Arizona Health Care Cost Containment System


# Contract Year Ending 2020
# External Quality Review Annual Report

*for*

# Regional Behavioral Health Authorities

*July 2021*

HSAG HEALTH SERVICES ADVISORY GROUP

# Contents

# 1. Executive Summary

## Overview of the Contract Year Ending (CYE) 2020 External Review

The Code of Federal Regulations (CFR) at 42 CFR §438.364 [1-1] requires that states use an external quality review organization (EQRO) to prepare an annual technical report that describes how data from activities conducted for Medicaid managed care organizations (MCOs), in accordance with the CFR, were aggregated and analyzed. The annual technical report draws conclusions about the quality and timeliness of, and access to healthcare services that MCOs provide.

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

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

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

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

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

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

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

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

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

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

HSAG has prepared the annual technical report for AHCCCS for 17 consecutive years. The report complies with all requirements set forth at 42 CFR §438.364.

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

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

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

- Overview of the Arizona Health Care Cost Containment System: An overview of AHCCCS' background including the Medicaid managed care history, AHCCCS' Strategic Plan with key accomplishments for CYE 2020, AHCCCS' quality strategy, and waivers and legislative changes impacting AHCCCS' Medicaid programs.
- Quality Initiatives: An overview of AHCCCS' statewide quality initiatives across its Medicaid managed care program and those specific to the Regional Behavioral Health Authority (RBHA) program for CYE 2020.
- Contractor Best and Emerging Practices: An overview of the Contractors' best and emerging practices for CYE 2020.
- Performance Measure Results: A presentation of results for AHCCCS-selected performance measures for each Contractor, as well as HSAG's associated findings and recommendations for CYE 2020 results.
- Performance Improvement Project Results: An overview of the *Preventive Screening* PIP implemented in CYE 2019.
- Organizational Assessment and Structure Performance: An overview of review processes and methodology for conducting operational reviews (ORs). ORs were not conducted in CYE 2019 or CYE 2020 for the RBHA Contractors.
- Network Adequacy Update: A presentation of results for the network adequacy validation (NAV) and analysis conducted in CYE 2020 and HSAG's associated findings.

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

Appendix D includes the NAV study methodology and RBHA Contractor results by quarter and county. Appendix E includes the complete text of AHCCCS' CYE 2020 Network Adequacy Report.

## Contracts Reviewed

During the CYE 2020 review cycle, AHCCCS contracted with the RBHA Contractors[1-2] listed below to provide services to members enrolled in the AHCCCS RBHA Medicaid managed care program. Associated abbreviations are included.

- Arizona Complete Health – Complete Care Plan – RBHA (AzCH – CCP – RBHA)
- Mercy Care – RBHA (Mercy Care – RBHA)
- Health Choice Arizona – RBHA (HCA – RBHA) (known as Steward Health Choice Arizona prior to January 1, 2020)

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

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

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

## *Performance Measures*

### Aggregate Results for CYE 2019

For the CYE 2019 measurement period, AHCCCS collected data and reported Contractor performance for a set of performance measures.

Contractor-specific results for performance measures with a minimum performance standard (MPS) are included in Section 6, with additional performance measures (i.e., measures without an established MPS) included in Appendix A of this report.

Throughout the report, references to "significant" changes in performance indicate statistically significant differences between performance from CYE 2018 to CYE 2019. The threshold for a significant result is traditionally reached when the *p* value is ≤0.05.

### Findings

Table 1-1 presents the CYE 2018 and CYE 2019 aggregate performance measure results with an MPS for RBHA Integrated Serious Mental Illness (SMI) Contractors.

The table displays the following information: CYE 2018 performance, where available; CYE 2019 performance; the relative percentage change between CYE 2018 and CYE 2019 rates, where available; the significance of the relative percentage change, where available; and the AHCCCS MPS. Performance measure rate cells shaded green indicate that aggregate performance met or exceeded the CYE 2019 MPS established by AHCCCS. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the established MPS are shaded green.

**Table 1-1—CYE 2018 and CYE 2019 Aggregate Performance Measure Results—RBHA Integrated SMI Contractors**

| Performance Measure | CYE 2018 Performance | CYE 2019 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| **Preventive Screening** | | | | | |
| ***Breast Cancer Screening*** | | | | | |
| *Total* | 37.3% | 36.9% | -1.0% | *p*=0.655 | 55.0% |
| ***Cervical Cancer Screening*** | | | | | |
| *Cervical Cancer Screening* | 44.8% | 43.2% | -3.5% | ***p*=0.005** | 53.0% |

| Performance Measure | CYE 2018 Performance | CYE 2019 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| **Behavioral Health** | | | | | |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | | |
| *7-Day Follow-Up—Total* | 68.5% | 68.6% | 0.2% | *p*=0.847 | 60.0% |
| *30-Day Follow-Up—Total* | 85.6% | 85.4% | -0.2% | *p*=0.716 | 85.0% |
| **Utilization** | | | | | |
| ***Ambulatory Care (per 1,000 Member Months)—Total*** | | | | | |
| *ED Visits—Total** | 122.1 | 117.1 | -4.1% | — | 150.0 |
| ***Plan All-Cause Readmissions***[2] | | | | | |
| *Observed Readmissions—Total** | — | 13.6% | — | — | 23.0% |

** A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.*
*[1] Significance levels (p values) noted in the table were calculated by HSAG on behalf of AHCCCS and demonstrate whether the differences in performance between CYE 2018 and CYE 2019 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.*
*[2] Due to changes in the technical specifications for this measure, a break in trending between CYE 2019 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.*
*— Indicates that a comparison of performance between CYE 2018 and CYE 2019 was not possible or appropriate.*
*Cells shaded green indicate that the rate met or exceeded the CYE 2019 MPS established by AHCCCS.*

## Conclusions

Compared to the CYE 2019 MPS, the RBHA Integrated SMI aggregate performance in the **quality**, **access**, and **timeliness** areas indicated strength as both *Follow-Up After Hospitalization for Mental Illness* measure indicator rates met or exceeded the MPS.

Performance for the RBHA Integrated SMI aggregate within the **quality** area indicated opportunities for improvement as two of three measure rates (*Breast Cancer Screening—Total* and *Cervical Cancer Screening*) fell below the MPS. In contrast, the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure rate met or exceeded the MPS.

There were no performance measure rates related to **timeliness** selected for the RBHA Integrated SMI Contractors; therefore, this area was not discussed. Additionally, the utilization performance measure rate (*Ambulatory Care*) should be monitored for information only.

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

## Recommendations

HSAG recommends that AHCCCS work with the RBHA Integrated SMI Contractors to increase preventive screenings for women. The RBHA Integrated SMI Contractors should examine potential barriers to women receiving breast cancer and cervical cancer screenings and implement

multicomponent interventions to reduce structural barriers. Evidence suggests multicomponent interventions lead to greater effects when they combine strategies to increase community demand for, and access to, cancer screening. Interventions include increasing community demand (e.g., patient reminders; one-on-one education; and mass media such as television, radio, and newspapers), increasing access to screenings (e.g., assisting with appointment scheduling, addressing transportation barriers, offering child care), and increasing provider participation (e.g., provider incentives and provider reminders).[1-3,1-4] The RBHA Integrated SMI Contractors should ensure that members receive screenings in accordance with the United States (U.S.) Preventive Services Task Force (USPSTF) screening recommendations for breast cancer and cervical cancer.[1-5, 1-6]

## Performance Improvement Projects

In CYE 2016 (October 1, 2015, through September 30, 2016), AHCCCS implemented a new PIP, *E-Prescribing*. AHCCCS implemented the *E-Prescribing* PIP because research suggested that an opportunity existed to improve preventable errors experienced using the standard, handwritten paper method to communicate a medication between a prescriber and a pharmacy. CYE 2019 served as Remeasurement 2 for the *E-Prescribing* PIP for the AzCH – CCP – RBHA and HCA – RBHA Contractors; whereas, Mercy Care – RBHA's Remeasurement 2 was CYE 2018. As a result, the *CYE 2019 EQR Annual Report for Acute Care and Comprehensive Medical and Dental Program, Regional Behavioral Health Authorities Children's Rehabilitative Services*[1-7] included final reporting for Mercy Care – RBHA/MMIC only. This RBHA EQR Report includes Remeasurement Year 2 reporting for the AzCH – CCP – RBHA and HCA – RBHA Contractors.

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Preventive Screening* PIP for the RBHA serious mental illness (SMI) population. Breast cancer 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

[1-3] The Community Guide. *Cancer Screening: Multicomponent Interventions—Cervical Cancer*. Available at: https://www.thecommunityguide.org/findings/cancer-screening-multicomponent-interventions-cervical-cancer. Accessed on: Apr. 29, 2021.
[1-4] The Community Guide. *Cancer Screening: Multicomponent Interventions—Breast Cancer*. Available at: https://www.thecommunityguide.org/findings/cancer-screening-multicomponent-interventions-breast-cancer. Accessed on: Apr. 29, 2021.
[1-5] U.S. Preventive Services Task Force. *Breast Cancer: Screening*. Available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening. Accessed on: Apr. 29, 2021.
[1-6] U.S. Preventive Services Task Force. *Cervical Cancer: Screening*. Available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening. Accessed on: Apr. 29, 2021.
[1-7] Health Services Advisory Group. *CYE 2019 EQR Annual Report for Acute Care and Comprehensive Medical and Dental Program, Regional Behavioral Health Authorities Children's Rehabilitative Services*. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2019/CYE2019ExternalQualityReviewAnnualReport-AcuteCMDPRBHACRS.pdf. Accessed on: March 10, 2021.

ensure that individuals are provided with the information and support needed to participate in preventive screenings. The purpose of the *Preventive Screening* PIP is to increase the number and percentage of breast cancer and cervical cancer screenings.

### Organizational Assessment and Structure Standards

ORs were not conducted in CYE 2020 for the RBHA Contractors due to restrictions resulting from the coronavirus disease 2019 (COVID-19) pandemic. Results for ORs conducted in CYE 2021 will be included in the CYE 2021 annual technical reports.

### Network Adequacy Validation

Each quarter, each RBHA Contractor submits its contracted network and internal assessment of compliance with the applicable standards to AHCCCS. HSAG's NAV considered compliance with 12 AHCCCS-established time/distance standards for specific provider types and populations applicable to the RBHA Contractors. HSAG assembled quarterly analytic results for the July 1, 2019, through June 30, 2020, measurement period for all beneficiary coverage areas for each RBHA Contractor.[1-8]

HSAG's quarterly NAV evaluated the extent that RBHA Contractors' provider networks met AHCCCS' minimum time/distance network requirements. Mercy Care – RBHA and HCA – RBHA met all applicable minimum network standards in each quarter. AzCH – CCP – RBHA met all network standards except for the Dentist, Pediatric standard in Graham County during CYE 2019 Quarter 4 and CYE 2020 Quarter 1; however, fewer than five beneficiaries residing in Graham County were enrolled with AzCH – CCP – RBHA during the measurement period. Refer to Appendix D for the complete study methodology and RBHA Contractor results by quarter and county.

Refer to Appendix D for the complete study methodology and RBHA Contractor results by quarter and county.

