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.

Table 11-19—Time/Distance Validation Results for UHCCP DD North GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Apache	Coconino	Mohave	Navajo	Yavapai
Behavioral Health Outpatient and Integrated Clinic, Adult	69.1^	81.4^	96.3^	94.4^	99.9^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	71.8^	83.5^	94.9^	95.1^	100.0^
BHRF	NA	NA	NA	NA	NA
Cardiologist, Adult	64.3^	99.7^	100.0^	96.8^	100.0^
Cardiologist, Pediatric	84.0^	100.0^	100.0^	100.0^	100.0^
Dentist, Pediatric	86.0	94.6	94.4	96.0	98.1
Hospital	100.0	100.0	100.0	100.0	100.0
OB/GYN	100.0	100.0	100.0	100.0	100.0

Minimum Network Requirement	Apache	Coconino	Mohave	Navajo	Yavapai
Pharmacy	88.3	94.8	99.7	96.7	99.1
PCP, Adult	70.0^	96.6^	99.5^	100.0^	100.0^
PCP, Pediatric	76.0^	92.6^	99.8^	99.3^	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.
^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.

Table 11-20—Time/Distance Validation Results for UHCCP DD South GSA—Percent of Members Meeting Minimum Network Requirements for CYE 2024 S1

Minimum Network Requirement	Cochise	Graham	Greenlee	La Paz	Pima	Santa Cruz	Yuma
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0^	100.0^	100.0^	100.0^	98.2^	100.0^	100.0^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0^	100.0^	100.0^	100.0^	96.0^	100.0^	100.0^
BHRF	NA	NA	NA	NA	89.4	NA	NA
Cardiologist, Adult	100.0^	100.0^	100.0*^	100.0^	99.9^	100.0^	100.0^
Cardiologist, Pediatric	100.0^	100.0^	100.0^	100.0^	99.9^	100.0^	100.0^
Dentist, Pediatric	100.0	100.0	55.0	95.2	98.7	100.0	99.8
Hospital	100.0	100.0	100.0	100.0	99.9	100.0	100.0
OB/GYN	100.0	100.0	100.0*	100.0*	100.0	100.0	100.0
Pharmacy	99.8	100.0	100.0	100.0	99.0	100.0	99.9
PCP, Adult	100.0^	100.0^	100.0*^	100.0^	99.9^	100.0^	100.0^
PCP, Pediatric	100.0^	100.0^	100.0^	100.0^	99.5^	100.0^	99.8^

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
represents time/distance standard results that do not meet the compliance standard based on HSAG's results.
* indicates that fewer than 10 members were included in the denominator of HSAG's results.
^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.

Strengths, Opportunities for Improvement, and Recommendations

Table 11-21 presents strengths, opportunities for improvement, and recommendations for DES/DDD, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 11-21—DES/DDD Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • The DES/DDD subcontracted health plans received *High Confidence* for both appointment availability and time/distance indicators. **[Access]** • The DES/DDD subcontracted health plans met all minimum time/distance network standards for Cochise, Coconino, Graham, Maricopa, Mohave, Navajo, Pinal, Santa Cruz, Yavapai, and Yuma counties. **[Access]** • The DES/DDD subcontracted health plans consistently met Cardiologist, Pediatric; Hospital; and OB/GYN standards. **[Access]** • Mercy Care DD demonstrated its capability for ensuring the accuracy and completeness of its provider network by conducting rigorous quality assurance processes, including monthly provider data reconciliations, maintaining regular provider outreach and communication, and conducting annual audits of provider data. **[Access]** • Mercy Care DD met all minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Pediatric; BHRF; Cardiologist, Pediatric; Hospital; OB/GYN; PCP, Adult and Pediatric; and Pharmacy. **[Access]** • UHCCP DD had processes in place to maintain accurate and complete provider data, including a quarterly attestation process, secret shopper campaigns, and quality assurance reviews. **[Access]** • UHCCP DD met all minimum network requirements for Cardiologist, Pediatric; Hospital; and OB/GYN. **[Access]** Note: DES/DDD provides coverage in the following counties: Apache, Cochise, Coconino, Gila, Graham, Greenlee, La Paz, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma.
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: • Isolated data issues may have contributed to specific instances affecting the DES/DDD subcontracted health plans' compliance with time/distance standards. **[Access]** Recommendation: HSAG recommends that AHCCCS support the DES/DDD subcontracted health plans in continuing to monitor their processes for creating the PAT file and review this file for accuracy prior to submitting to AHCCCS.

Strengths, Opportunities for Improvement, and Recommendations
• Based on the NAV results, neither of the DES/DDD subcontracted health plans met the standards for Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult; and Dentist, Pediatric. **[Access]** Recommendation: HSAG recommends that AHCCCS support each DES/DDD subcontracted health plan in continuing to monitor and maintain its existing provider network coverage as of CYE 2024 S1, with specific attention to ensuring the availability of the following provider categories where both DES/DDD subcontracted health plans did not meet the network requirement: • Behavioral Health Outpatient and Integrated Clinic, Adult in Apache County. • Cardiologist, Adult in Apache County. • Dentist, Pediatric in Apache, Gila, Greenlee, and La Paz counties. • HSAG identified an opportunity for Mercy Care DD to improve the results to calculate time/distance indicators. **[Access]** Recommendation: HSAG recommends that Mercy Care DD incorporate additional oversight and monitoring when transferring Quest-generated output to the ACOM Policy 436 template to ensure the most accurate results are being submitted to AHCCCS. • Mercy Care DD had a high level of compliance mismatch between its submitted results and HSAG's calculated results. **[Access]** Recommendation: HSAG recommends that Mercy Care DD continue to work with AHCCCS and HSAG to reduce the amount of compliance discrepancies**.** • Mercy Care DD did not meet the minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult; and Dentist, Pediatric. **[Access]** Recommendation: HSAG recommends that Mercy Care DD maintain current compliance with network standards and continue to address network gaps, as applicable. • UHCCP DD had a high level of compliance mismatch between its submitted results and HSAG's calculated results. **[Access]** Recommendation: HSAG recommends that UHCCP DD continue to work with AHCCCS and HSAG to reduce the amount of compliance discrepancies**.**

Strengths, Opportunities for Improvement, and Recommendations
• UHCCP DD did not meet the minimum network requirements for Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; BHRF; Cardiologist, Adult; Dentist, Pediatric; PCP, Adult and Pediatric; and Pharmacy. **[Quality]** Recommendation: HSAG recommends that UHCCP DD maintain current compliance with network standards and continue to address network gaps, as applicable.

Follow-Up on Prior Year's Recommendations (Requirement 438.364[a][6])

Table 11-22 presents NAV recommendations made to DES/DDD in the CYE 2023 Annual Technical Report[249] and DES/DDD's follow-up to the recommendations, as well as an assessment of the degree to which DES/DDD has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 11-22—DES/DDD Program Follow-Up to CYE 2023 NAV Recommendations

Prior Year's Recommendation From the EQR Technical Report for NAV
HSAG recommended that: • AHCCCS support DES/DDD in continuing to monitor its processes for creating the PAT file and that DES/DDD review the PAT file for accuracy prior to submitting to AHCCCS. • AHCCCS support the DES/DDD in continuing to monitor and maintain existing provider network coverage as of CYE 2023 Q4, with specific attention to ensuring the availability of the following provider types: – Behavioral Health Outpatient and Integrated Clinic, Adult in Apache County. – Behavioral Health Outpatient and Integrated Clinic, Pediatric in Apache County – Cardiologist, Adult in Apache County – Dentist, Pediatric in Apache, Greenlee, Gila, and La Paz counties – Hospital in Apache County and Greenlee County – Pharmacy in Apache County • DES/DDD should maintain current compliance with network standards but continue to address network gaps, as applicable.
DES/DDD's Response:

[249] Health Services Advisory Group. *Arizona Health Care Cost Containment System: Contract Year Ending 2023 External Quality Review Annual Technical Report*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2023/CYE2023ExternalQualityReviewAnnualTechnicalReport.pdfAccessed on: Feb 23, 2025.

Prior Year's Recommendation From the EQR Technical Report for NAV
The Division will continue to partner with AHCCCS and subcontracted health plans to ensure there is an adequate network of providers able to serve the DD population. UHCCP: UHCCP DD will continue to monitor and review the PAT file quarterly. Although UHCCP DDD only submits biannually to the State of Arizona, UHCCP DDD runs the PAT process quarterly to ensure any data discrepancies, as well as internal/external errors, and root cause analyses are addressed. In addition, UHCCP DDD performs monthly reviews and audits of provider data to ensure the highest level of accuracy is maintained. UHCCP DDD evaluates the contracted network quarterly. When gaps in the network are identified, UHCCP DDD 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 who enter the county. While UHCCP DDD will continue to evaluate our network quarterly, we have submitted an exception to the Division for the following standards: • Maricopa County: – Behavioral Health Residential Facility (BHRF) • Pima County: – Behavioral Health Residential Facility (BHRF) • Apache County: – Outpatient and Integrated Clinic—Adult – Outpatient and Integrated Clinic—Pediatric – Cardiologist—Adult – Cardiologist—Pediatric – Dentist—Pediatric – Pharmacy – Coconino County: – Outpatient and Integrated Clinic—Adult – Outpatient and Integrated Clinic—Pediatric – La Paz – Dentist—Pediatric – Pharmacy • Coconino County: – Outpatient and Integrated Clinic—Adult – Outpatient and Integrated Clinic—Pediatric • La Paz – Dentist—Pediatric

Prior Year's Recommendation From the EQR Technical Report for NAV
UHCCP DD was able to successfully correct our reporting which previously excluded two facilities in Greenlee. With this correction, UHCCP DDD is meeting the network standard for Hospitals in Greenlee as reflected in our CYE 2024 Period 1 submission. UHCCP DDD has a process in place to identify addresses that have ZIP distributive geocoding and restrict the addresses from receiving a new latitude/longitude location every time the data are reported. This process maintains a particular address to a static location and limits the number of floating members. We believe this contributes to the discrepancies between our reporting and the data compiled by HSAG. Although UHCCP DDD network submissions did not reflect that we missed the standard for Hospitals in Apache or Dentist—Pediatric in Greenlee or Gila, UHCCP DDD will continue to monitor these counties during the quarterly reviews and address any potential recruitment opportunities. Mercy Care: Mercy Care continues existing processes to ensure that the plan maintains compliance with the AHCCCS-required network coverage requirements.
HSAG's Assessment: HSAG has determined that DES/DDD has satisfactorily addressed these prior year's recommendations.