## Overall Assessment of Progress in Meeting EQRO Recommendations

During previous years, HSAG made recommendations in the annual reports for each activity conducted. Below are summaries of the follow-up actions per activity in response to HSAG's recommendations. Some of the Contractors may have included rates in their responses to the recommendations. Please note that these are self-reported rates and are not validated by AHCCCS or the EQRO. In addition, ORs were not conducted in CYE 2019 for the RBHA Contractors; therefore, OR recommendations are not included in these tables.

[1-8] AHCCCS suspended the CYE 2020 Quarter 2 AHCCCS Contractor Operations Manual (ACOM) 436 data reporting during the COVID-19 public health emergency, and RBHA Contractors' ACOM 436 results were not available for comparison to HSAG's CYE 2020 Quarter 2 time/distance calculation results.

## RBHA Line of Business

Table 1-2 is a summary of the follow-up actions during CYE 2020 that AHCCCS completed in response to HSAG's recommendations.

**Table 1-2—HSAG Recommendations With AHCCCS Responses to HSAG Recommendations**

| HSAG Recommendation | AHCCCS Activities |
|---|---|
| **Performance Measures** | |
| HSAG recommends that AHCCCS examine potential barriers to women receiving breast cancer (RBHA Integrated SMI Contractors only) and cervical cancer screenings and implement multicomponent interventions to reduce structural barriers. | Contractors not meeting performance standards for their CYE 2018 performance measures (child and adult) were required to submit a CAP to AHCCCS outlining root causes, new interventions, or enhanced interventions that will be implemented to improve the Contractors' performance, and the methods for monitoring the Contractors' progress toward their performance goals.<br><br>AHCCCS selected the *Preventive Screening* PIP for the RBHA-SMI population (baseline measurement year: CYE 2019) with the goal of demonstrating a statistically significant increase in the number and percentage of women receiving breast cancer and cervical cancer screenings, followed by sustained improvement for one consecutive year. As part of the PIP, Contractors are required to conduct a root cause and barrier analysis, examining and reporting potential barriers to women receiving breast cancer and cervical cancer screenings and implementing interventions to promote screenings. |
| HSAG recommends that AHCCCS focus efforts on identifying the factors contributing to low rates for these measures and implement improvement strategies to increase screenings for breast cancer in women and follow-up visits after hospitalization for mental illness. | AHCCCS policy outlines quality improvement CAP Proposal and Update requirements. Contractors not meeting AHCCCS performance measure standards are required to submit a CAP. AHCCCS reviews and provides feedback for each Contractor's PIP submission, noting items that do not meet AHCCCS requirements. Contractors are required to either incorporate AHCCCS' feedback in future PIP submissions or resubmit the PIP per AHCCCS direction.<br><br>During CYE 2020, AHCCCS updated its PIP reporting templates to include additional requirements for Contractors to conduct and report root cause analyses, activities, and findings. |

| HSAG Recommendation | AHCCCS Activities |
|---|---|
| | AHCCCS selected the *Preventive Screening* PIP for the RBHA-SMI population (baseline measurement year: CYE 2019) with the goal of demonstrating a statistically significant increase in the number and percentage of women receiving breast cancer and cervical cancer screenings, followed by sustained improvement for one consecutive year. As part of the PIP, Contractors are required to conduct a root cause and barrier analysis, examining and reporting potential barriers to women receiving breast cancer and cervical cancer screenings and implementing interventions to promote screenings. |
| HSAG recommends that AHCCCS ensure that members receive screenings in accordance with the United States Preventive Services Task Force (USPSTF) screening recommendations for breast cancer and cervical cancer. | Contractors not meeting performance standards for their CYE 2018 performance measures (child and adult) were required to submit a CAP to AHCCCS outlining root causes, new interventions, or enhanced interventions that will be implemented to improve the Contractors' performance, and the methods for monitoring the Contractors' progress toward their performance goals.<br><br>AHCCCS selected the *Preventive Screening* PIP for the RBHA-SMI population (baseline measurement year: CYE 2019) with the goal of demonstrating a statistically significant increase in the number and percentage of women receiving breast cancer and cervical cancer screenings, followed by sustained improvement for one consecutive year. |
| **Performance Improvement Projects** | |
| AHCCCS has made significant progress in making PIP process improvements in the past year, including the development of a new reporting template. HSAG recommends that AHCCCS consider offering and facilitating training opportunities to enhance the RBHA Contractors' capacities to implement robust interventions, quality improvement (QI) processes, and strategies for the *E-Prescribing* PIP. Increasing the RBHA Contractors' efficacy with QI tools such as root cause | AHCCCS provides individual Contractor technical assistance, as requested by the Contractor or mandated by AHCCCS, to facilitate Contractor compliance in meeting AHCCCS expectations pertaining to performance measures, PIPs, and CAPs. AHCCCS conducted technical assistance with two Contractors specific to PIPs. The technical assistance included information related to QI topics such as process and outcome measures, use of QI tools, and enhancing interventions to help remove barriers to successfully achieving improvement for the PIP indicator rates. |

| HSAG Recommendation | AHCCCS Activities |
|---|---|
| analyses, key driver diagrams, process mapping, failure modes and effects analysis (FMEA), and plan-do-study-act (PDSA) cycles should help to remove barriers to successfully achieving improvement for the PIP indicator rates. | |
| HSAG recommends that AHCCCS use the quarterly collaboration meetings with stakeholders as opportunities to identify and address systemwide barriers to the PIP process, which may be impacting the ability to achieve meaningful improvement. | AHCCCS provides individual Contractor technical assistance, as requested by the Contractor or mandated by AHCCCS, to facilitate Contractor compliance in meeting AHCCCS expectations pertaining to performance measures, PIPs, and CAPs. AHCCCS conducted technical assistance with two Contractors specific to PIPs. The technical assistance included information related to QI topics such as process and outcome measures, use of QI tools, and enhancing interventions to help remove barriers to successfully achieving improvement for the PIP indicator rates. |
| HSAG recommends that AHCCCS continue the collaboration among RBHA Contractors in the workgroup to improve the PIP study indicator rates. AHCCCS should consider including in the workgroup additional stakeholders who may help with improvement of the PIP study indicator rates. | During CYE 2020, AHCCCS updated its PIP reporting templates to include additional requirements for Contractors to conduct and report root cause analyses, activities, and findings. AHCCCS reviews and provides feedback for each Contractor's PIP submission, noting items that do not meet AHCCCS requirements. Contractors are required to either incorporate AHCCCS' feedback in future PIP submissions or resubmit the PIP per AHCCCS direction. In addition, AHCCCS provides individual Contractor technical assistance, as requested by the Contractor or mandated by AHCCCS, to facilitate Contractor compliance in meeting AHCCCS expectations pertaining to performance measures, PIPs, and CAPs.<br><br>AHCCCS selected the *Preventive Screening* PIP for the RBHA-SMI population (baseline measurement year: CYE 2019) with the goal of demonstrating a statistically significant increase in the number and percentage of women receiving breast cancer and cervical cancer screenings, followed by sustained improvement for one consecutive year. |
| HSAG recommends that AHCCCS use more timely data to support performance | AHCCCS PIPs often use national standardized performance measures to serve as associated study indicators and the basis for performance evaluation. |

| HSAG Recommendation | AHCCCS Activities |
|---|---|
| improvement activities that can be monitored in real time. | AHCCCS will soon transition its performance measure calculations from a CYE to a calendar year (CY) basis to better align with national standards. In addition, AHCCCS will be transitioning from AHCCCS-calculated to Contractor-calculated measures. It is anticipated that this transition will allow for more timely reporting of data; however, it is and has been AHCCCS' expectation that Contractors use internal data to monitor their performance for AHCCCS-mandated PIP indicators on a routine and ongoing basis with new and revised interventions implemented, as necessary, to promote enhanced performance.<br><br>AHCCCS also requires Contractors to submit quarterly Performance Measure Monitoring Reports, which are inclusive of Contractor self-reported data and associated interventions; however, these submission requirements were suspended in CYE 2020 due to the COVID-19 public health emergency. |
| HSAG recommends that AHCCCS work with the general mental health substance use (GMH/SU) and RBHA Integrated SMI Contractors to increase rates for the *Follow-Up After Hospitalization for Mental Illness* performance measure that failed to meet the CYE 2018 performance standards. | Contractors not meeting performance standards for their CYE 2018 performance measures (child and adult) were required to submit a CAP to AHCCCS outlining identified root causes, new or enhanced interventions that will be implemented to improve the Contractors' performance, and the methods for monitoring the Contractors' progress toward their performance goals.<br><br>Please note: As part of AHCCCS' performance measure transition, AHCCCS will no longer use Minimum Performance Standards (MPS) to evaluate Contractor performance. Beginning with the CYE 2021 contract amendments, Contractor performance will be evaluated against the associated National Committee for Quality Assurance (NCQA) Medicaid mean/CMS Medicaid median. This approach incorporates national benchmarks reflective of year-to-year changes in performance measure specification. |
| HSAG recommends that AHCCCS conduct root cause analyses for the low rates of follow-up visits after hospitalization for mental illness to determine the nature and scope of the | Contractors not meeting performance standards for their CYE 2018 performance measures (child and adult) were required to submit a CAP to AHCCCS outlining identified root causes, new or enhanced interventions that will be implemented to improve the Contractors' |

| HSAG Recommendation | AHCCCS Activities |
|---|---|
| issue (e.g., barriers to care, lack of continuity of care, transportation issues, ineffective communication). | performance, and the methods for monitoring the Contractors' progress toward their performance goals. |
| HSAG recommends that AHCCCS work with RBHA Integrated SMI Contractors to increase preventive screenings for women. | Contractors not meeting performance standards for their CYE 2018 performance measures (child and adult) were required to submit a CAP to AHCCCS outlining identified root causes, new or enhanced interventions that will be implemented to improve the Contractors' performance, and the methods for monitoring the Contractors' progress toward their performance goals.<br><br>AHCCCS selected the *Preventive Screening* PIP for the RBHA-SMI population (baseline measurement year: CYE 2019) with the goal of demonstrating a statistically significant increase in the number and percentage of women receiving breast cancer and cervical cancer screenings, followed by sustained improvement for one consecutive year. |

Table 1-3 presents a summary of the follow-up actions per activity that the AzCH – CCP – RBHA reported completing in response to HSAG's recommendations included in the *CYE 2019 EQR Annual Report for Acute Care and Comprehensive Medical and Dental Program, Regional Behavioral Health Authorities Children's Rehabilitative Services* cited earlier in this report.

The text located after each HSAG recommendation box is a summary of the content submitted by the Contractor.

**Table 1-3—AzCH – CCP – RBHA's Responses to HSAG's Follow-Up Recommendations**

| AzCH – CCP – RBHA |
|---|
| **Performance Measures** |
| **HSAG Recommendation:** Contractors should conduct root cause analyses for the low rates of follow-up visits after hospitalization for mental illness to determine the nature and scope of the issue (e.g., barriers to care, lack of continuity of care, transportation issues, ineffective communication). Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase follow-up visits and improve member transitions of care. |
| AzCH – CCP – RBHA evaluated the root cause analysis for low rates of follow-up visits during the planning stage of the Coordination of Care performance improvement project. AzCH – CCP – RBHA has increased the level of discharge planning and follow-up after hospitalization through the Care Management (CM) and Transitions of Care team (ToC). The ToC team provides intensive |

| AzCH – CCP – RBHA |
|---|
| discharge planning assistance for high-risk members who do not have a case manager assignment. The My Health Direct scheduling platform is interfacing with all health home schedules for follow-up and intake appointments after a crisis episode. AzCH – CCP – RBHA Medical Management has implemented quarterly meetings with health homes and Hospital Care Management leadership to collaborate on solutions. AzCH – CCP – RBHA care coordinators follow up on all members admitted to assist with discharge planning, as well as having staff co-located at a high-volume hospital. AzCH – CCP – RBHA implemented direct outreach by ToC team and CM for members, as well as provided technical assistance to providers and continued to evaluate internal processes to better assist members in meeting their wellness needs. AzCH – CCP – RBHA has implemented a cross-functional workgroup focusing specifically on the follow-up after hospitalization measures. This workgroup implemented an automatic hospital authorization and inpatient report that is provided daily to Health Homes so the wraparound services can begin to be put in place and no member is left without a solid discharge plan, needed appointments, and is evaluated for potential barriers such as transportation. |
| **HSAG Recommendation:** Contractors should increase preventive screenings for women by examining potential barriers to women receiving cervical cancer screenings and implement multicomponent interventions to reduce structural barriers. |
| AzCH – CCP – RBHA coordinated with multiple community stakeholders to participate in health fairs. AzCH – CCP – RBHA is planning to continue to participate and offer such events in the future. AzCH – CCP – RBHA implemented direct outreach and mailer campaigns for members for all preventive screenings and continued the My Health Pays member incentive program that offers a $25 reloadable Visa gift card once the member has completed a cervical cancer screening. AzCH – CCP – RBHA continues to provide technical assistance to providers and continues to evaluate internal processes to better assist members in meeting their wellness needs. AzCH – CCP – RBHA will continue to monitor this measure with quarterly updates to the AzCH – CCP – RBHA Quality Improvement Committee and focus efforts to find and sustain improvement. |
| **Performance Improvement Projects** |
| **HSAG Recommendation:**<br>Contractors should conduct monthly updates on all interventions at the CEO meeting with a focus on financial incentives and CAP interventions. In addition, contractors should conduct monitoring of outcomes associated with reported interventions and adjust as necessary. |
| AzCH – CCP – RBHA explored the possibility of tying this PIP to provider financial incentives but was unable to put it into place. Due to the statistically significant high engagement from the prescriber network, AzCH – CCP – RBHA is only providing monitoring updates to leadership on an as-needed basis at this time.<br>AzCH – CCP – RBHA attributes the improvement in e-prescribing utilization to multiple actions taken within this project. Firstly, identifying targets and barriers to provider implementation of e-prescribing of controlled and non-controlled substances to provide a network-wide view of AzCH – CCP – RBHA's standing at the beginning of this project. Secondly, the continuous evaluation of all interventions and the flexibility within multiple departments to respond to successful or |

| AzCH – CCP – RBHA |
|---|
| unsuccessful interventions. These actions provided a solid base for the responsiveness needed to meet all goals.<br>The interventions that are in place now will be continuing despite the closure of this PIP. AzCH – CCP – RBHA's Pharmacy Department will continue to provide educational materials and technical assistance to individual prescribers via the dedicated pharmacy liaison. AzCH – CCP – RBHA's Pharmacy Department will also continue providing education, and technical assistance will be provided to the prescriber network on a routine basis. |

Table 1-4 presents a summary of the follow-up actions per activity that Mercy Care – RBHA reported completing in response to HSAG's recommendations included in the *CYE 2019 EQR Annual Report for Acute Care and Comprehensive Medical and Dental Program, Regional Behavioral Health Authorities Children's Rehabilitative Services* cited earlier in this report.

The text located after each HSAG recommendation box is a summary of the content submitted by the Contractor.

**Table 1-4—Mercy Care – RBHA's Responses to HSAG's Follow-Up Recommendations**

| Mercy Care – RBHA |
|---|
| **Performance Measures** |
| **HSAG Recommendation:** HSAG recommends that the Contractors conduct root cause analyses for the low rates of follow-up visits after hospitalization for mental illness to determine the nature and scope of the issue (e.g., barriers to care, lack of continuity of care, transportation issues, ineffective communication). After the key factors related to the low rates are identified, the Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase follow-up visits and improve member transitions of care. |
| Mercy Care – RBHA identified root causes of the deficiency:<br>• Lack of member understanding of the importance of a follow-up visit with seven days.<br>• Visits occurring, but the provider "type" is not that of a behavioral health provider.<br>• Visits occurring outside of the seven-day time frame.<br><br>Mercy Care – RBHA established new/enhanced interventions: evidence-based practices shown to effective in the same/similar populations. This included internal, external, member-focused and provider focused interventions:<br>• Implementation of a member engagement program through Revel Health, which is developed to be member-specific based on what outreach modality will be most impactful in improving compliance for each member, specifically. |

| Mercy Care – RBHA |
|---|
| • Surveying of the Community Based Integrated Health Committee (CBIHCS), which is comprised of community practitioners, to identify best practices to increase screening rates in this population.<br>• Increase data capture through the health information exchange (HIE)—Health Current direct data feeds. |
| **Performance Improvement Projects** |
| **HSAG Recommendation:** Mercy Care – RBHA should examine potential barriers to women receiving breast cancer and cervical cancer screenings and implement multicomponent interventions to reduce structural barriers. |
| Mercy Care – RBHA identified root causes of the deficiency:<br>• Member perception of the invasiveness of breast and cervical cancer screening.<br>• Member perception of the need for screening for chlamydia if no obvious symptoms are present.<br>• Potential lack of screening data for screenings that occurred prior to enrollment with the health plan.<br>• Accurate member demographic information.<br>• Lack of utilization of text messaging/emailing technology to outreach members.<br>• Incomplete claims data.<br><br>Mercy Care – RBHA established new/enhanced interventions: evidence-based practices shown to be effective in the same/similar populations. This included internal, external, member-focused, and provider-focused interventions:<br>• Implementation of a member engagement program through Revel Health, which was developed to be member-specific based on what outreach modality will be most impactful in improving compliance for each member, specifically.<br>• Surveying of the CBIHCS, which is comprised of community practitioners, to identify best practices to increase screening rates in this population.<br>• Increase data capture through the HIE—Health Current direct data feeds. |

Table 1-5 presents a summary of the follow-up actions per activity that the HCA – RBHA reported completing in response to HSAG's recommendations included in the *CYE 2019 EQR Annual Report for Acute Care and Comprehensive Medical and Dental Program, Regional Behavioral Health Authorities Children's Rehabilitative Services* cited earlier in this report.

The text located after each HSAG recommendation box is a summary of the content submitted by the Contractor.

**Table 1-5—HCA – RBHA's Responses to HSAG's Follow-Up Recommendations**

| HCA – RBHA |
|---|
| **Performance Measures** |
| **HSAG Recommendation:** No performance measure rates within the Preventive Screening (*Breast Cancer Screening* and *Cervical Cancer Screening*) or Behavioral Health (*Follow-Up After Hospitalization for Mental Illness*) domains met or exceeded the CYE 2018 MPS, demonstrating opportunities to improve care coordination and access to screenings for members with SMI. |
| HCA – RBHA has held mobile mammography events and conducted extensive outreach to this population. The Disease Management team has conducted several events to increase member and provider outreach. HCA – RBHA also identified an opportunity to educate behavioral health [BH] providers on these and other screenings so that BH case managers can assist members with SMI in navigating the primary care system. |
| **HSAG Recommendation:** Contractors should conduct root cause analyses for the low rates of follow-up visits after hospitalization for mental illness to determine the nature and scope of the issue (e.g., barriers to care, lack of continuity of care, transportation issues, ineffective communication). Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase follow-up visits and improve member transitions of care. |
| HCA – RBHA has initiated multiple PDSA cycles to address each measure after conducting root cause analysis which is documented on an Ishikawa Diagram. HCA – RBHA is conducting extensive analysis of barriers to providing required follow-up appointments after hospitalization. In a chart review of members with identified discharges, it was discovered that there are many members who receive extensive services both before and after the hospitalization that do not count for the measure. Some of these members receive more than 15 services in the 30 days following the discharge. Using this information, several data issues were identified that prevented accurate reporting of the measure. |
| **Performance Improvement Projects** |
| **HSAG Recommendation:** HSAG recommends that Health Choice integrated Plan (now HCA) monitor outcomes associated with the reported interventions, making applicable adjustments to any current interventions, and possibly developing more interventions. In addition, HSAG recommends that AHCCCS continue the collaboration among Contractors to improve these indicators. |
| HCA – RBHA initiated a further PDSA cycle to ensure that improvement continued and would be sustained after project completion. The PDSA included that plans provide technical assistance and hold a provider meeting. The results will be shared with the providers that fell below the MPS [minimum performance standard] on indicator 1. HCA – RBHA stated that as this is the last report, no further PDSA cycles will be initiated. |

# 2. Introduction to the Annual Technical Report

## Description of EQR Activities

### *Mandatory Activities*

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

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

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

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

### *Optional Activities*

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

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

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

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

## Quality, Access, and Timeliness

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

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

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

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

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

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

## AHCCCS Medicaid Managed Care Program History

Since 1982, AHCCCS, the single state Medicaid agency for Arizona, has operated under the authority of the federal Research and Demonstration 1115 Waiver, which has allowed for the operation of an integrated managed care model. AHCCCS uses State, federal, and county funds to administer pediatric, acute, long-term, and behavioral healthcare programs to the State's Medicaid members. AHCCCS has an appropriated budget of approximately $17.1 billion to administer its programs, which provide services for 2.2 million individuals and families in Arizona through a provider network credentialed and contracted by its Contractors. The AHCCCS Acute Care Program began in 1982 and in 1988, AHCCCS added the Arizona Long Term Care System (ALTCS) Program for individuals with developmental disabilities, and then expanded the program in January 1989 to include the elderly and physically disabled (EPD) populations. ALTCS provides acute care, behavioral health services, LTC, and case management to AHCCCS members who are elderly, physically disabled, or developmentally disabled and who meet the criteria for receiving care in a residential setting. Services for individuals with developmental disabilities in ALTCS are offered through the Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD). The ALTCS members account for less than 4.0 percent of the AHCCCS population, with approximately 21.7 percent of the costs. American Indian/Alaskan Native (AI/AN) members may choose to receive services through the managed care structure, may opt to receive services through the fee-for-service program.

In October 1990, AHCCCS began coverage of comprehensive behavioral health services for seriously emotionally disabled (SED) children younger than 18 years of age who required residential care. Through further expansion, AHCCCS added comprehensive behavioral health coverage for all Medicaid-eligible individuals. The Children's Health Insurance Program (CHIP) was incorporated in

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

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

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

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

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

same access to Indian Health Service (IHS) providers, Tribal 638 providers, and Urban Indian Health providers regardless of whether they are receiving services through managed care or the fee-for-service program.

## AHCCCS Waiver Amendment Requests and Legislative Updates

### *1135 Waiver Update*

On March 17 and March 24, 2020, AHCCCS submitted requests to the administrator for CMS to waive certain Medicaid and KidsCare requirements to enable the State to combat the continued spread of COVID-19. AHCCCS was seeking a broad range of emergency authorities to strengthen the provider workforce and remove barriers to care for AHCCCS members, enhance Medicaid services and supports for vulnerable members for the duration of the emergency period, and remove cost sharing and other administrative requirements to support continued access to services.