Appendix A. Methodology

Appendix A. Methodology presents, for each EQR activity:

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

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

Validation of Performance Measures

Objectives

Conducted in alignment with the CMS EQR Protocol 2 cited earlier in this report, the primary objectives of the PMV process were to:

- Evaluate the accuracy of performance measure data collected by the Contractors.
- Determine the extent to which the specific performance measures calculated by the Contractors (or on behalf of the Contractors) followed the specifications established for each performance measure.
- Identify overall strengths and areas for improvement in the performance measure calculation process.

Technical Methods of Data Collection

The CMS EQR Protocol 2 identifies key types of data that should be reviewed as part of the validation process. The following list describes the types of data collected and how HSAG analyzed these data:

- **ISCAT:** Contractors completed and submitted an ISCAT to address data collection and reporting specifics of their performance measures. HSAG used the responses from the ISCAT to complete the pre-on-site assessment of information systems.
- **Source code (programming language) for performance measures:** Contractors calculated, or contracted with vendors to calculate, the non-HEDIS performance measures using source code and were required to submit the source code used to generate non-HEDIS performance measures being validated. HSAG completed a line-by-line review of the supplied source code to ensure compliance

with the measure specifications required by AHCCCS. If HEDIS Certified Measures[SM, 250] vendors were used, HSAG reviewed a copy of the certified measures reports to confirm each measure's certification status. HSAG identified any areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any).

- **Medical record documentation:** Contractors submitted the following documentation for review: medical record hybrid tools and instructions, training materials for MRR staff, and policies and procedures outlining the processes for monitoring the accuracy of the reviews performed by the review staff.
- **Supporting documentation:** HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

Pre-Review Activities:

In alignment with CMS EQR Protocol 2, several steps and actions were involved in preparing both the EQRO and each Contractor to implement and conduct the PMV activity, including:

- **Define the scope of the validation**: HSAG worked with AHCCCS to identify the performance measures to be validated for each Contractor and to confirm all standardized measure specifications (e.g., sampling guidelines, eligible population criteria, and numerator and denominator identification). HSAG submitted final validated performance measure results in an agreed-upon, AHCCCS-approved Microsoft Excel workbook format. HSAG provided AHCCCS with each Contractor's program-specific rate reporting template and provided AHCCCS with a consolidated view of the final validated rates as well. HSAG used Contractor-to-Contractor comparisons; comparisons to CY 2022 rates, where applicable; and comparisons to national Medicaid benchmarks, as reasonability checks.
  - A rate was considered materially biased and received a *Do Not Report* (*DNR*) designation if any identified error or errors impacted the performance measure rate by more than 5 percentage points.
  - For hybrid measure reporting, each Contractor's sampling and oversampling methodology was required to align with the measure steward's hybrid reporting specifications. If the Contractor used an oversampling rate greater than 20 percent, HSAG required the Contractor to provide evidence of NCQA approval. HSAG did not accept an oversampling rate greater than the established NCQA standard without the Contractor providing its evidence of NCQA approval.
  - HSAG followed CMS EQR Protocol 2 in reviewing hybrid measures by conducting MRR validation of 30 records for at least two performance measures, across programs as applicable per Contractor, as selected by each Contractor's lead auditor.

[250] HEDIS Certified Measures[SM] is a service mark of the NCQA.

- **Audit preparation**: HSAG confirmed the final scope of the audit with AHCCCS to ensure all written communication to the Contractors contained accurate information on the measures being reported. Upon obtaining AHCCCS' approval of the document request packet templates, HSAG prepared customized document request packets for each Contractor. The memorandum accompanying the packet provided details of the audit process and requirements, including:
  - The audit timeline.
  - Information about virtual review scheduling.
  - A list of all measures under the scope of the audit.
  - The ISCAT to complete and reference to appropriate use of the HEDIS MY 2022 Roadmap.
  - Information on source code review, as well as MRRV and supplemental database review, as applicable.
  - Information on where and how to submit performance measure rates and required documentation.
  - Next steps and whom to contact for additional information.
- **Assess the integrity of the Contractor's information systems (IS)**: As part of the ISCAT, HSAG received detailed information regarding all data systems that feed into collecting and reporting performance measures, including patient data, provider data, claims/encounter data, survey data, and data integration processes.

HSAG used the completed ISCATs to evaluate Contractors' IS and environments, identify any existing potential barriers to data collection and reporting, verify the use and oversight of contracted vendors, and review the medical record abstraction process. Upon completing its review of the ISCAT, HSAG prepared preliminary follow-up actions and items that needed clarification in an IS Tracking Grid. HSAG used the grid throughout the audit process to communicate with the Contractors about items that needed follow-up and to document resolution of each item.

If a Contractor had a comprehensive, independent assessment of its IS during or after July 2023 as conducted during an NCQA HEDIS Compliance Audit, HSAG reviewed and assessed the Contractor's responses to NCQA's Roadmap and its associated attachments. Additionally, if the Contractor had not yet received NCQA Medicaid Health Plan Accreditation but was working through a certified HEDIS compliance auditor specific to its Arizona Medicaid rates, HSAG accepted and reviewed the HEDIS Roadmap responses as applicable to the Contractor's Medicaid product.

- **Conduct detailed review of measures**: HSAG obtained from each Contractor the detailed source code and programming logic used to calculate each measure when HEDIS Certified Measures vendors were not used. HSAG programmers, assigned according to familiarity and expertise with the programming language each Contractor used, conducted a detailed review of each line of code to ensure strict compliance with measure specifications, identifying and estimating any potential bias, and identifying any necessary corrections. As part of this step, HSAG provided each Contractor with feedback on each measure selected for source code review. HSAG's source code reviewers conducted a line-by-line review to meet the following three objectives:

1. Ensure strict compliance with current technical specifications, regardless of source (e.g., HEDIS or CMS) and the accuracy of programming logic. The reviewer documented any noted deviation from the specifications and provided detailed feedback to the Contractor's programmer.
2. Identify and estimate the potential for bias that each deviation can introduce to the measure calculation.
3. Flag issues requiring corrections to code, further investigation, or fixes to the sample. The reviewer documented each issue clearly and initiated discussion with the Contractor to determine action steps for resolving the identified issues.

HSAG made every attempt to identify all issues requiring action before the virtual audit so it could discuss specific strategies with the Contractor during the virtual review. After verifying all corrections to code, HSAG provided the Contractor with a final, written summary of the programming review findings and implications for measure designations. If HEDIS Certified Measures vendors were used, HSAG requested the Contractors to provide a copy of the certified measures reports to confirm each measure's certification status.

- **Medical record and Case Management Record review and Validation (MRRV/CMRRV)**: HSAG provided the Contractors with guidance through each step of the MRR and CMRR to ensure all obstacles that potentially impact hybrid reported rates were identified and corrected early in the audit process. HSAG's MRR team participated in each Contractor's kick-off call to discuss the MRR process and answer any of the Contractor's questions. HSAG did not request a convenience sample but conducted an over-read of approximately 30 records from two hybrid measures to ensure the accuracy of the medical record data abstracted by each Contractor. HSAG followed NCQA's guidelines to validate the integrity of the MRRV processes used by each Contractor and used the MRRV results to determine if the findings impacted the audit results for each performance measure rate. As part of the MRRV, the MRR team:
  - Reviewed and clarified all ISCAT responses (inclusive of the Roadmap, when applicable) pertaining to the Contractor's MRR process, including reviewer training and quality assurance, the medical record procurement approach, data integration with administrative data, and medical record vendor oversight.
  - Conducted a thorough review of the Contractor's selected data abstraction tools, functionality, and reviewer instructions.
  - Conducted a final over-read review of a sample of 30 records from two hybrid measures and all medical record exclusions, inclusive of cases across the Contractors' applicable programs (when applicable), to ensure the accuracy of the medical record data abstracted.
  - Identified errors and determined if they were critical or noncritical based on the following definitions:
    - **Critical error**: Any finding that changed the compliance of a measure from numerator positive to numerator negative impacting the overall rate.
    - **Non-critical error**: Any finding that did not change the overall compliance of the member and resulted in no change to the overall rate; e.g., data entry errors, lab result date collected versus read by MD.

  - If errors were identified, a Contractor could be required to provide additional records for review, based on the auditor's request. Samples with errors equal to or exceeding 10 percent were determined to be materially biased, and HSAG reported the results to AHCCCS to consider adjusting the Contractor's reporting from hybrid to administrative in such instances (although none occurred during the CY 2022 PMV). Error rates less than 10 percent were evaluated for overall rate impact, and hybrid data collection would be allowed if the rate was not materially biased, based on an impact analysis.