Specifically, Arizona requested authority to implement the following flexibilities, for the duration of the emergency period, under an 1135 Waiver:[3-2]

- Permit providers located out of state to offer both emergency and non-emergency care to Arizona Medicaid and CHIP enrollees.
- Streamline provider enrollment requirements.
- Cease revalidation of providers who are located in state or otherwise directly impacted by the disaster event.
- Waive the requirement that physicians and other healthcare professionals be licensed in Arizona, to the extent consistent with state law.
- Waive payment of the provider enrollment application fee.
- Waive requirements for site visits to enroll a provider.
- Suspend Medicaid fee-for-service (FFS) prior authorization requirements.
- Require FFS providers to extend existing prior authorizations through the termination of the emergency declaration.
- Suspend pre-admission screening and annual resident review (PASRR) Level I and Level II assessments.
- Waive requirements for written member consents and member signatures on plans of care.
- Waive the face-to-face requirement applicable to Home Health Services including medical supplies, equipment, and appliances.

[3-2] Arizona Health Care Cost Containment System. RE: Request for Emergency Authorities to Support Arizona's Response to COVID-19 [Letter]. Available at: https://azgovernor.gov/governor/news/2020/03/arizona-medicaid-program-receives-authority-implement-program-changes-address. Accessed on: Mar 10, 2021.

- Temporarily allow services provided within the ALTCS program to be provided in settings that have not been determined to meet the home and community-based services (HCBS) criteria.

In addition to the 1135 Waiver flexibilities, Arizona also requested the following 1115 Waiver and Appendix K authorities for the duration of the emergency period:[3-3]

- Expand the current limit for respite hours to 720 hours per benefit year (current limit is 600 hours per benefit year).
- Permit payment for HCBS rendered by family caregivers or legally responsible individuals.
- Expand the provision of home-delivered meals to all eligible populations.
- Provide temporary housing (not to exceed six months) if a beneficiary is homeless or is at imminent risk of homelessness and has tested positive for COVID-19.

This also included the authority to:[3-4]

- Make retention payments to all provider types as appropriate (including but not limited to HCBS providers).
- Provide long-term care services and supports to impacted members regardless of whether or not timely updates are made in the plan of care, or if services are delivered in alternative settings.
- Waive the State from complying with the HCBS settings requirement at 42 CFR §441.301(c)(4)(vi)(D), which details that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014 (the State is seeking this authority to minimize the spread of infection during the COVID-19 pandemic).
- Add an electronic method of service delivery (e.g., telephonic), allowing services to continue to be provided remotely in the home setting for case managers, personal care services that only require verbal cueing, and in-home habilitation.
- Expand the provision of home-delivered meals to LTC members enrolled in the ALTCS DES/DDD.
- Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers.
- Allow case management entities to provide direct services in response to COVID-19.
- Extend reassessments and reevaluations of a member's institutional level of need for up to one year past the due date, if needed.
- Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.
- Adjust prior approval/authorization criteria approved in the waiver.
- Adjust assessment requirements.

[3-3] Ibid.
[3-4] Arizona Health Care Cost Containment System. Summary of AHCCCS Request to CMS for Additional Flexibilities. Available at: https://azgovernor.gov/governor/news/2020/03/arizona-medicaid-program-receives-authority-implement-program-changes-address. Accessed on: Mar 10, 2021.

- Add an electronic method of signing off on required documents, such as the person-centered service plans.
- Temporarily expand setting(s) where services may be provided (e.g., hotels, shelters, schools, and churches).
- Temporarily allow for payment for services to support waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.

CMS approved components of Arizona's request under the 1135 Waiver, Appendix K, and State Plan. Information regarding the status of AHCCCS Emergency Authority Requests (for the federally declared COVID-19 emergency) can be found on the AHCCCS COVID-19 Federal Emergency Authorities Request web page.

## *1115 Waiver Renewal*

Arizona's 1115 Waiver demonstration is set to expire on September 30, 2021. As a result of the COVID-19 pandemic, AHCCCS received a three-month extension from CMS to submit the waiver renewal application packet. AHCCCS is requesting a five-year renewal of Arizona's demonstration project under Section 1115 of the Social Security Act. Arizona's existing demonstration project is currently approved through September 30, 2021, and the application is seeking a renewal period from October 1, 2021, through September 30, 2026. AHCCCS submitted a waiver application to CMS to renew its 1115 Waiver demonstration on December 22, 2020.

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, including Arizona's, must establish budget neutrality where Medicaid costs to the federal government are not expected to exceed costs to the federal government in the absence of the demonstration.

CMS' approval of Arizona's demonstration renewal application will continue the success of Arizona's unique Medicaid program and statewide managed care model, extending authority for Arizona to implement programs including, but not limited to:[3-5]

- Mandatory managed care.
- Home and community-based services for individuals in ALTCS.

[3-5] Arizona Health Care Cost Containment System. AHCCCS Requests Public Comment on Proposed 2021–2026 Waiver Renewal. Available at: https://www.azahcccs.gov/shared/News/PressRelease/AHCCCSRequestsPublicCommentOnWaiverRenewal.html. Accessed on: Mar 10, 2021.

- Administrative simplifications that reduce inefficiencies in eligibility determination.
- Integrated health plans for AHCCCS members.
- Payments to providers participating in the Targeted Investments (TI) Program.
- Waiver of Prior Quarter Coverage for specific populations.
- AHCCCS Works Community Engagement Program (not yet implemented).

In addition to renewing current waiver and expenditure authorities, AHCCCS is seeking to implement the following:[3-6]

- Authority to allow for verbal consent in lieu of written signature for up to 30 days for all care and treatment documentation for ALTCS members when included in the member's record and when identity can be reliably established.
- Authority to reimburse traditional healing services provided in, at, or as part of services offered by facilities and clinics operated by the IHS, a tribe or tribal organization, or an Urban Indian health 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 $1,000 dental limit for individuals ages 21 or older enrolled in the ALTCS program.

More details on Arizona's Section 1115 Waiver renewal request (2021–2026), along with the proposal and supplemental documentation, can be found on the Arizona's Section 1115 Waiver Renewal Request (2021-2026) web page.

## 1115 Waiver Evaluation

In accordance with Special Terms and Conditions (STC) 59, AHCCCS must submit a draft Waiver Evaluation Design for its 1115 Waiver Demonstration. In addition, AHCCCS is also required by CMS to submit an Interim Evaluation Report and a Summative Evaluation Report of the 1115 Waiver Demonstration by December 31, 2020, and February 12, 2023, respectively.

AHCCCS has contracted with HSAG to serve as the independent evaluator for Arizona's 1115 Waiver Demonstration. In SFY 2019, AHCCCS worked with HSAG to develop evaluation design plans for the following programs: ACC Program; ALTCS Program; Comprehensive Medical and Dental Program (CMDP); RBHAs; TI Program; Waiver of Prior Quarter Coverage; and the AHCCCS Works Program.

[3-6] Arizona Health Care Cost Containment System. AHCCCS Requests Public Comment on Proposed 2021–2026 Waiver Renewal. Available at: https://www.azahcccs.gov/shared/News/PressRelease/AHCCCSRequestsPublicCommentOnWaiverRenewal.html. Accessed on: Mar 10, 2021..

On November 13, 2019, AHCCCS submitted an evaluation design plan to CMS for Arizona's Demonstration components (ACC, ALTCS, CMDP, RBHA, TI Program, and Waiver of Prior Quarter Coverage). Additionally, HSAG developed and submitted a separate evaluation design plan to CMS for the AHCCCS Works program. Arizona intends to use this design plan to guide the evaluation of the AHCCCS Works program upon implementation of the community engagement requirements, if the program is implemented. Arizona's Waiver Evaluation Design Plan was approved by CMS on November 19, 2020.

As required by the STCs of Arizona's approved Demonstration, an interim evaluation report must be submitted that discusses the evaluation progress and findings to date in conjunction with Arizona's Demonstration renewal application. Arizona's Interim Evaluation Report was submitted along with the Waiver Renewal Application in December 2020.

Due to limitations in the availability of data and operational constraints imposed by the COVID-19 pandemic, Arizona's current interim evaluation report does not include data from all sources described in Arizona's evaluation design plan. Qualitative data based on key informant interviews and focus groups, as well as beneficiary survey data, were not collected. For this reason, HSAG will complete an updated interim evaluation report in fall of 2021. This report will contain results for additional years and include findings to date from focus groups and qualitative interviews. In addition, the updated interim evaluation report will use statistical techniques, where possible, to control for confounding factors and identify the impact of Arizona's Demonstration initiatives on access to care, QOC, and member experience with care. AHCCCS intends to post the updated interim evaluation report to its website.

## Legislative Updates

The legislature passed several bills in the 2020 Legislative session that will impact AHCCCS including:

- HB 2244—Requires AHCCCS to request CMS approval for the provision of dental services beyond current service limitations when provided at IHS/638 facilities which are eligible for 100 percent Federal Medical Assistance Percentage (FMAP).
- HB 2668—Establishes a new hospital assessment which can be used to create a hospital directed payment program, increase practitioner and dental rates, and pay for administrative expenses. Funds cannot be used to pay for base reimbursement levels.
- SB 1523—The Mental Health Omnibus bill requires commercial insurers to report on mental health parity, establishes funding to pay for behavioral health services in schools for uninsured/underinsured children, and creates the suicide mortality review team at the Arizona Department of Health Services.

The Arizona Legislature adjourned *sine die* on May 26, 2020; the general effective date for legislation was August 25, 2020.

## AHCCCS' Strategic Plan

AHCCCS' Strategic Plan for SFY 2021 presents the strategy and direction for AHCCCS, including new programs, initiatives, and past accomplishments. The Strategic Plan identifies AHCCCS' mission, vision, and core values:[3-7]

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

The Strategic Plan offers four multi-year strategies:

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

- Incentivize performance-based contracting.
- Increase Arizona Medicaid providers' capacity to deliver services via telemedicine.

**2. Pursue continuous quality improvement.**

- Stand up Electronic Visit Verification (EVV) system, aimed at enhancing the provision of quality care while reducing fraud, waste, and abuse (FWA).
- Stand up automated provider enrollment system (AHCCCS Provider Enrollment Portal or APEP).
- Address health disparities through care coordination and case management.

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

- Promote integration at practice level/point of care.
- Promote AHCCCS member connectivity to critical social services.
- Establish singular entity to administer the distribution of housing funding, including housing and housing supports, statewide.

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

- Maintain ongoing functionality of AHCCCS eligibility system, HEAplus.
- Increase employee engagement.

[3-7] Arizona Health Care Cost Containment System. *AHCCCS Strategic Plan State Fiscal Years 2018–2023*. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan_18-23.pdf. Accessed on: Mar 11, 2021.

- Ensure staff have technology needed to perform job functions in office and in remote work environments.