- **Prepare for the Contractor virtual audit**: HSAG worked with each Contractor to identify a date for the virtual audit so that all appropriate Contractor staff could be present. Once the audit schedule was finalized, HSAG sent it to AHCCCS and coordinated for AHCCCS staff to observe audits based on AHCCCS' request. HSAG produced a detailed agenda for the virtual audit and worked with each Contractor to ensure the agenda timeline included appropriate staff in the sessions for which they are responsible. Before the date of the virtual audit, HSAG sent the agenda to the Contractor and to AHCCCS, if applicable.
  - Before the virtual audit, HSAG scheduled and facilitated a kick-off call with each Contractor to:
    - Discuss the audit logistics, including virtual review hosting preferences (i.e., Contractor or HSAG), key Contractor attendees, and potential vendor and/or subcontractor attendance if applicable.
    - Review the draft agenda.
    - Discuss any changes in the Contractor's processes or systems since the previous year's PMV audit.
    - Discuss the MRR/CMRR process and timeline.
    - Discuss the timelines for ISCAT submission, use of the HEDIS Roadmap, identification of supplemental data, administrative rate review, preliminary rate review, and performance measure rate submission.
    - Remind the Contractor of the scope of the audit, including measures and primary source verification (PSV) processes.
    - Discuss supplemental databases.
    - Confirm the Contractor's vendor for certified measures, if applicable.
    - Address any Contractor questions or concerns.

Virtual Site Review Activities:

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

- **Opening meeting:** The opening meeting included an introduction of the validation team and key Contractor staff 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 (if applicable) documentation:** This session was designed to be interactive with key Contractor staff so that the validation team could obtain a complete picture of all

steps taken to generate responses to the ISCAT and evaluate the degree of compliance with written documentation. Additionally, to reduce the administrative burden on the Contractors, HSAG allowed submission of the same Roadmap used for the NCQA HEDIS Compliance Audit conducted by the Contractors' NCQA-licensed organizations, where appropriate and applicable, as part of their ISCAT submissions. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and ascertained that 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 IS focusing on claims processing, enrollment and disenrollment data processing, and change tracking. 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. Throughout the evaluation, HSAG conducted interviews with key staff familiar with processing, monitoring, reporting, and calculating the performance measures. Key Contractor staff included executive leadership, enrollment specialists, claims processors, business analysts, customer operations staff, data analytics staff, and other front-line staff familiar with processing, monitoring, and generating 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 reporting 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 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 screen shots that allowed for validation against the source data in the system. These data were also reviewed live in the Contractor's systems during the virtual on-site review for verification, which provided the Contractor with 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 virtual 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 Contractor had system documentation which supported that it appropriately included records for measure reporting. This technique did not rely on a specific number of cases for review to determine compliance; rather, it was 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 could 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 ISCAT review and virtual on-site visit, and revisiting the documentation requirements for any post-virtual on-site activities.

Table A-1 provides a general timeline of the PMV activities and milestones during CYE 2024.

Table A-1—CYE 2024 PMV Activities

PMV Activities and Milestones	Dates
HSAG conducts PMV introductory kick-off call with MCOs.	07/10/2024
HSAG finalizes virtual site review dates with MCOs.	07/15/2024 – 07/22/2024
HSAG conducts MRRV/CMRRV technical assistance call with MCOs.	07/16/2024
MCOs submit completed document request packet, including ISCAT, source code, MRRV Attachment 1: Final Summary of Medical Record/Case Management Record Abstraction Counts and preliminary performance measure rates, if available, to HSAG.	08/09/2024
HSAG conducts desk review and source code review.	08/09/2024 – 09/06/2024
HSAG conducts virtual site reviews with each MCO.	09/16/2024 –0 9/27/2024
MCOs submit final auditor-approved performance measure rate reporting templates to HSAG.	11/26/2024
HSAG submits final (F1) PMV reports with final performance measure rates for each LOB/MCO to AHCCCS and MCOs.	03/30/2025

Description of Data Obtained

As identified in the CMS EQR Protocol 2, HSAG obtained and reviewed the following key types of data for CY 2023 as part of the PMV:

1. **ISCAT:** This was received from each Contractor. The completed ISCAT provided HSAG with background information on the Contractor's IS, policies, processes, and data in preparation for the virtual validation activities.
2. **Source code (programming language) for performance measures:** This was obtained from each Contractor and was used to determine compliance with the performance measure definitions. If HEDIS Certified Measures vendors were used, HSAG requested the Contractors to provide a copy of the certified measure reports to confirm each measure's certification status.
3. **Supporting documentation:** This provided additional information needed by HSAG reviewers to complete the validation process, including performance measure definitions, file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.
4. **Current performance measure results:** HSAG obtained the results from the measures each Contractor reported and calculated.

5. **Virtual interviews and demonstrations:** HSAG obtained information through interaction, discussion, and formal interviews with key Contractor staff as well as through system demonstrations.

How Data Were Aggregated and Analyzed

HSAG also performed a performance validation audit of each Contractor for AHCCCS' selected measures. HSAG evaluated each Contractor's eligibility and enrollment data systems, medical services data systems, and data integration process through an ISCAT, source code review, virtual review of the Contractor, and PSV of a selected sample of measure data.

HSAG analyzed the quantitative results obtained from the above PMV activity to identify strengths and opportunities for improvement in each domain of Quality, Timeliness, and Access as they relate to services furnished by each Contractor. HSAG then identified common themes and the salient patterns that emerged across Contractors related to the PMV activity conducted.

How Conclusions Were Drawn

Information Systems Standards Review

Contractors were required to demonstrate compliance with IS standards. Contractors' compliance with IS standards is linked to the validity and reliability of reported performance measure data. HSAG reviewed and evaluated all data sources to determine Contractor compliance with *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*.[251] The IS standards are as follows:

- Medical Services Data (Claims/Encounters): Sound Coding Methods and Data Capture, Transfer, and Entry
- Enrollment Data: Data Capture, Transfer, and Entry
- Practitioner Data: Data Capture, Transfer, and Entry
- Medical Record Review Processes: Training, Sampling, Abstraction, and Oversight
- Supplemental Data: Capture, Transfer, and Entry
- Data Preproduction Processing: Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity
- Data Integration: Accurate Reporting, Control Procedures That Support Measure Reporting Integrity

[251] National Committee for Quality Assurance. HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5. Washington D.C.

HSAG used the following standardized rating methodology for PMV, as outlined in the current CMS EQR Protocol 2:

- *Reportable (R)*: The measure was compliant with the applicable technical specifications
- *Do Not Report (DNR)*: The Contractor rate was materially biased and should not be reported
- *Not Applicable (NA)*: The Contractor was not required to report the measure due to a small denominator
- *Not Required (NR)*: The measure was not reported because the measure was optional to report

Based on all validation activities, HSAG determined results for each performance measure. According to the CMS EQR Protocol 2, the validation designation for each performance measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be noncompliant based on the review findings. Consequently, an error for a single audit element may result in a designation of *DNR* because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, leading to a designation of *R*.

Any suggested corrective action that was closely related to accurate rate reporting that could not be implemented in time to produce validated results rendered a particular measure as *DNR*.

Performance Measure Results

Each Contractor's performance measure results for CY 2023 were compared to program-level aggregate rates, prior year's Contractor-specific performance, and NCQA's Quality Compass national Medicaid HMO mean for CY 2023, where applicable.

To draw conclusions about the quality and timeliness of, and access to care and services provided by the Contractors, HSAG assigned each of the performance measures to one or more of the three domains of care (i.e., Quality, Timeliness, and Access). This assignment to domains of care is depicted in Table A-2. The measure marked "NA" indicates the measure is related to utilization of services and therefore is not assigned to a domain of care.

Table A-2—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains

Performance Measure	Quality	Timeliness	Access
Maternal and Perinatal Care			
Prenatal and Postpartum Care—Timeliness of Prenatal Care	✓	✓	✓
Prenatal and Postpartum Care—Postpartum Care	✓	✓	✓
Behavioral Health			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	✓		

Performance Measure	Quality	Timeliness	Access
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	✓		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	✓		
Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	✓	✓	✓
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	✓	✓	✓
Use of Opioids at High Dosage	✓		
Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total and *Engagement of SUD Treatment—Total—Total*	✓	✓	✓
Care of Acute and Chronic Conditions			
Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 Percent) and *HbA1c Poor Control (>9.0 Percent)*	✓		
Controlling High Blood Pressure	✓		
Pediatric Health			
Child and Adolescent Well-Care Visits	✓		✓
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months and *Well-Child Visits for Age 15 Months–30 Months*	✓		✓
Oral Evaluation, Dental Services			✓
Childhood Immunization Status— *Combination 3: diphtheria, tetanus and acellular pertussis [DTaP]; polio [IPV]; measles, mumps and rubella [MMR]; haemophilus influenza type B [HiB]; hepatitis B [HepB]; chicken pox [VZV]; pneumococcal conjugate [PCV]* *Combination 7: DTaP, IPV, MMR, HiB, HepB, VZV, PCV, hepatitis A [HepA], rotavirus [RV]* *Combination 10: DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV, influenza [flu]*	✓		✓
Immunizations for Adolescents—Combinations 1 (tetanus; diphtheria toxoids and acellular pertussis [Tdap]) and 2 (tetanus, Tdap, human papillomavirus [HPV])	✓		
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing	✓		

Performance Measure	Quality	Timeliness	Access
Preventive Screening			
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Appropriate Utilization of Services			
*Ambulatory Care—ED Utilization**	NA	NA	NA
Plan All-Cause Readmissions	✓		

*Not assigned to a domain as a lower or higher rate does not indicate better or worse performance.

Validation of Performance Improvement Projects

Objectives

The purpose of PIPs is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in both clinical and nonclinical areas. For the projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, the PIPs must be designed, conducted, and reported using sound methodology and must be completed in a reasonable time. This structured method of assessing and improving health plan processes is expected to have a favorable effect on health outcomes and member satisfaction.

The primary objective of PIP validation is to determine the validity and reliability of a PIP through assessing a Contractor's compliance with the requirements. For CY 2024, AHCCCS required Contractors to conduct PIPs in accordance with 42 CFR 438.330(b)(1) and 438.330(d)(2)(i–iv). In accordance with 438.330(d)(2)(i–iv), each PIP must include:

- Measuring performance using objective quality indicators.
- Implementing system interventions to achieve improvement in quality.
- Evaluating effectiveness of the interventions.
- Planning and initiating activities for increasing and sustaining improvement.