### Key Accomplishments for AHCCCS

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

- Retained 98 percent of Targeted Investment Program providers.
- Increased the number of provider organizations participating in the statewide Health Information Exchange by 25 percent.
- Increased the number of pre-release inmates who received a service within three months of release by over 50 percent.
- Increased the number of CMDP enrollees accessing behavioral health services by more than 15 percent.
- Exceeded target of a 10 percent increase in students receiving behavioral health services on school campuses with an actual increase of more than 43 percent over the prior year.
- Successfully housed 25 individuals who were chronically homeless in downtown Phoenix.
- Established six American Indian Medical Homes.
- Served more than 25,000 individuals under the State Opioid Response grant.

## AHCCCS Quality Strategy

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

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

# 4. Quality Initiatives

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

## Quality Initiative Selection and Initiation

AHCCCS has several initiatives underway aimed at building a more cohesive, effective healthcare system in Arizona by reducing fragmentation, structuring provider reimbursements to incentivize quality outcomes, leveraging health information technology (HIT), and working with private sector partners to further innovation to the greatest extent.

## Systemwide Quality Initiatives/Collaboratives

### *Accessing Behavioral Health Services in Schools*[4-1]

AHCCCS partnered with the Arizona Department of Education (ADE) and others to ensure students who are Medicaid eligible can receive behavioral health services in school settings. AHCCCS helps school administrators and leaders connect with behavioral health providers statewide to meet their students' needs.

While schools have historically been approved settings for Medicaid-covered behavioral health services, in 2018 $3 million in State General Fund dollars were appropriated to expand behavioral health services in schools; $1 million of this funding is being used in partnership with the ADE to provide mental health training to schools and school districts. The remaining dollars are matched with federal funds to generate $10 million in Medicaid funding to AHCCCS health plans to bring established behavioral health providers into the school setting, meet Medicaid-eligible students where they are and where they have health needs, and pay for Medicaid-covered behavioral health services in schools.

AHCCCS is Arizona's Managed Care Medicaid Program, developed as a result of Title XIX of the Social Security Act. While AHCCCS also administers other State and federal healthcare programs, only Title XIX members are eligible for the Direct Service Claiming (DSC) Program. The Medicaid Administrative Claiming (MAC) program is one of the two federally funded programs endorsed by the

[4-1] Arizona Health Care Cost Containment System. Accessing Behavioral Health Services in Schools. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/BehavioralHealthServices/. Accessed on: Mar 11, 2021.

ADE and AHCCCS. AHCCCS is the agency that develops the policies and administers the Medicaid School Based Claiming Program through the Public Consulting Group (PCG) and in collaboration with the ADE.

In 2020, the Arizona Legislature passed Jake's Law, which allocated $8 million for the provision of behavioral health services to uninsured and underinsured children referred through an educational institution. AHCCCS has leveraged the RBHAs to oversee the delivery of these services and has partnered with multiple system stakeholders including ADE to promote the availability of these services. A report on the services provided and survey responses from individuals who were served through this funding will be compiled and sent to the Governor's office in December 2022.

## *AHCCCS Works Community Engagement Program*[4-2]

When people engage in their communities—through employment, education, skills training, or volunteering—they are more likely to experience improved health outcomes. Some able-bodied, 19 to 49-year-old members will be required to participate in community engagement activities for at least 80 hours every month and report activities monthly. American Indian/Alaska Native members are exempt from this requirement.

Qualifying activities include:

1. Employment (including self-employment).
2. Less than full-time education.
3. Job or life skills training.
4. Job search activities.
5. Community service.

All members will have a three-month period at the start in which to become familiar with requirements and tools available to ensure their success. After that three-month period, members who do not complete at least 80 hours of community engagement in a month will be suspended from AHCCCS coverage for two months, and then automatically reinstated. On October 17, 2019, AHCCCS informed CMS of Arizona's decision to postpone implementation of AHCCCS Works until further notice. This decision was informed by the evolving national landscape concerning Medicaid community engagement programs and ongoing related litigation.

[4-2] Arizona Health Care Cost Containment System. AHCCCS Works Community Engagement Program. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/AHCCCSWorksCommunityEngagement/. Accessed on: Mar 11, 2021.

## Building an Integrated Health Care System[4-3]

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

Integrating Services for ALTCS DDD Members—The DES/DDD provides healthcare to eligible DDD members through ALTCS. Starting October 1, 2019, behavioral health service responsibility for these enrolled members has transitioned from the RBHAs to two integrated health plans subcontractors—Mercy Care Plan and UnitedHealthcare Community Plan. This transition included members with an SMI designation and DDD members with qualifying CRS conditions.

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

Although a significant portion of the behavioral health service delivery for adults and children has been moved to the AHCCCS Complete Care (ACC) plans, the RBHAs have played a critical role in providing the following services:

- Integrated physical and behavioral health services for members determined to have an SMI designation. Enrollment in each geographic service area (GSA) as of November 1, 2020, for Title XIX XXI covered members determined to have an SMI designation:
  - North GSA: 6,114.
  - Central GSA: 25,074.
  - South GSA: 13,992.
- Behavioral health services for members in the custody of the Department of Child Safety and enrolled in the Department of Child Safety/Comprehensive Medical and Dental Program. Effective 4/1/2021, this program became known as Mercy Care Department of Child Safety/Comprehensive Health Plan (Mercy Care DCS CHP) enrollment as of September 1, 2020, was 13,563
- Behavioral health services for ALTCS members enrolled with the Department of Economic Security/Division of Developmental Disabilities (DES/DDD); enrollment as of September 1, 2020, was 35,870.

[4-3] Arizona Health Care Cost Containment System. Building an Integrated Health Care System. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/. Accessed on: Mar 11, 2021.

- Crisis services including telephone, community-based mobile, and facility-based stabilization (including observation not to exceed 24 hours), and Substance Abuse and Mental Health Services Administration (SAMHSA) grants and other services, including housing.

Medicare and Medicaid Alignment for Dual Eligibles: 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 150,000 Arizonans who are eligible for both Medicare and Medicaid, navigating these two separate systems of care can be overwhelming. Under these circumstances, people "fall through the cracks," inefficient care is provided, and optimal health outcomes are not achieved.

AHCCCS 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 partner ACC Medicaid health plan. Requiring each ACC Medicaid health plan to offer a partner Medicare D-SNP promotes the enrollment or alignment of dual-eligible members in the same health plan for both Medicare and Medicaid services to the greatest possible extent. Enrolling in specialized Medicare plans allows dual-eligible members to receive all of their healthcare services, including prescription drug benefits, from a single, integrated health plan.

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

Beginning October 1, 2018, members that qualify for a CRS designation and are not enrolled with DES/DDD have a choice of ACC plans that service their area. The ACC plan manages care for all services (including CRS, other non-CRS physical health services, and all covered behavioral health services). Effective October 1, 2019, members enrolled with DES/DDD will use their assigned DES/DDD plan for all of their CRS and non-CRS physical health and behavioral health services. DES/DDD continues to provide long-term care services for these members, thus minimizing the need for members to navigate multiple systems for care.

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

To facilitate this transition, AHCCCS is engaged with the ADOC and most Arizona counties covering the majority of the State's population, including the two largest—Maricopa and Pima—in a data exchange process that allows AHCCCS to suspend eligibility upon incarceration, rather than terminate

coverage. This exchange also allows ADOC and counties to electronically send discharge dates, which simplifies the process of transitioning directly into care. Through this enrollment suspension process, care can be coordinated by county jails or prisons upon discharge. To support this, all RBHAs are contractually required to have a justice systems contact that can ensure a connection to needed behavioral health services. In addition, AHCCCS medical management coordinates with counties to facilitate a transition to care into acute health plans for persons being discharged with serious physical illnesses, such as cancer or other illness, that present public health concerns or require immediate attention.

## *Connecting Communities: The Importance of Private Sector Partners*[4-4]

The AHCCCS program was founded on a competitive, public/private partnership model. AHCCCS began in 1982 as the first statewide mandatory managed care program, placing all enrollees (except American Indians/Alaska Natives) in health plans for acute care, long-term care, and behavioral health (known as RBHAs). Medicaid managed care has evolved and answered the call toward continued innovation and population health strategies.

These contractors do far more than simply pay claims. Today's health plans use sophisticated data analytics tools to assess member risk and develop innovative intervention protocols. In addition, health plans engage their members in person-centered approaches. This often means engaging families and communities, too, so that members have the tools they need to manage their own health. This level of engagement also assists the health plan in developing strategies that respond to community needs.

The relationship between AHCCCS and the health plans is of critical importance. It is integral to the success of the partnership that both parties are willing to come to the table and engage in meaningful discussions about our members, delivery systems, and stakeholders. The connection, partnership, and transparency between AHCCCS and the health plans is the cornerstone to their success.

## *Electronic Visit Verification*[4-5, 4-6]

Electronic visit verification (EVV) ensures timely service delivery for members including real-time service gap reporting and monitoring. EVV will serve as an electronic verification method to help reduce administrative burden associated with hard copy timesheet processing as well as generate cost savings from the prevention of fraud, waste, and abuse. AHCCCS is mandated to implement EVV for non-skilled, in-home services (attendant care, personal care, homemaker, habilitation, respite) and for in-home skilled nursing services (home health).

[4-4] Arizona Health Care Cost Containment System. Connecting Communities: The Importance of Private Sector Partners. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/PrivateSectorPartners/. Accessed on: Mar 11, 2021.
[4-5] Arizona Health Care Cost Containment System. AHCCCS E.V.V. Electronic Visit Verification. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/EVV/. Accessed on: Mar 11, 2021.
[4-6] Arizona Health Care Cost Containment System. AHCCCS Initiatives and Best Practices. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/. Accessed on: Mar 11, 2021.

## Emergency Triage, Treat and Transport to Transform EMS Delivery[4-7]

The Emergency Triage, Treat and Transport initiative (ET3) is a voluntary, five-year CMS Innovation Center Payment Model designed to provide greater flexibility to ambulance care teams addressing emergency healthcare needs. ET3 aims to reduce unnecessary transports to emergency departments, while simultaneously connecting members with the appropriate level of care, at the right time and at the right place. AHCCCS is working toward implementing a model based on ET3 for providers registered with AHCCCS as an emergency ambulance provider in the Fall of 2021. The goal of this program is to reduce hospital admissions, while improving quality and reducing costs.

## Health Equity Committee[4-8]

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

Healthy People 2020 defines health equity as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."

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

Committee Goals:

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

[4-7] Ibid.
[4-8] Arizona Health Care Cost Containment System. Health Equity Committee. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/HEC/index.html. Accessed on: Mar 11, 2021.

## Improving Communications and Care Coordination: Health Information Technology

Since 2006, AHCCCS providers and MCOs have been supporting a single statewide HIE, now called Health Current. Health Current has become an integral part of AHCCCS' Quality Strategy and has grown to include over 880 participating organizations representing laboratories, physical health and behavioral health providers, state agencies, 42 other HIEs, and other payers, such as Accountable Care Organizations and for-profit health plans. These organizations represent thousands of healthcare practitioners and delivery sites across Arizona.

MCOs are using the clinical data available at Health Current to support their healthcare coordination and care management operations. MCOs provide member panels to the HIE in order to receive a variety of real-time alerts (including COVID-19 test results and hospital admission, discharge, and transfer (ADT); other inpatient; or discharge clinical event alerts), as determined by the MCOs.

## Incentivizing Quality: Payment Modernization[4-9]

Modernizing the way healthcare services are purchased means rethinking the end product. Traditional reimbursement structures favor the provider with higher production numbers (i.e., performs more services without regard to outcome). To bend the cost curve, there must be a paradigm shift such that reimbursement favors the provider who achieves a quality health outcome. That is why payment modernization is a critical policy strategy for moving to a financially sustainable and value-based healthcare delivery system.

To that end, AHCCCS is continuing its pursuit to implement long-term strategies that bend the cost curve while improving member health outcomes. The overall mission is to leverage the AHCCCS managed care model toward value-based healthcare systems where patients' experience and population health are improved, per-capita healthcare costs are limited to the rate of general inflation through aligned incentives with MCO and provider partners, and there is a commitment to continuous quality improvement and learning.

**Strategies**

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

[4-9] Arizona Health Care Cost Containment System. AHCCCS Payment Modernization. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/PaymentModernization/. Accessed on: Mar 15, 2021.

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

## *Telehealth Services*[4-10]

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

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

AHCCCS covers all major forms of telehealth services. Asynchronous (also called "store and forward") occurs when services are not delivered in real-time but are uploaded by providers and retrieved, perhaps to an online portal. Telephonic services (audio-only) use a traditional telephone to conduct healthcare appointments. Telemedicine involves interactive audio and video, in a real-time, synchronous conversation. AHCCCS also covers telehealth for remote patient monitoring and teledentistry.

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

## *Transforming Healthcare Delivery: Targeted Investments Program*[4-11]

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

[4-10] Arizona Health Care Cost Containment System. Telehealth Services. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/Telehealth/. Accessed on: Mar 11, 2021.
[4-11] Arizona Health Care Cost Containment System. Targeted Investments Program Overview. Available at: https://www.azahcccs.gov/PlansProviders/TargetedInvestments/. Accessed on: Mar 11, 2021.

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

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

### *Virtual Office*[4-12]

Since the start of the COVID-19 public health emergency, the majority of AHCCCS employees have been working remotely. Once the public health emergency ends and in-office work environments are again safe, more than 60 percent of employees in the Central Phoenix office will continue to work from "virtual offices," thus allowing the agency to consolidate its physical footprint. In February 2021, AHCCCS reduced its Phoenix office space by half, saving $1.2 million annually. This transition promotes efficient and productive staff and allows for better work/life balance, as well as staff health and wellbeing. AHCCCS has also been able to directly correlate the move to virtual offices to greater staff retention.

## AHCCCS 2020 Year in Review[4-13]

The COVID-19 public health emergency was an overarching priority in 2020 as AHCCCS worked to put measures in place to ensure provider viability and member access to care. Technology, policy, and member service innovations like the AHCCCS Provider Enrollment Portal (APEP), EVV, and American Indian Medical Homes will streamline business processes and improve care coordination.

### *Innovations in Service Delivery and Technology*

- Successfully transitioned more than 60 percent of AHCCCS employees to a virtual work environment, allowing AHCCCS to consolidate two main campus buildings into one.
- Supported the work of the Governor's Abuse and Neglect Prevention Task Force through the Oct. 1, 2020, implementation of minimum subcontract provisions aimed at preventing abuse, neglect, and exploitation. This Task Force brings a comprehensive prevention focus to the most vulnerable

[4-12] Arizona Health Care Cost Containment System. State Medicaid Agency Consolidates Downtown Phoenix Office Space to Save $1.2 Million Annually. Available at: https://www.azahcccs.gov/shared/News/GeneralNews/BuildingConsolidation.html. Accessed on: Mar 11, 2021.

[4-13] Arizona Health Care Cost Containment System. 2020 Year in Review. Available at: https://www.azahcccs.gov/shared/Downloads/News/2020/2020_YearInReview.pdf. Accessed on: Mar 11, 2021.

members and supports a cross-functional approach across numerous agencies and stakeholders as well as with support from the Governor's Office.

- Launched the APEP, allowing providers to enroll with AHCCCS electronically any time of day.
- Implemented an EVV system to verify member receipt of critical in-home services.
- Improved the timely processing of Medicaid applications to 94 percent for non-ALTCS applications and to 91 percent for ALTCS applications.
- Increased influenza vaccine rates by 10 percent to incentivize provider administration of the vaccine and partnered with health plans to offer managed care members a $10 gift card for receiving a flu shot.
- Added more than 3,000 members to American Indian Medical Homes, improving care coordination for members served in IHS and 638 facilities. Arizona is the only state in the country to have American Indian Medical Homes.
- Created a Health Equity Committee to examine and understand health disparities that exist within the program and to develop strategies to ensure health equity for all AHCCCS members.
- Partnered with policy makers and hospitals to develop a new assessment, increasing payments to eligible hospitals by $800 million annually.
- Increased rates by an estimated $380 million for dental providers and practitioners.
- Secured more than $37 million in grant funding to address the opioid epidemic, expand the State's suicide prevention work, and meet emergent needs related to the COVID-19 pandemic.

## *Response to the COVD-19 Public Health Emergency*

- Obtained permission to pursue more than 46 programmatic flexibilities from CMS. Key flexibilities implemented include:
  - Expanding the program's telehealth benefit to allow for a broader range of services to be provided electronically.
  - Expediting the provider enrollment process.
  - Reimbursing parents for care offered to their minor children and allowing spouses offering paid care to be paid beyond the standard 40 hours per week limit.
- Offered provider financial relief:
  - Made over $59 million in additional payments to nursing facilities, assisted living facilities, home and community-based service providers, and critical access hospitals.
  - Advanced or accelerated more than $90 million in funding to hospitals, primary care providers, behavioral health outpatient providers, and justice clinic providers who participate in AHCCCS' Targeted Investments Program and hospitals participating in the graduate medical education program.

# Other Systemwide Quality Initiatives/Collaboratives[4-14]

## *SAMHSA SSI/SSDI Outreach, Access, and Recovery[4-15]*

Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR) helps states and communities increase access to Social Security disability benefits for eligible adults and children who are experiencing or are at risk of homelessness and have SMI, medical impairment, and/or a co-occurring substance use disorder. SOAR spotlighted AHCCCS for adding behavioral health support services to its policy manual, broadening access to community mental health programs.

## *Building State Capacity to Address Behavioral Health Needs Through Crisis Services and Early Intervention*

To help ensure patients experiencing a behavioral health crisis are able to get the right care at the right time in the right place, states such as Arizona have developed behavioral health crisis models of care that provide early intervention and divert individuals in crisis from hospitals, jails, and prisons.

Arizona's exemplary crisis system uses a variety of services and settings to meet an individual's immediate needs. These services may include screening, counseling, medication, monitoring, observation, and follow-up to ensure stabilization. Arizona has a "no wrong door" approach to treating behavioral health crises, with a data analytics-enabled call center that navigates callers to appropriate providers, on-call crisis mobile teams that meet people where they are, and partnerships with law enforcement to deliver individuals to open-door observation units in lieu of incarceration.

Approximately 92 percent of calls placed from Arizona to the National Suicide Prevention Lifeline are answered within Arizona, which is the second highest in-state answer rate in the country. When calls are answered within the state's boundaries, the crisis response can be most effective in immediately connecting the caller to the most appropriate crisis interventions.

## *AHCCCS Receives Leadership in Policy Award for COVID-19 Response*

On July 23, Director Jami Snyder accepted the 2020 Leadership in Policy Award from the ASU Center for Applied Behavioral Health Policy.

[4-14] Arizona Health Care Cost Containment System. Awards, Studies, and Highlights. Available at: https://www.azahcccs.gov/AHCCCS/AboutUs/awardsandstudies.html. Accessed on: Mar 11, 2021.
[4-15] Substance Abuse and Mental Health Services Administration. 2020 SOAR Outcomes. Available at: https://www.azahcccs.gov/shared/Downloads/News/2020/2020_SAMHSA_SOAROutcomes.pdf. Accessed on: Mar 11, 2021.

"At the beginning of the pandemic, AHCCCS made two commitments," said Snyder, who accepted the award. "One, ensuring access to care for members during the public health emergency, and two, maintaining the ongoing viability of the provider network."

Dr. Michael Franczak, director of Population Health at Partners in Recovery, presented the award to the AHCCCS leadership team (who attended via webinar), specifically noting the policy changes implemented to address the COVID-19 public health emergency. Reading from the nomination submitted by Mary Jo Whitfield, vice president of behavioral health at Jewish Family & Children's Service, he cited an extensive [sic], including AHCCCS' ability to streamline provider enrollment, change the PASRR assessment process, provide continuous eligibility to enrolled members, waive member premiums and co-pays, provide COVID-19 testing reimbursement, and expand respite care.

Vicki Staples, Director of Outpatient Behavioral Health at Valleywise Health, co-presented the award, noting AHCCCS' extensive efforts to communicate with its stakeholders since the start of the public health emergency. She also highlighted the attention AHCCCS has focused on social determinants of health, how it sought to increase housing for homeless individuals, and how Health Current, the HIE, has been able to improve coordination of care.

Snyder credited AHCCCS employees with their ability to work quickly and collaboratively on behalf of members and providers. "I'm privileged to serve with the qualified and professional experts at AHCCCS, and on behalf of all AHCCCS employees, I thank ASU for this award and for recognizing our efforts," she said.

# 5. Contractor Best and Emerging Practices

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

## Arizona Complete Health – Complete Care Plan – Regional Behavioral Health Authority (AzCH – CCP – RBHA)

- Provider Assistance—Provider Analytics: AzCH – CCP – RBHA created a quality care gap list [of] self-serve options, so providers are able to maximize their internal capabilities to engage members in care. This intervention was implemented in July 2020, and provider training commenced in August 2020. Since Provider Analytics went live, 160 providers have accessed the tool. Evaluation of the tool will continue, and modifications will be applied if found necessary.
- Member Outreach—Behavioral Health Homes Daily Inpatient Report: In August 2020, AzCH – CCP – RBHA implemented an intervention to give Behavioral Health Homes a list of its members who have gone inpatient as soon as possible utilizing authorization data, so they can immediately start on an appropriate discharge plan which would set the necessary follow-up after hospital visit, address any barriers the member may have to attending the visit, as well as setting up wraparound services to help prevent readmission.
- EPSDT—Behavioral Health Residential Facility (BHRF) Quality Care Gap Closure Education: AzCH – CCP – RBHA worked to provide an alternative opportunity for members to obtain their needed immunizations while considering the barriers the COVID-19 pandemic created. Beginning in July 2020, AzCH – CCP – RBHA's EPSDT team coordinated with Behavioral Health Residential Facilities (BHRFs) to provide staff education virtually regarding the differences between a well-child visit and a check-up or sick visit. Additionally, the EPSDT team reviews rates and requirements to meet for preventive dental and follow-up after hospitalization measures. During the education sessions, providers are given a geo-access map detailing the closest contracted PCP and dental providers to their location.

  The EPSDT team is completing follow-up actions to all BHRFs that have received the detailed education above to provide any additional clarification or technical assistance.

## Mercy Care – Regional Behavioral Health Authority (Mercy Care – RBHA)

- Community Re-investment Program: Since 2017, Mercy Care – RBHA's Community Re-Investment (CRI) program focused primarily on offering training opportunities designed to expand and sustain the use of best practices within the provider network. For 2020, Mercy Care – RBHA had a focus on expanding best practices including Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Trauma Responsive Strategies for members with Intellectual and/or Developmental Disabilities (I/DD), and Multi-Systemic Therapy (MST).