The goal of HSAG's PIP validation is to ensure that AHCCCS and key stakeholders can have confidence that the Contractor executed a methodologically sound improvement project, and any reported improvement is related to and can be reasonably linked to the QI strategies and activities conducted by the Contractor during the PIP.

Technical Methods of Data Collection

In its PIP evaluation and validation, HSAG used the CMS EQR *Protocol 1: Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023.[252] HSAG's evaluation of the PIP includes two key components of the QI process:

- HSAG evaluates the technical structure of the PIP to ensure that the Contractor designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (i.e., Aim statement, population, sampling methods, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
- HSAG evaluates the implementation of the PIP. Once designed, a Contractor's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the Contractor improves its rates through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results).

HSAG used the *AHCCCS Performance Improvement Project (PIP) Report* which each Contractor completed and submitted to HSAG for review and validation. The *AHCCCS Performance Improvement Project (PIP) Report* standardizes the process for submitting information regarding PIPs and ensures alignment with the CMS EQR Protocol requirements.

HSAG, with AHCCCS's input and approval, developed a PIP Validation Tool to ensure a uniformed validation of the PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS EQR Protocols. The HSAG PIP Team consisted of, at a minimum, an analyst with expertise in statistics, PIP design, and performance improvement processes and a clinician with expertise in performance improvement processes. The CMS EQR Protocol 1 identifies nine steps that should be validated for each PIP.

The nine steps included in the PIP Validation Tool are listed below:

1. Review the Selected PIP Topic
2. Review the PIP Aim Statement
3. Review the Identified PIP Population
4. Review the Sampling Method
5. Review the Selected Performance Indicator(s)
6. Review the Data Collection Procedures
7. Review the Data Analysis and Interpretation of PIP Results

[252] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 21, 2025.

8. Assess the Improvement Strategies
9. Assess the Likelihood that Significant and Sustained Improvement Occurred

HSAG used the following methodology to evaluate PIPs conducted by the Contractors to determine PIP validity and to rate the compliance with the CMS EQR Protocol 1 for conducting PIPs.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as "critical elements." For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall rating of *No Confidence* for the PIP. The Contractor is assigned two confidence levels, the overall confidence of adherence to acceptable methodology for all phases of the PIP and the overall confidence that the PIP achieved significant improvement.

In addition to the two overall confidence levels, HSAG assigns the PIP a percentage score for all evaluation elements (including critical elements) for each confidence level. HSAG calculates the percentage scores by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met* with *Not Assessed* and *Not Applicable* elements removed. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met* with *Not Assessed* and *Not Applicable* elements removed. HSAG assessed the PIP's results for the two confidence levels using the following methods.

Confidence Levels for Acceptable PIP Methodology

- *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
- *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
- *Low Confidence*: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*, or one or more critical evaluation elements were *Partially Met*.
- *No Confidence*: No confidence in reported PIP results. Less than 65 percent of all evaluation elements were *Met* across all steps, or one or more critical evaluation elements were *Not Met.*

Confidence Levels for Significant Improvement

- *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
- *Moderate Confidence*: To receive *Moderate Confidence* for significant improvement, one of the three scenarios below occurred:
  - All performance indicators demonstrated improvement over the baseline **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.

  - All performance indicators demonstrated improvement over the baseline **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
  - Some but not all performance indicators demonstrated improvement over baseline **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
- *Low Confidence*: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
- *No Confidence*: The remeasurement methodology differed from the baseline methodology for all performance indicators **or** none of the performance indicators demonstrated improvement over the baseline.

The Contractors had the opportunity to receive initial PIP validation scores and detailed feedback, request technical assistance and guidance from HSAG, make any necessary corrections, and resubmit the PIP for final validation. HSAG forwarded the completed validation tools to AHCCCS and the Contractors.

Table A-3 provides a general timeline of the PIP activities and milestones during CYE 2024.

Table A-3—CYE 2024 PIP Activities

PIP Activities and Milestones	Dates
Initial PIP submissions due to HSAG	09/09/2024
Initial PIP validation tools due to MCOs for review and approval	11/26/2024
PIP resubmissions due to HSAG	12/19/2024
Final PIP validation tools due to MCOs and AHCCCS	02/18/2025

Description of Data Obtained

For the CYE 2024 validation, the Contractors submitted Remeasurement 2 data for the *Back to Basics*, *Breast Cancer Screening,* and *Preventive Screening* PIPs. Contractor-calculated indicator results, validated by the EQRO in alignment with the CMS EQR Protocol 1, were utilized for PIP validation. The performance indicator measurement period dates for the PIPs are listed below.

Table A-4 presents the measurement periods for the *Back to Basics, Breast Cancer Screening,* and *Preventive Screening* PIPs. HSAG did not validate the *Prenatal and Postpartum Care* PIPs in CYE 2024 as requested by AHCCCS. The Contractors submitted updated *Prenatal and Postpartum Care* PIP intervention information for inclusion in this report.

Table A-4—Measurement Periods for *Back to Basics, Breast Cancer Screening,* and *Preventive Screening* PIPs

PIPs—*Back to Basics, Breast Cancer Screening,* and *Preventive Screening*				
CYE 2019	**CY 2020**	**CY 2021**	**CY 2022**	**CY 2023**
Baseline Measurement (10/01/2018–09/30/2019)	Intervention Year 1 (01/01/2020–12/31/2020)	Intervention Year 2 (01/01/2021–12/31/2021)	Remeasurement Year 1 (01/01/2022–12/31/2022)	Remeasurement Year 2 (01/01/2023–12/31/2023)

Table A-5 presents the measurement periods for the *Prenatal and Postpartum Care* PIP.

Table A-5—Measurement Periods for *Prenatal and Postpartum Care* PIPs

PIP—*Prenatal and Postpartum Care*			
CY 2022	**CY 2023**	**CY 2024**	**CY 2025**
Baseline Measurement (01/01/2022–12/31/2022)	Intervention Year 1 (01/01/2023–12/31/2023)	Remeasurement Year 1 (01/01/2024–12/31/2024)	Remeasurement Year 2 (01/01/2025–12/31/2025)

How Data Were Aggregated and Analyzed

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

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

Annual measurements (Remeasurement Year 1, Remeasurement Year 2, as well as any subsequent remeasurement years necessary for the Contractor to meet the required criteria for PIP closure) are utilized to evaluate Contractor performance. AHCCCS may require interim measurements, depending on the resources required, to collect and analyze data. Annual measurements (rates and results) are used as the basis for quantitative and qualitative analyses and the selection/modification of interventions.

Contractors are required to submit a formal PIP report to AHCCCS in accordance with the contract. AHCCCS reviews and validates each Contractor PIP report submission to ensure alignment with AHCCCS PIP policy and checklist requirements. Following this review, each AHCCCS Contractor is provided formal feedback and may be required to resubmit its PIP report if such requirements are not met.

AHCCCS reviews Contractors' submissions to verify adequate participation in the PIP until Contractors' demonstration of significant and sustained improvement is shown, as outlined below.

How Conclusions Were Drawn

HSAG validated the PIPs to ensure the Contractor used a sound methodology in its design, implementation, analysis, and reporting of the PIP's findings and outcomes. The process assesses the validation findings on the likely validity and reliability of the results by assigning two confidence ratings, one for overall methodological soundness of the PIP design and the second for significant improvement achieved. The confidence levels assigned to the two ratings were either *High Confidence, Moderate Confidence, Low Confidence,* or *No Confidence.*

To draw conclusions about the quality and timeliness of, and access to care and services provided by the Contractors, HSAG assigned each of the components reviewed for PIP validation to one or more of the three domains (i.e., Quality, Timeliness, and/or Access). While the focus of a Contractor's PIP may have been to improve performance related to healthcare Quality, Timeliness, or Access, PIP validation activities were designed to evaluate the validity and quality of the Contractor's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the Quality domain. In addition, the PIP topic was also assigned to other domains as appropriate. This assignment to domains is shown in Table A-6.

Table A-6—Assignment of PIPs to the Quality, Timeliness, and Access Domains

PIP	Quality	Timeliness	Access
Back to Basics	✓	✓	✓
Breast Cancer Screening	✓		✓
Preventive Screening	✓		✓
Prenatal and Postpartum Care	✓	✓	✓

Compliance Review

Objectives

AHCCCS' objectives for conducting compliance reviews are as follows:

- Determine if the Contractor satisfactorily met AHCCCS' requirements as specified in its contract, AHCCCS policies, Arizona Revised Statutes, the Arizona Administrative Code (AAC), and Medicaid managed care regulations (42 CFR 438).
- Provide technical assistance and identify areas in which the Contractor can improve as well as areas of noteworthy performance and accomplishments.

- Review the Contractor's progress in implementing recommendations that AHCCCS made during prior compliance reviews.
- Determine if the Contractor complied with its own policies and evaluate the effectiveness of those policies and procedures.
- Determine Contractor compliance with commitments made during the RFP process.
- Perform oversight of the Contractor as required by CMS in accordance with AHCCCS' 1115 Waiver.
- Provide information to HSAG as AHCCCS' EQRO to use in preparing the annual EQR technical report as described in 42 CFR 438.364.

Technical Methods of Data Collection

AHCCCS conducts compliance reviews on a three-year cycle. During the first year of the compliance review cycle, AHCCCS conducts the compliance review of all standards. During the second and third years of the cycle, Contractors submit proposed CAPs and evidence of compliance to AHCCCS for approval.

To assess the Contractors' compliance with regulations, AHCCCS conducted the five activities described in the CMS EQR *Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations,* February 2023.[253] Table A-7 describes the five protocol activities and the specific tasks that AHCCCS performed to complete each activity.

Table A-7—Protocol Activities Performed for Assessment of Compliance With Regulations

For this protocol activity,	AHCCCS completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	• AHCCCS determined the timing and scope of the reviews, as well as scoring strategies. • AHCCCS developed monitoring tools and templates, agendas, and set review dates. • AHCCCS conducted training for all reviewers to ensure consistency in scoring across the Contractors.
Activity 2:	**Perform Preliminary Review**
	• AHCCCS notified the Contractors in writing of the request for desk review documents via email delivery of the compliance monitoring tool and an agenda.