  - Mercy Care – RBHA offered a TF-CBT training for clinicians working with children and families that have I/DD. This was an opportunity to expand and sustain the use of best practices within the provider network, statewide for the I/DD community. Following the training series, consultation calls were used to support providers using TF-CBT in their practice. Consultation included assessment review, clinical case reviews, and feedback on implementation of TF-CBT principles. Consultation is required for clinicians seeking TF-CBT national certification.
  - Mercy Care – RBHA developed a workshop, Trauma Responsive Strategies for I/DD Members, focused on understanding trauma and identifying strategies for well-being and emotion-focused communication skills for those caring for individuals with intellectual and developmental disabilities across a variety of settings. This training was selected for paraprofessionals including CMs, direct support workers, family support staff, as well as individuals from the Division of Developmental Disabilities.
  - Mercy Care – RBHA's Community Re-Investment also focused this year on expanding MST, which is an intensive family and community-based treatment that addresses the multiple causes of serious antisocial behavior in juvenile offenders. Part of the expansion focused on expanding MST for problem sexual behavior (MST-PSB), which is guided by the same principles and uses many of the same evidence-based techniques as in MST for nonsexual offenders but focuses on aspects of the youth's ecology that are functionally related to the problem sexual behavior.

- BHRF Referral Process: The goal of this initiative was to reduce delays in transitioning members to Behavioral Health Residential Facilities (BHRFs) from inpatient, subacute, and community settings. The population identified for this project comprised adult members approved for BHRF placement. This included serious mental illness (SMI) and GMH/SU members in all lines of business. Weekly data collection and trending included the number of members approved for BHRF, type of BHRF requested, number of BHRF beds available, and number of members placed. A statewide dashboard was also created of all BHRFs meeting the referral criteria to assist outpatient providers and Mercy Care – RBHA staff to identify open beds that met the needs and choice of the member and expedite transition. As a result, there was a 70 percent reduction in members waiting for open beds, increased autonomy and choice for BH providers and their patients, and a database/dashboard of all BHRFs across the State that can be used by health plans, providers, and regulators.
- Pharmacist Clinical Reviews: Two pharmacy clinical review programs used best practices to focus on care coordination among specific medically vulnerable populations.
  - The Medicaid Hospital Readmission Reduction Program (HRRP) focused on coordinating care between providers, case managers (CMs), and clinical pharmacists as members are discharged from the hospital. Eligibility criteria included members who were admitted and discharged from the hospital for a condition related to an eligible diagnosis; the member had an assigned CM; and the member was on four or more medications for a chronic disease. The pharmacy team provided medication reviews, recommendations, and collaborated with CMs for interventions to improve member safety and adherence. Outreaches were completed by the clinical pharmacist, and communication was provided to the assigned CM. The pharmacy team provided reporting regarding the number of members reviewed and number of recommendations delivered. Pharmacy clinical review metrics were provided monthly to pharmacy directors and CM leadership.

- The Medicaid Pharmacy Supported Comorbid Condition Management (PCCM) Program focused on coordinating care between members, CMs, and clinical pharmacists. The primary goal of the program was to improve medication-related outcomes in complex high-risk members through the completion of a thorough clinical medication review. CMs refer a member to the PCCM Program for any chronic disease state or chronic medication issue that warrants a clinical medication review. The clinical pharmacy advisor completes the medication review and documents findings and drug therapy recommendations and sends the task back to the referring CM within 24 hours of final contact with the member and/or provider. The data analytic pharmacist was responsible for reporting the metrics related to this program which includes the number of members referred, disease states referred to the programs, number and type of quality metrics impacted, and an annual overall financial performance of the program including associated costs and outcomes.

## Health Choice Arizona – Regional Behavioral Health Authority (HCA – RBHA)

- Axial Healthcare—Pain Medication and Care Improvement Program: HCA – RBHA has partnered with Axial Healthcare to improve care coordination for members with substance use disorder. Axial Healthcare leverages analytics and interdisciplinary teams to bring evidence-based care and care coordination to members and the provider community. Action plans are created for high-risk members and focus on specific concerns such as morphine-equivalent dose (MED) prescribing, Polypharmacy, emergency department overdose, and concerns with multiple prescribers. In July 2020, HCA – RBHA launched Recovery Solutions, a new specialty program with Axial Healthcare. This peer-driven program uses premier data analytics to identify individuals diagnosed with opioid use disorders, or who are at risk of developing opioid use disorders, and provides direct patient outreach by a person with lived experience. These peer-providers then assist individuals to navigate the physical and behavioral health system, they coordinate care, and ultimately reduce a wide range of negative outcomes associated with opioid use and misuse. While still in its first six months of operation, and despite the impact of the COVID-19 epidemic, Recovery Solutions has made great progress at developing provider relations with ASAM [American Society of Addiction Medicine] 3 and ASAM 4 facilities, and adapted to engage individuals in safe and effective ways. The service model includes the following elements: quality stratification to identify and develop critical relationships with key facilities and outpatient providers; use of provider referral and census to directly engage with members for enrollment; use of face-to-face technology to engage with members through their recovery journey by removing barriers and enhancing adherence.
- Clinical Management During the COVID-19 public health emergency (PHE): HCA – RBHA implemented numerous best-practice initiatives in response to the COVID-19 public health emergency to ensure members' needs were met. Member risk stratification, using predictive modeling data, identified members at high-risk for complications of COVID-19. High-risk members were reached by phone to provide education on prevention measures. Population Health staff notified behavioral health homes of high-risk members and coordinated member outreach. In addition, HCA – RBHA partnered with the following providers:
  - Health Homes and providers to manage members post-discharge.

- Providers, specialty hospitals, and ambulatory surgery.
- Centers to monitor [whether] essential outpatient procedure needs were being met.
- Durable medical equipment (DME) providers to monitor and manage DME delivery; prior authorization was waived for COVID-19 related procedures.
- Dialysis providers to identify those centers with isolation units.
- Unique Lab Services for in-home lab draws for high-risk and home-bound members.

The Utilization Review team follows all members with a positive COVID-19 test result, follows every member's inpatient stay daily, and works with the hospital team to create discharge plans. Upon discharge, the transition of care nurse contacts the member to assist with care coordination. Education on COVID-19 is provided to the entire household in which a member was positive for COVID-19. Additionally, the Clinical Services team coordinates with Prior Authorization and Network Services regarding any issues with DMEs or provider concerns.

- Suicide Protocol—Safety, Help, Outreach, Understand, Track (SHOUT): HCA – RBHA has developed a comprehensive suicide prevention protocol using multiple evidence-based interventions and a High-Risk Registry to overcome limitations in human and system resources, while prioritizing effectiveness. Using research and evidence-based data, focus is more intensely on persons with high-risk attempts and multiple attempts.[5-1] Integrated care managers and physicians ensure that high-risk members are immediately identified and tracked, and that the SHOUT protocol is followed for that member during the subsequent year. Members with an attempted hanging, suffocation, strangulation, or use of a firearm, or more than one attempt requiring medical intervention, are placed on the registry. The SHOUT protocol uses actionable, evidence-based interventions, such as coordinating with the member's PCP and other providers to reduce access to medication stock, and intensification of outpatient services in the first year following a suicide attempt.

  In addition, the SHOUT protocol is incorporated into the provider contracts. Each person on the registry is followed through monthly clinical rounds conducted by an HCIC care manager with the provider clinical team to ensure protocol adherence and clinical oversight.

[5-1] Runeson B, et al. Method of Attempted Suicide as Predictor of Subsequent Successful Suicide: National Long Term Cohort Study. *British Medical Journal* 2010. BMJ 2010; 340:c3222 doi: 10.1136/bmj.c3222. Available at: https://www.bmj.com/content/341/bmj.c3222 Accessed on: Mar 23, 2021.

# 6. Performance Measure Results

## Methodology

The following section presents the results for the mandatory performance measure activity conducted during the CYE 2019 (October 1, 2018–September 30, 2019) reporting period. To evaluate performance levels and to provide an objective, comparative review of the Contractors' performance, HSAG calculated results on AHCCCS' behalf for a variety of performance measures to address different quality initiatives using the following technical specifications: NCQA's HEDIS and CMS Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set).

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

## Required Performance Measures

The CYE 2019 performance measures selected by AHCCCS for the RBHA Integrated SMI Contractors were grouped into the following domains of care: Preventive Screening, Behavioral Health, Medication Management, and Utilization. While performance is reported primarily at the measure indicator level, grouping these measures into domains encourages the Contractors and AHCCCS to consider the measures as a whole rather than in isolation and to develop strategic changes required to improve overall performance.

Table 6-1 displays the CYE 2019 performance measures presented within this report; the associated measure specifications used to calculate each measure rate; and the established MPS, if applicable, for the RBHA Integrated SMI Contractors. An MPS had not been established for all reported performance measure rates.

**Table 6-1—CYE 2019 Performance Measures for RBHA Integrated SMI Contractors**

| Performance Measure | Measure Specification | MPS |
|---|---|---|
| **Preventive Screening** | | |
| *Breast Cancer Screening—Total* | Adult Core Set | 55.0% |
| *Cervical Cancer Screening* | Adult Core Set | 53.0% |
| **Behavioral Health** | | |
| *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* | Adult Core Set | 60.0% |
| *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total* | Adult Core Set | 85.0% |
| **Medication Management** | | |

| Performance Measure | Measure Specification | MPS |
|---|---|---|
| *Use of Opioids at High Dosage in Persons Without Cancer—Total** | Adult Core Set | — |
| **Utilization** | | |
| *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total** | HEDIS | 150.0 |
| *Inpatient Utilization—General Hospital/Acute Care—Days per 1,000 Member Months (Total Inpatient)—Total* | HEDIS | N/A |
| *Mental Health Utilization—Any Service—Total* | HEDIS | N/A |
| *Plan All-Cause Readmissions—Observed Readmissions—Total** | Adult Core Set | 23.0% |

*— Indicates that an MPS had not been established by AHCCCS.*
** A lower rate indicates better performance for this measure. If the measure has a MPS, rates must fall at or below the established MPS in order to exceed the CYE 2019 MPS.*
*N/A indicates lower or higher rates are not considered to be an appropriate measure of care for this measure.*

## Performance Measure Results—RBHA Integrated SMI Contractors

Table 6-2 presents the CYE 2019 performance measure rates with an MPS for each RBHA Integrated SMI Contractor and the program aggregate. Performance measure rate cells shaded green indicate that the Contractor met or exceeded the CYE 2019 MPS established by AHCCCS. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the established MPS are shaded green.