[253] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Jan 13, 2025.

For this protocol activity,	AHCCCS completed the following activities:
	The desk review request included instructions for organizing and preparing the documents to be submitted. • Prior to the review, the Contractors provided data files from which AHCCCS chose samples to be reviewed, including grievance, appeal, and denial cases. AHCCCS provided the final samples to the Contractors via AHCCCS' SFTP site. Prior to the scheduled review, the Contractors provided documentation for the desk review, as requested. • Examples of documents submitted for the desk review and compliance review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The AHCCCS review team reviewed all documentation submitted prior to the scheduled webinar and prepared a request for further documentation, as needed, and an interview guide to use during the webinar.
Activity 3:	**Conduct the Review**
	• During the review, AHCCCS met with groups of the Contractors' key staff to obtain a complete picture of the Contractors' compliance with Medicaid and CHIP managed care regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the Contractors' performance. • AHCCCS requested, collected, and reviewed additional documents, as needed. • At the close of the review, AHCCCS may provide the Contractors' staff with a high-level overview of how the overall review process went.
Activity 4:	**Compile and Analyze Findings**
	• AHCCCS used a compliance report template to compile the findings and incorporate information from the compliance review activities. • AHCCCS analyzed the findings and calculated scores based on pre-determined scoring strategies. • AHCCCS determined opportunities for improvement, recommendations, and corrective actions required based on the review findings.
Activity 5:	**Report Results**
	• AHCCCS populated the report template. • AHCCCS submitted the draft report to the Contractors for review and comment. • AHCCCS considered the Contractors' requests for reconsideration, as applicable, and finalized the report.

For this protocol activity,	AHCCCS completed the following activities:
	• AHCCCS included a CAP template with the final report for all requirements determined to be out of compliance with managed care regulations (i.e., received a score less than 95 percent). • AHCCCS distributed the final report, scores, and CAP template to the Contractor.

Table A-8 provides a general timeline of the compliance review activities and milestones during CYE 2024.

Table A-8—CYE 2024 Compliance Review Activities

Compliance Review Activities and Milestones	Dates
AHCCCS conducted compliance reviews of the ACC-RBHA Contractors.	12/11/2023 – 02/15/2024
AHCCCS finalized the compliance review report of findings for the ACC-RBHA Contractors.	03/08/2024 – 05/02/2024
AHCCCS reviewed and accepted the ACC-RBHA Contractors' CAPs.	03/08/2024 – 05/31/2024
AHCCCS conducted ongoing reviews of all Contractors' outstanding CAP items for required revisions or successful closure.	01/01/2024 – 12/31/2024

Description of Data Obtained

The following are examples of documents reviewed and sources of the data obtained:

- Committee meeting agendas, minutes, and reports
- Policies and procedures
- Management/monitoring reports
- Quarterly reports
- Provider manual and directory
- Member handbook and informational materials
- Staff training materials and documentation of training attendance
- Applicable correspondence or template communications
- Records or files related to administrative tasks (grievances and appeals)
- Interviews with the Contractors' key staff

How Data Were Aggregated and Analyzed

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

Focus areas include standards articulated at 42 CFR Part 438 as well as additional contractual requirements. In addition, there may be focus areas based solely on contract requirements.

AHCCCS included the following focus areas in its compliance review. Table A-9 includes a list of each focus area crosswalked with the related federal requirements found in 42 CFR Part 438. While the CYE 2024 compliance reviews did not include an assessment of the MCOs' performance in relation to 42 CFR 438.56, AHCCCS will include this CFR within compliance reviews to be conducted in CYE 2025. Results of the CYE 2025 operational reviews will be included in the EQR annual technical report posted to the AHCCCS website in April 2026.

Table A-9—Crosswalk of AHCCCS Focus Areas and Federal Requirements

Focus Areas	Federal Requirements Included
CC	438.242, 438.608, 438.610, 455.1, 455.17, 455.100–106, 455.436
CIS	433.135, 434.6, 438.242, 438.600
CM*	438.208, 438.608, 440.70, 440.169, 440.180, , 441.18, 441.400, 441.468, 441.725, 441.730
DS	438.12, 438.102, 438.206, 438.207, 438.214, 438.242
GA	164.530, 438.3, 438.224
GM**	This focus area reflects the Contractor's fulfillment of State requirements or regulations outside of CFR 438.
GS	438.10, 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.420, 438.424
MCH	441.56, 441.58
MM	438.62, 438.114, 438.208, 438.210, 438.228, 438.230, 438.236, , 438.330, 438.404, 456.125–133
MI	438.10, 438.100, 438.206, 438.207, 438.208, 438.406
QM	438.3, 438.66, 438.206, 438.214, 438.228, 438.230, 438.402, 438.406, 438.408, 438.416, 438.330, 476.160
QI	438.330, 438.242
RI	This focus area reflects the Contractor's fulfillment of State requirements or regulations outside of CFR 438.
TPL	This focus area reflects the Contractor's fulfillment of State requirements or regulations outside of CFR 438.

Focus Areas	Federal Requirements Included
ISOC	This focus area reflects the Contractor's fulfillment of State requirements or regulations outside of CFR 438.

*The CM Focus Area does not apply to ACC Program Contractors.
**The GM Focus Area is only applicable to ACC-RBHA Contractors.

IS review is part of the PMV process for AHCCCS; therefore, there is no IS component in the compliance review. In addition to the PMV process, AHCCCS evaluates the Contractors' IS through ongoing monthly deliverables, encounter editing processes, and data validation processes. Further, as of CY 2020, AHCCCS transitioned to using Contractor-calculated performance measure rates that are validated by HSAG.

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

HSAG analyzed the quantitative results obtained from the compliance activity to identify strengths and opportunities for improvement in each domain of Quality, Timeliness, and Access to services furnished by each Contractor. HSAG then identified common themes and the salient patterns that emerged across Contractors related to the compliance activity conducted.

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

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

In years 2 and 3 of the compliance review cycle, AHCCCS reviews Contractors' proposed CAPs and either approves or requests more information. Once approved, Contractors must provide AHCCCS with evidence of compliance. AHCCCS reviews the evidence of compliance, and if sufficient, accepts and closes the Contactor's CAP.

HSAG reviewed AHCCCS' assessment of CAPs and assigned a score of *Met, Partially Met, Not Met,* or *Not Applicable* for each focus area reviewed:

- *Not Applicable:* A CAP was not required as the score was 95 percent or greater.
- *Partially Met*: AHCCCS approved the Contractor's proposed CAP. The Contractor must submit evidence of compliance.
- *Met*: AHCCCS accepted and closed the Contractor's CAP.

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to care and services, AHCCCS assigned each of the components reviewed for assessment of compliance with regulations to one or more of the three domains (i.e., Quality, Timeliness, and/or Access). Each standard may involve assessment of more than one domain of care due to the combination of individual requirements within each standard. To draw conclusions and make recommendations, HSAG then analyzed the individual requirements within each standard that assessed the quality or timeliness of, or access to care and services provided by the Contractors.

Table A-10 depicts assignment of the standards to the domains of care.

Table A-10—Assignment of Focus Areas to the Quality, Timeliness, and Access Domains

Focus Areas	Quality	Timeliness	Access
CC	✓		✓
CIS			✓
CM*	✓		✓
DS		✓	✓
GA		✓	✓
GM**	✓		✓
GS	✓	✓	✓
MCH		✓	✓
MM	✓	✓	✓
MI	✓		
QM	✓		
QI	✓		✓
RI	✓		
TPL	✓	✓	✓
ISOC	✓		✓

*The CM Focus Area does not apply to ACC Program Contractors.
**The GM Focus Area is only applicable to ACC-RBHA Contractors.

Network Adequacy Validation

AHCCCS contracted with HSAG to support the validation of its healthcare provider networks subcontracted to AHCCCS' Contractors. HSAG's validation of managed care network adequacy

considered each Contractor's compliance with all applicable AHCCCS-established standards[254] for specific provider categories and populations within the Contractors' provider networks.

Objectives

As guided by the CMS EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023,[255] HSAG conducted the following tasks during the CYE 2024 NAV activity:

- **Defined the scope of the validation of the quantitative network adequacy standards:** HSAG obtained needed information from the State, identified and defined network adequacy indicators for validation, identified and defined provider categories subject to standards, and established a timeline for activities.
- **Identified data sources for validation:** HSAG worked with AHCCCS and the Contractors to identify NAV-related data sources and to answer clarifying questions regarding the data sources.
- **Reviewed the information systems underlying network adequacy monitoring:** HSAG developed NAV document request materials and an ISCAT, reviewed each Contractor's ISCA, and assessed systems and processes for collecting and maintaining network adequacy data used to inform the calculation and reporting of network adequacy standards and indicators in scope of review.
- **Validated network adequacy assessment data, methods, and results:** HSAG assessed the reliability and validity of each Contractor's network adequacy data, methods, and results; performed an independent calculation of the percentage of members with access within time/distance standards; and calculated validation ratings for all indicators and summarized validation findings.

Table A-11 lists the Contractors that HSAG included in the CYE 2024 NAV, as well as the LOB and geographic region(s) associated with each Contractor. Each Contractor may serve members living in Arizona's Central, North, and/or South Geographic Service Areas (GSAs).[256]

[254] The ACOM, Section 417–Appointment Availability, Transportation Timeliness, Monitoring, and Reporting and Section 436–Network Standards defines time/distance standards. The ACOM is available at: https://www.azahcccs.gov/shared/ACOM/

[255] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 23, 2025.

[256] The Arizona counties associated with the Central, North, and South GSAs for all LOBs are as follows:
- Central GSA: Gila, Maricopa, and Pinal counties
- North GSA: Apache, Coconino, Mohave, Navajo, and Yavapai counties
- South GSA: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma counties

Table A-11—AHCCCS Contractors by LOB and GSA

Contractor Name	Contractor Abbreviation	LOB and GSA				
		ACC	ACC-RBHA	ALTCS-DD	ALTCS-EPD	DCS CHP
Arizona Complete Health–Complete Care Plan	**AzCH-CCP**	Central South	South			
Banner–University Family Care	**BUFC**	Central South			Central South	
Care1st Health Plan[1]	**Care1st**	North	North			
Health Choice Arizona	**HCA**	Central North				
Mercy Care	**Mercy Care**	Central	Central	Statewide	Central South (Pima only)	Statewide
Molina Complete Care	**Molina**	Central				
UnitedHealthcare Community Plan	**UHCCP**	Central South (Pima Only)		Statewide	Central North	

[1] As of October 1, 2024, Care1st transferred network responsibilities to AzCH-CCP.

Scope of Validation of Quantitative Network Adequacy Standards

The CYE 2024 NAV included study indicators from the following domains, described in further detail below:

- **Time and Distance Validation**: HSAG's validation of results for all applicable AHCCCS-established time/distance standards by Contractor, LOB, and county, using PMMIS and PAT data.
  - Study indicators will show the percentage of members assigned by AHCCCS to the specified county, with access to any provider location serving the LOB within the time/distance standard.
- **Appointment Access and Availability Validation**: HSAG's validation of results for all applicable AHCCCS-established appointment access and availability standards by Contractor and LOB using provider directory source data.

Time and Distance Validation

The PMMIS and PAT data were used to calculate the percentage of members within the time/distance standards described in Table A-12.

Table A-12—Time and Distance Network Standards for AHCCCS Contractors by Provider Type and County

Provider Category	Member Population	Network Standard Maricopa and Pima Counties	Network Standard All Other Arizona Counties
Behavioral Health Outpatient and Integrated Clinic, Adult[5,6]	Members ages 18 years and older	90 percent of members within 15 minutes or 10 miles	90 percent of members within 60 miles
Behavioral Health Outpatient and Integrated Clinic, Pediatric[4,6]	Members younger than 18 years of age	90 percent of members within 15 minutes or 10 miles	90 percent of members within 60 miles
BHRF[1]	All members	90 percent of members within 15 minutes or 10 miles	Not Applicable
Cardiologist, Adult[5,6]	Members ages 21 years and older	90 percent of members within 30 minutes or 20 miles	90 percent of members within 75 minutes or 60 miles
Cardiologist, Pediatric[6]	Members younger than 21 years of age	90 percent of members within 60 minutes or 45 miles	90 percent of members within 110 minutes or 100 miles
Crisis Stabilization Facility[2]	All members	90 percent of members within 15 minutes or 10 miles	90 percent of members within 45 miles
Dentist, Pediatric	Members younger than 21 years of age	90 percent of members within 15 minutes or 10 miles	90 percent of members within 40 minutes or 30 miles
Hospital	All members	90 percent of members within 45 minutes or 30 miles	90 percent of members within 95 minutes or 85 miles
Nursing Facility[3]	All members currently residing in their own home	90 percent of members within 45 minutes or 30 miles	90 percent of members within 95 minutes or 85 miles
OB/GYN	Female members ages 15 to 45 years	90 percent of members within 45 minutes or 30 miles	90 percent of members within 90 minutes or 75 miles
Pharmacy	All members	90 percent of members within 12 minutes or 8 miles	90 percent of members within 40 minutes or 30 miles
PCP, Adult[5,6]	Members ages 21 years and older	90 percent of members within 15 minutes or 10 miles	90 percent of members within 40 minutes or 30 miles
PCP, Pediatric[6]	Members younger than 21 years of age	90 percent of members within 15 minutes or 10 miles	90 percent of members within 40 minutes or 30 miles

[1] Applies only to Maricopa and Pima counties.

[2] Applies only to ACC-RBHA Contractors.

[3] Applies only to ALTCS Contractors.

[4] Applies to all Contractors except ACC-RBHA Contractors.

[5] Calculations for DCS CHP do not include standards applicable only to adults (i.e., Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult; or PCP, Adult).

[6] Services identified as eligible for a telehealth standard modification only require 80 percent of a county's membership to meet the time/distance standards where telehealth services are available for that provider category.

Additionally, HSAG mapped providers to a provider category consistent with AHCCCS' ACOM 436 requirements by using a combination of provider type and/or provider specialty codes. Table A-13 provides a network crosswalk for each provider category in the time/distance analyses.

Table A-13—Provider Category Crosswalk

Provider Type/Provider Specialty Codes	
Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric	
Provider Type Code: • 77–Behavioral Health Outpatient Clinic • IC–Integrated Clinics	
BHRF	
Provider Type Code: • B8–Behavioral Health Residential Facility	
Cardiologist, Adult	
Provider Type Code: • 08–MD-Physician • 31–DO-Physician Osteopath	**with a Provider Specialty Code:** • 062–Cardiovascular Medicine • 927–Cardiologist
Cardiologist, Pediatric	
Provider Type Code: • 08–MD-Physician • 31–DO-Physician Osteopath	**with a Provider Specialty Code:** • 062–Cardiovascular Medicine • 151–Pediatric Cardiologist • 927–Cardiologist
Crisis Stabilization Facility	
Provider Type Code: • 02–Hospital • 71–Psychiatric Hospital • 77–Behavioral Health Outpatient Clinic	• B5–Subacute Facility • B6–Subacute Facility • B7–Crisis Services Provider
or	
Provider Type Code: • IC–Integrated Clinics that are authorized to provide behavioral health observation/stabilization in accordance with A.A.C. 9-10-1012	
Dentist, Pediatric	
Provider Type Code: • 07–Dentist	**with a Provider Specialty Code:** • 800–Dentist-General • 804–Dentist-Pediatric Dentist
or	
Provider Type Code:	

Provider Type/Provider Specialty Codes	
• C2–Federally Qualified Health Centers (FQHCs) identified by AHCCCS	
Hospital	
Provider Type Code: • 02–Hospital • C4–Specialty Per Diem Hospitals	
Nursing Facility	
Provider Type Code: • 22–Nursing Home	
Obstetrician/Gynecologist (OB/GYN)	
Provider Type Code: • 08–MD-Physician • 19–Registered Nurse Practitioner • 31–DO-Physician Osteopath • CN–Clinical Nurse Specialist	**with a Provider Specialty Code:** • 089–OB/GYN • 090–Gynecologist • 091–Obstetrician • 095–Women's Health Care-OB/GYN Nurse Practitioner • 181–Surgery-Obstetrical • 219–Surgery-Gynecological
Pharmacy	
Provider Type Code: • 03–Pharmacy • 05–Clinic	
PCP, Adult	
Provider Type Code: • 08–MD-Physician • 31–DO-Physician Osteopath	**with a Provider Specialty Code:** • 050–Family Practice • 055–General Practice • 060–Internal Medicine • 089–OB/GYN • 091–Obstetrician
or	
Provider Type Code: • 19–Registered Nurse Practitioner • CN–Clinical Nurse Specialist	**with a Provider Specialty Code:** • 084–RN-Family Nurse Practitioner • 095–Women's Health Care-OB/GYN Nurse Practitioner • 097–RN-Adult Nurse Practitioner
or	
Provider Type Code:	**with a Provider Specialty Code:**

Provider Type/Provider Specialty Codes	
• 18–Physician Assistant	• 798–Physician Assistant
PCP, Pediatric	
Provider Type Code: • 08–MD-Physician • 31–DO-Physician Osteopath	**with a Provider Specialty Code:** • 050–Family Practice • 150–Pediatrician • 176–Adolescent Medicine
or	
Provider Type Code: • 19–Registered Nurse Practitioner • CN–Clinical Nurse Specialist	**with a Provider Specialty Code:** • 084–Family Nurse Practitioner • 087–RN-Pediatric Nurse Practitioner • 097–RN-Adult Nurse Practitioner
or	
Provider Type Code: • 18–Physician Assistant	**with a Provider Specialty Code:** • 798–Physician Assistant

Appointment Access and Availability Validation

The provider directory data were used to ensure providers were meeting the appointment access and availability standards described in Table A-14.

Table A-14—Appointment Access and Availability Standards for AHCCCS Contractors by Provider Category and LOB

Provider Category	Appointment Type	Appointment Standard
General Appointment Standards for All LOBs		
Primary Care	Urgent	no later than 2 business days of request[1]
	Routine	within 21 calendar days of request
Specialty Physician, Including Dental Specialists	Urgent	no later than 2 business days of request[1]
	Routine	within 45 calendar days of referral
Dental	Urgent	no later than 3 business days of request[1]
	Routine	within 45 calendar days of request[2]
Maternity Care[3]	First Trimester	within 14 calendar days of request

Provider Category	Appointment Type	Appointment Standard
	Second Trimester	within 7 calendar days of request
	Third Trimester	within 3 business days of request
	High Risk Pregnancy	no later than 3 business days of identification of high risk[1,4]
Psychotropic Medication Appointment Standards for All LOBs		
Behavioral Health	Referral for Psychotropic Medications	Provide an appointment, if clinically indicated, with a practitioner who can prescribe psychotropic medications within a time frame that ensures the member: • Does not run out of needed medications, or • Does not decline in their behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need
Behavioral Health Appointment Standards or ACC, ACC-RBHA, ALTCS-DD, and ALTCS-EPD LOBs		
Behavioral Health	Urgent	no later than 24 hours from identification of need[1]
	Routine: Initial Assessment	within 7 calendar days after the initial referral or request
	Routine: First Service Following Initial Assessment (Adult)	no later than 23 calendar days after the initial assessment
	Routine: First Service Following Initial Assessment (Child)	no later than 21 days after the initial assessment
	Routine: Subsequent Services	no longer than 45 calendar days from identification of need[5]
Behavioral Health Appointment Standards for DCS CHP LOB		
Behavioral Health	Rapid Response When a Child Enters Out-of-Home Placement	no later than 72 hours after notification by the DCS that a child has been or will be removed from their home
	Initial Assessment	within 7 calendar days after the initial referral or request for behavioral health services
	Initial Appointment	no later than 21 calendar days after the initial assessment[5]
	Subsequent Services	no longer than 21 calendar days from the identification of need[5]

[1] As expeditiously as the member's health condition requires

[2] For DCS CHP only, routine care appointments within 30 calendar days of request

[3] For initial prenatal care appointments with the provider for enrolled pregnant members

[4] Within 3 days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists

[5] Within time frames indicated by clinical need

Technical Methods of Data Collection

The CMS EQR Protocol 4 identifies key activities and data sources needed for NAV. The following describes the types of data collected and how HSAG conducted an analysis of these data.

Review Information Systems Underlying Network Adequacy Monitoring

HSAG completed a desk review of the submitted ISCAT, followed by virtual interviews that included Contractor network-related information systems demonstrations and discussion of data management processes described in the ISCAT submission.

HSAG conducted an ISCA using each Contractor's completed ISCAT and relevant supplemental documentation to understand the processes for maintaining and updating provider data, including how the Contractor tracks providers over time, across multiple office locations, and through changes in participation in the Contractor's network. The ISCAT was used to assess the ability of the Contractor's information systems to collect and report accurate data related to each network adequacy indicator. To do so, HSAG sought to understand the Contractor's information technology (IT) system architecture, file structure, information flow, data processing procedures, and completeness and accuracy of data related to current provider networks. HSAG thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.

Validate Network Adequacy Assessment Data, Methods, and Results

Validate Network Adequacy Data and Methods

HSAG assessed data and documentation from each Contractor including, but not limited to, network data files or directories, member enrollment data files, and/or provider and member handbooks. HSAG assessed all data files used for network adequacy calculation at the indicator level for validity and completeness. HSAG required each Contractor to submit its methodology for calculating each indicator within the scope of the validation. HSAG identified whether the required variables were present and required each Contractor to submit documentation describing the steps the Contractor followed for indicator calculation.

Validate Network Adequacy Results

HSAG assessed each Contractor's ability to collect reliable and valid network adequacy reporting data, use sound methods to assess the adequacy of its managed care provider networks, and produce accurate results to support network adequacy reporting. HSAG validated network adequacy reporting against state-defined standards and against the most recent network adequacy reports (i.e., ACOM 417 and ACOM 436 submissions) to assess reasonability of reported indicator-level results. HSAG assessed whether the results were valid, accurate, and reliable, and whether the Contractor's interpretation of the data was accurate.

HSAG conducted an independent review of the time/distance network requirements wherein HSAG calculated the percentage of members with required access according to standards using Quest Analytics

software to calculate the travel time and driving distance between the addresses of specific members and the addresses of their nearest provider for all applicable provider categories identified in the analysis. All study results were stratified by Contractor, as well as by LOB and county. HSAG's results were compared to the results submitted by the Contractors. Additionally, HSAG performed a saturation analysis and assessed the degree to which each Contractor's provider network reflected available AHCCCS-contracted providers for indicators that failed to meet the minimum network standards.

Provide Validation Ratings for Network Adequacy Results Submitted by the Contractor

HSAG used the CMS EQR Protocol 4 Worksheet 4.6 as a guide to systematic assessment of the quality of Contractor network adequacy data, methods, and results. The worksheet was completed for each network adequacy indicator for each Contractor. The worksheet consisted of 10 questions regarding data collection procedures, 16 questions regarding network adequacy methods, and four questions regarding results. For each question, a "Yes" response indicated that the Contractor met quality expectations, a "No" response indicated that the Contractor fully or partially failed to meet expectations, and an "N/A" response indicated that the question did not apply to the Contractor or the specific indicator. For each indicator, HSAG calculated a validation score equal to the number of "Yes" responses divided by the total number of "Yes" and "No" responses. Based on where the score fell within ranges defined by CMS, the Contractor received a rating for the indicator of *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*.

Table A-15 provides a general timeline of the NAV activities and milestones during CYE 2024.

Table A-15—CYE 2024 NAV Activities

NAV Activities and Milestones	Dates
Study Design (Develop and finalize workplan and methodology)	04/09/24 – 04/30/24
Data Collection[1]	04/09/24 – 05/31/24
NAV Analysis (Conduct time/distance analysis and provider saturation analysis)	06/01/24 – 07/02/24
Tableau Dashboard (Validate and deploy CYE 2024 S1 Tableau dashboard)	07/02/24 – 07/16/24
ISCA (Collect ISCAT, review ISCAT, conduct virtual review sessions with the Contractors, and complete Worksheet 4.6)	05/03/24 – 12/04/24
Report (Draft and finalize report)	08/01/24 – 01/27/25

[1] Data include Mercy Care ACC-RBHA's CYE 2024 S1 ACOM 436 resubmission submitted on December 17, 2024.

Description of Data Obtained

HSAG identified the data sources needed for NAV which included the following data and documentation from AHCCCS and the Contractors: (1) provider and member data (2) Contractor-specific ACOM 417 and 436 submissions (3) Contractor-submitted ISCATs and documentation, and (4) information gathered in subsequent communication and interviews with the Contractors.

For each semiannual measurement period, AHCCCS and the Contractors supplied HSAG with the following data files to conduct the time/distance and appointment access and availability validations, as well as perform supplemental analyses (i.e., provider saturation):

- PMMIS provider data—Data files maintained by AHCCCS that list all AHCCCS-contracted providers and their corresponding addresses.
- AHCCCS member data—A data file compiled by AHCCCS from the PMMIS and Client Assessment and Tracking System (CATS) data. PMMIS data elements include the addresses and other necessary demographic information on AHCCCS members. Specific data elements from CATS identify all AHCCCS members who live in their own homes for calculation of the Nursing Facility time/distance standard.
- Contractor-specific PAT files—An aggregated data file listing each Contractor's network providers, as identified to AHCCCS by each Contractor.
- Contractor-specific internal provider directories—An aggregated data file listing each Contractor's network providers along with provider contact information.
- Contractor-specific ACOM 436 submissions—Microsoft Excel workbook(s) for each Contractor and LOB with a tab listing the Contractor's results for compliance with county-level time/distance standards.
- Contractor-specific ACOM 417 submissions—Microsoft Excel workbook(s) for each Contractor and LOB with a tab listing the Contractor's results for compliance with appointment access and availability standards.
- DCS CHP member data—A data file identifying the place of residence for DCS CHP members.

How Data Were Aggregated and Analyzed

HSAG used the Quest Analytics Suite software, version 2023.4 (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 A-12. County-specific time/distance calculations were conducted separately for each Contractor's LOB and county. HSAG's time/distance calculations considered the driving time/distance between a member and the nearest provider (i.e., the time or distance for the member to reach the provider using established roadways). Driving time calculations assumed 30 miles per hour (mph) for Maricopa and Pima counties and 55 mph for all other counties.

How Conclusions Were Drawn

HSAG calculated county-specific time/distance results for each provider category, LOB, and Contractor. HSAG then compared these analytic results to AHCCCS' minimum network standards and identified the Contractors that failed to meet the minimum network standards. HSAG determined each Contractor's substantial strengths and weaknesses by considering the degree to which the Contractor met minimum network standards for its GSA(s).

Semiannual analyses reflect the following measurement periods:

- CYE 2024 S1: January 1–March 31, 2024
- CYE 2024 S2: July 1–September 30, 2024

Note, the ISCA and analytic findings presented in this report reflect the CYE 2024 S1 measurement period.

Detailed time/distance results were presented to AHCCCS and the Contractors as interactive Tableau dashboards containing the following information:

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

Additionally, HSAG evaluated each Contractor's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support the Contractor's and AHCCCS' network adequacy reporting efforts.

HSAG used the CMS EQR Protocol 4 indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that the Contractor used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated each network adequacy indicator's validation score by identifying the number of *Met* and *Not Met* elements recorded in HSAG's CMS EQR Protocol 4 Worksheet 4.6, noted in Table A-16.

Table A-16—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of *Met* elements
B. Total number of *Not Met* elements
Validation Score = A / (A + B) x 100%
Number of *Not Met* elements determined to have significant bias on the results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the Contractor's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. The CMS EQR Protocol 4 defines validation rating designations at the indicator level, which are defined in Table A-17. HSAG assigns a rating once it has calculated the validation score for each indicator.

Table A-17—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

If applicable, significant bias was determined based on the magnitude of errors detected and not solely based on the number of elements *Met* or *Not Met*. HSAG determined that a *Not Met* element had significant bias on the results by:

- Requesting that the Contractor provide a root cause analysis of the finding.
- Working with the Contractor to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- Tasking HSAG's NAV Oversight Review Committee with reviewing the root cause, proposed corrective action, timeline for corrections, and estimated impact to determine the degree of bias.
- Tasking HSAG's NAV Oversight Review Committee with finalizing a bias determination based on the following threshold:
  - The impact biased the reported network adequacy indicator result by more than 5 percentage points, the impact resulted in a change in network adequacy compliance (i.e., the indicator result changed from compliant to noncompliant or changed from noncompliant to compliant), or the

impact was unable to be quantified and therefore was determined to have the potential for significant bias.

Analytic Considerations

AHCCCS does not define the software or process by which each Contractor calculates the semiannual ACOM 436 time/distance results. HSAG uses 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.[257]

AHCCCS members may seek care from network providers practicing outside of the member's county of residence. As such, HSAG considered all applicable provider locations within a program when calculating time/distance results. However, HSAG's time/distance calculations included all available provider locations noted in Contractors' PAT data files, without considering potential barriers to new patient acceptance or appointment availability at individual provider locations.

Additionally, HSAG's time/distance calculations did not include some facilities available to American Indian members enrolled with an MCO. American Indian members, Title XIX and Title XXI, on- or off-reservation, and eligible to receive services may choose to receive services at any time from an American Indian Health Facility—Indian Health Service (IHS) Facility, a Tribally-Operated 638 Health Program, or an Urban Indian Health Program (I/T/U) (American Reinvestment and Recovery Act of 2009 [ARRA] Section 5006[d], and State Medicaid Director Letter [SMDL] 10-001). These facilities are not included in the calculations in this report. As a result, member access may be underreported, particularly in areas with high concentrations of these facilities.

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

Objectives

The overarching objective of the KidsCare and Statewide CAHPS surveys was to effectively and efficiently obtain information and gain understanding about the healthcare experience of adult members

[257] 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.

and parents/caretakers of child patients. These surveys cover topics important to members, such as communication skills of providers and accessibility of services.

Technical Methods of Data Collection

To support the reliability and validity of the findings, standardized sampling and data collection procedures were followed for member selection and survey distribution. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data.

The technical method of data collection for the child ACC Program, KidsCare, and DCS CHP was the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set (with the children with chronic conditions [CCC] measurement set). Child members included as eligible for the surveys were 18 years of age or younger (less than 19 years of age) as of December 31, 2023, for the KidsCare, and child members included as eligible for surveys were 17 years of age or younger (less than 18 years of age) as of December 31, 2023, for the child ACC Program and DCS CHP. Parents/caretakers of child members as part of the child ACC Program, KidsCare, and DCS CHP completed the surveys from May to August 2024. The technical method of data collection for the adult population as part of the adult ACC Program and ACC-RBHA SMI-Designated Population Program was the CAHPS 5.1 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set. Adult members included as eligible for surveys were 18 years of age or older as of December 31, 2024. Adult members completed surveys from May to August 2024.

The survey process allowed two methods by which a survey could be completed in English or Spanish: (1) complete the paper-based survey and return it using the pre-addressed, postage-paid return envelope, or (2) complete the web-based survey through the survey website with a designated login. Members who were identified as Spanish speaking through administrative data were mailed a Spanish version of the cover letter, with an English backside, and a Spanish version of the survey. Members who were not identified as Spanish speaking received an English version of the cover letter, with a Spanish backside, and an English survey. The English and Spanish versions of the survey included a toll-free number that members and parents/caretakers of child members could call to request a survey in another language (i.e., English or Spanish). The first survey mailing was followed by a reminder postcard. A second survey mailing was sent to all nonrespondents, which was followed by a second reminder postcard. Finally, a third survey mailing was sent to all nonrespondents.

The surveys included a set of standardized items that assess respondents' perspectives on care as follows:

- Seventy-six items for the CAHPS 5.1 Child Medicaid Health Plan Survey yielded 14 measures of member experience.
- Thirty-nine items for the CAHPS 5.1 Adult Medicaid Health Plan Survey with the HEDIS supplemental item yielded 12 measures of member experience.

These measures included four global ratings, four composite scores, one individual item measure, three medical assistance with smoking and tobacco use cessation measure items (adult population only), and five CCC composites/items (CCC population only). The global ratings reflected respondents' overall experience with their/their child's health plan, health care, personal doctors, and specialists. The composite scores were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *Getting Care Quickly*). The individual item measure is an individual question that looks at coordination of care. The medical assistance with smoking and tobacco use cessation measure items assess the various aspects of providing medical assistance with smoking and tobacco use cessation for the adult population. The CCC composites and items are sets of questions and individual questions that look at different aspects of care for the CCC population (e.g., *Access to Prescription Medicines* and *Access to Specialized Services*). If a minimum of 100 respondents for a measure was not achieved, the result of the measure was denoted with a cross (+).

Table A-18 provides a general timeline of the CAHPS activities and milestones during CYE 2024.

Table A-18—CYE 2024 CAHPS Activities

CAHPS Activities and Milestones	Dates
Survey Administration	05/31/2024 – 08/30/2024
HSAG submitted weekly disposition reports in Microsoft Excel format while the surveys were in the field to AHCCCS	June 2024 – August 2024
HSAG submitted draft (D1) Statewide CAHPS Reports (unsuppressed and suppressed), respondent-level data files, and crosstabulations to AHCCCS	11/06/2024
AHCCCS submitted feedback on draft (D1) Statewide CAHPS Reports to HSAG	11/21/2024
HSAG submitted draft (D2) Statewide CAHPS Reports to AHCCCS for review and feedback	12/06/2024
AHCCCS submitted feedback on draft (D2) Statewide CAHPS Reports to HSAG	12/16/2024
HSAG submitted final Statewide CAHPS Reports to AHCCCS	12/23/2024

Description of Data Obtained

HSAG aggregated data from survey respondents into a database for analysis. Results of the CAHPS surveys are found in Section 4. ACC Program-Level Comparative Results, Section 6. ACC-RBHA SMI-Designated Population Program-Level Comparative Results, and Section 8. DCS CHP Program Results.

For each of the global ratings, composite measures, individual item measure, and CCC composites/items, the percentage of respondents who chose a positive or top-box response was calculated. Response choices for the CAHPS global ratings in the adult and child Medicaid surveys

ranged from 0 to 10, where 0 is the worst rating possible and 10 is the best rating possible. A positive or top-box response for these measures was defined as a response of "9" or "10." Response choices for the CAHPS composite questions, individual item, and CCC composites/items (i.e., child Medicaid only) in the adult and child Medicaid surveys were (1) "Never," "Sometimes," "Usually," and "Always" and (2) "Yes" and "No." A positive or top-box response for these measures was defined as a response of (1) "Usually" or "Always" and (2) "Yes." For the three medical assistance with smoking and tobacco use cessation items, the percentages of smokers or tobacco users who were advised to quit, were recommended cessation medications, and were provided cessation methods or strategies were calculated. Response choices of the CAHPS medical assistance with smoking and tobacco use cessation items in the adult Medicaid survey were "Sometimes," "Usually," and "Always," which were used to determine if the member qualified for inclusion in the numerator. The scores presented deviate from NCQA's methodology of calculating a rolling average using the current and prior years' results since only the current year's results were available.

How Data Were Aggregated and Analyzed

HSAG performed national comparisons of the results to NCQA's Quality Compass Benchmark and Compare Quality Data to derive the overall member experience ratings.[258] Ratings of one (★) to five (★★★★★) stars were determined for each measure using the percentile distributions shown in Table A-19.

Table A-19—Star Rating Percentile Distributions

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentile
★★★ Good	At or between the 50th and 74th percentile
★★ Fair	At or between the 25th and 49th percentile
★ Poor	Below the 25th percentile

Also, HSAG performed a trend analysis that compared the 2024 scores to their corresponding 2023 scores to determine whether there were statistically significant differences for these populations: KidsCare, the child and adult ACC Program, and DCS CHP's general child and CCC populations. A *t*-

[258] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2022.* Washington, DC: NCQA, September 2022.

test was performed to determine whether 2024 results were statistically significantly different from 2023 results. A difference was considered statistically significant if the two-sided *p* value of the *t* test was less than to 0.05. The two-sided *p* value of the *t* test is the probability of observing a test statistic as extreme as or more extreme than the one actually observed by chance. Scores that were statistically significantly higher in 2024 than in 2023 are noted with black upward triangles (▲). Scores that were statistically significantly lower in 2024 than in 2023 are noted with black downward triangles (▼). 2024 scores that were not statistically significantly different from 2023 scores are noted with a dash (—). A trend analysis was not performed for the ACC-RBHA Program since this was the first year this population was surveyed.

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to services provided by KidsCare, child and adult ACC Program, DCS CHP, and ACC-RBHA SMI-Designated Population Program, HSAG assigned each of the measures to one or more of the three domains (i.e., Quality, Timeliness, and/or Access). The assignment to domains is depicted in Table A-20.

Table A-20—Assignment of CAHPS Measures to the Quality, Timeliness, and Access Domains

CAHPS Topic	Quality	Timeliness	Access
Rating of Health Plan	✓		
Rating of All Health Care	✓		
Rating of Specialist Seen Most Often	✓		
Rating of Personal Doctor	✓		
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		
Coordination of Care	✓		
Advising Smokers and Tobacco Users to Quit	✓		
Discussing Cessation Medications	✓		
Discussing Cessation Strategies	✓		
Access to Specialized Services	✓		✓
FCC: Personal Doctor Who Knows Child	✓		
Coordination of Care for Children with Chronic Conditions	✓		
Access to Prescription Medicines	✓		✓
FCC: Getting Needed Information	✓		

Aggregating and Analyzing Program-Level Data

HSAG follows a four-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the quality and timeliness of, and access to care furnished by each Contractor, as well as the program overall. To produce AHCCCS' annual technical reports, HSAG performed the following steps to analyze the data obtained and draw program-level conclusions about the quality and timeliness of, and access to care and services provided by the Contractors:

Step 1: HSAG analyzed the quantitative results obtained from each EQR activity for each Contractor to identify strengths and opportunities for improvement in each domain of Quality, Timeliness, and Access to services furnished by the Contractor for the EQR activity.

Step 2: From the information collected, HSAG identified common themes and the salient patterns that emerged across EQR activities for each domain and drew conclusions about the overall quality and timeliness of, and access to care and services furnished by the Contractor.

Step 3: From the information collected, HSAG identified common themes and the salient patterns that emerged across all EQR activities related to strengths and opportunities for improvement in one or more of the domains of Quality, Timeliness, and Access to care and services furnished by the Contractor.

Step 4: HSAG identified any patterns and commonalities that exist across the program to draw conclusions about the quality and timeliness of, and access to care for the program.

Appendix B. Acknowledgements and Copyrights

CAHPS® refers to the Consumer Assessment of Healthcare Providers and Systems and is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA).

HEDIS Certified Measures℠ is a service mark of the NCQA.

HEDIS Compliance Audit™ is a trademark of NCQA.

Quality Compass® is a registered trademark of NCQA.