**Table 6-2—CYE 2019 Performance Measure Results—RBHA Integrated SMI Contractors**

| Performance Measure | AzCH – CCP – RBHA | HCA – RBHA | Mercy Care – RBHA | Aggregate |
|---|---|---|---|---|
| **Preventive Screening** | | | | |
| ***Breast Cancer Screening*** | | | | |
| *Total* | 38.5% | 36.6% | 35.8% | 36.9% |
| ***Cervical Cancer Screening*** | | | | |
| *Cervical Cancer Screening* | 43.9% | 41.0% | 43.5% | 43.2% |
| **Behavioral Health** | | | | |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total* | 63.3% | 64.5% | 71.3% | 68.6% |
| *30-Day Follow-Up—Total* | 83.6% | 81.2% | 86.6% | 85.4% |
| **Utilization** | | | | |
| ***Ambulatory Care (per 1,000 Member Months)*** | | | | |
| *ED Visits—Total** | 111.7 | 120.0 | 119.6 | 117.1 |

| Performance Measure | AzCH – CCP – RBHA | HCA – RBHA | Mercy Care – RBHA | Aggregate |
|---|---|---|---|---|
| ***Plan All-Cause Readmissions*** | | | | |
| *Observed Readmissions—Total** | 12.9% | 11.5% | 14.3% | 13.6% |

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

*Cells shaded green indicate that the rate met or exceeded the CYE 2019 MPS established by AHCCCS.*

Table 6-3 presents a comparison of the RBHA Integrated SMI Contractors' CYE 2018 to CYE 2019 rates. Performance measure rates were compared to determine if there was a significant difference between CYE 2018 and CYE 2019 using a Chi-square test of proportions. In cases where the value was less than five (i.e., fewer than five members were either numerator positive or numerator negative for either reporting year), a Fisher's exact test was used in place of a Chi-square test. The results of the statistical tests were considered significant when the *p* value was ≤0.05. A green upward arrow (↑) indicates a significant improvement in performance, a red downward arrow (↓) indicates a significant decline in performance, and a dash (—) indicates that the change in performance was not significant.

For some measures, statistical significance testing was not performed because the measure data were not appropriate for statistical testing (i.e., *Ambulatory Care*, *Inpatient Utilization,* and *Mental Health Utilization*).

**Table 6-3—Trend Analysis From CYE 2018 to CYE 2019—RBHA Integrated SMI Contractors**

| Performance Measure | AzCH – CCP – RBHA | HCA – RBHA | Mercy Care – RBHA | Aggregate |
|---|---|---|---|---|
| **Medication Management** | | | | |
| ***Use of Opioids at High Dosage in Persons Without Cancer*** | | | | |
| *Total** | — | ↑ | — | — |
| **Preventive Screening** | | | | |
| ***Breast Cancer Screening*** | | | | |
| *Total* | — | ↑ | — | — |
| ***Cervical Cancer Screening*** | | | | |
| *Cervical Cancer Screening* | — | — | ↓ | ↓ |
| **Behavioral Health** | | | | |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total* | — | — | — | — |
| *30-Day Follow-Up—Total* | — | — | — | — |

↑ *Indicates a significant improvement in the Contractor's rate from CYE 2018 to CYE 2019.*

↓ *Indicates a significant decline in the Contractor's rate from CYE 2018 to CYE 2019.*

— *Indicates no significant difference in the Contractor's rate from CYE 2018 to CYE 2019.*

## Strengths and Opportunities for Improvement

For CYE 2019, the RBHA Integrated SMI Contractors demonstrated high performance within the Behavioral Health domain as all Contractors and the aggregate met or exceeded the MPS for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* measure indicator.

Conversely, neither performance measure rate within the Preventive Screening domain (*Breast Cancer Screening—Total* and *Cervical Cancer Screening*) met or exceeded the CYE 2019 MPS, demonstrating opportunities to improve care coordination and access to screenings for members with SMI. Research shows that women with SMI experience disparities in the timely screening for preventive diseases and care; yet, women with SMI develop cancer at the same rate as the general population.[6-1] Women with SMI have cited lack of preventive care due to perceived discrimination, provider characteristics (e.g., gender), and inaccurate health perception.[6-2] The RBHA Integrated SMI Contractors should focus efforts on identifying the factors contributing to low rates for these measures and implement improvement strategies to increase screenings for cancer in women.

HCA – RBHA demonstrated improvement for CYE 2019, with two of five (40.0 percent) performance measure rates demonstrating significant improvement in performance. Conversely, Mercy Care – RBHA and the RBHA Integrated SMI aggregate demonstrated significant decline in performance for one performance measure (*Cervical Cancer Screening).*

[6-1] Woodhead C, Cunningham R, Ashworth M, et al. Cervical and breast cancer screening uptake among women with serious mental illness: a data linkage study. *BMC Cancer*. 2016 Oct 21;16(1):819. doi: 10.1186/s12885-016-2842-8.

[6-2] Xiong GL, Iosif AM, Bermudes RA, et al. Preventive Medical Services Use Among Community Mental Health Patients With Severe Mental Illness: The Influence of Gender and Insurance Coverage. *Prim Care Companion J Clin Psychiatry*. 2010; 12(5): PCC.09m00927.

# 7. Performance Improvement Project Results

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

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

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

## Conducting the Review

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

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

## *E-Prescribing* PIP

In CYE 2016 (October 1, 2015, through September 30, 2016), AHCCCS implemented a new PIP, *E-Prescribing*. AHCCCS implemented the *E-Prescribing* PIP because research suggested that an opportunity existed to improve preventable errors experienced using the standard, handwritten paper method to communicate a medication between a prescriber and a pharmacy. CYE 2019 served as Remeasurement 2 for the *E-Prescribing* PIP for the AzCH – CCP – RBHA and HCA – RBHA

Contractors; whereas, Mercy Care – RBHA's Remeasurement 2 was CYE 2018. As a result, the *CYE 2019 EQR Annual Report for Acute Care and Comprehensive Medical and Dental Program, Regional Behavioral Health Authorities Children's Rehabilitative Services* included final reporting for Mercy Care – RBHA/MMIC only.[7-1] CYE 2019 Remeasurement 2 results for the *E-Prescribing* PIP for AzCH – CCP – RBHA and HCA – RBHA are included below.

## AzCH – CCP – RBHA

### Findings

Table 7-1 presents the baseline, Remeasurement 1, and Remeasurement 2 results for the *E-Prescribing* PIP for AzCH – CCP – RBHA. CYE 2016 was AzCH – CCP – RBHA's baseline measurement period for the statewide *E-Prescribing* PIP. CYE 2017 was an intervention year for AzCH – CCP – RBHA; therefore, rates will not be reported.

Indicator 1, which shows the percentage of providers with at least one electronic prescription, ended Remeasurement 2 with a performance rate of 78.47 percent. Indicator 1 showed an increase of 21.30 percent from the baseline to Remeasurement 2.

Indicator 2, which shows the percentage of e-prescriptions filled, ended Remeasurement 2 with a performance rate of 80.59 percent. Overall, Indicator 2 showed an increase of 21.49 percent from baseline to Remeasurement 2. Both indicators showed statistically significant overall positive progress throughout the PIP.

**Table 7-1—AzCH – CCP – RBHA Integrated *E-Prescribing* PIP**

| PIP Measure | CYE 2016 Baseline Year Rate | CYE 2018 Remeasurement 1 | CYE 2019 Remeasurement 2 | Overall Relative Percentage Change[1] | Overall Statistical Significance[1] |
|---|---|---|---|---|---|
| Indicator 1: The percentage of contracted providers who prescribed at least one electronic prescription. | 57.17% | 68.59% | 78.47% | 37.26% | **P<.0001** |
| Indicator 2: The percentage of prescriptions, which are submitted electronically to a pharmacy. | 59.10% | 73.69% | 80.59% | 36.36% | **P<.0001** |

[1] The relative percentage change and statistical significance are reflective of CYE 2019 compared to CYE 2016.

[7-1] Health Services Advisory Group. *CYE 2019 EQR Annual Report for Acute Care and Comprehensive Medical and Dental Program, Regional Behavioral Health Authorities Children's Rehabilitative Services.* Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2019/CYE2019ExternalQualityReviewAnnualReport-AcuteCMDPRBHACRS.pdf. Accessed on: March 10, 2021.

AzCH – CCP – RBHA submitted the following qualitative analysis:

Limitations:

At the start of CY 2019, AzCH – CCP – RBHA transitioned into a new claims system. The transition affected the timely processing of claims, which in turn affected AzCH – CCP – RBHA's ability to pull and analyze the data as a plan.

During CY 2019 Q4, the pharmacy department completed the hiring of a new pharmacy liaison. The pharmacy leadership had intended to fill this position earlier in the year but could not do so until Q4 due to unforeseen barriers. Filling this position at the originally intended time could have assisted in further improving AzCH – CCP – RBHA's rates because the liaison could have provided technical assistance and education to more providers.

Lessons Learned:

Key lessons learned during the course of this PIP include building and leveraging internal collaboration to create a one-message education and technical assistance model. Additionally, the plan to implement interventions to incorporate the network as a whole and then transition to a more focused approach was a success. This plan can be applied to other network-wide projects as an outline to follow for creating a solid knowledgebase of the network in consideration of the new project and how to best approach it.

## Strengths

AzCH – CCP – RBHA was successful in increasing performance rates for Indicator 1 with a rate of 78.47 percent, an increase from Remeasurement 1 of 27.3 percent, and for Indicator 2 with a rate of 80.59 percent, an increase of 21.49 percent. AzCH – CCP – RBHA demonstrated statistically significant improvements for all indicators for this PIP. In addition, AzCH – CCP – RBHA plans to continue the interventions that are in place after the PIP closure. AzCH – CCP – RBHA will continue to provide educational materials and technical assistance to individual prescribers via the dedicated pharmacy liaison. Additionally, continuing education and the offer of technical assistance will be provided to the prescriber network as a whole on a routine basis.

## Opportunities for Improvement and Recommendations

HSAG recommends that AzCH – CCP – RBHA continue to leverage the collaborations developed through this PIP and further promote partnerships to ensure that the success of this PIP is maintained.

## HCA – RBHA

### Findings

Table 7-2 presents the baseline, Remeasurement 1, and Remeasurement 2 results for the *E-Prescribing* PIP for HCA – RBHA. CYE 2016 was HCA – RBHA's baseline measurement period for the statewide *E-Prescribing* PIP. CYE 2017 was an intervention year for HCA – RBHA; therefore, rates will not be reported.

Indicator 1, which shows the percentage of providers with at least one electronic prescription, ended Remeasurement 2 with a performance rate of 78.02 percent. Overall, Indicator 1 showed an increase of 25.38 percent from baseline to Remeasurement 2.

Indicator 2, which shows the percentage of e-prescriptions filled, ended Remeasurement 2 with a performance rate of 80.46 percent. Overall, Indicator 2 showed an increase of 25.47 percent from baseline to Remeasurement 2. Both indicators showed statistically significant overall positive progress throughout the PIP.

**Table 7-2—HCA – RBHA Integrated *E-Prescribing* PIP**

| PIP Measure | CYE 2016 Baseline Year Rate | CYE 2018 Remeasurement 1 | CYE 2019 Remeasurement 2 | Overall Relative Percentage Change[1] | Overall Statistical Significance[1] |
|---|---|---|---|---|---|
| Indicator 1: The percentage of contracted providers who prescribed at least one electronic prescription. | 52.64% | 66.42% | 78.02% | 48.21% | **P<.0001** |
| Indicator 2: The percentage of prescriptions, which are submitted electronically to a pharmacy. | 54.99% | 69.89% | 80.46% | 46.32% | **P<.0001** |

[1] The relative percentage change and statistical significance are reflective of CYE 2019 compared to CYE 2016.

HCA – RBHA submitted the following qualitative analysis:

Limitations:

HCA – RBHA's most recent results do not contain the full claims lag for CYE 2020 due to the submission date requirements for the PIP, but HCA – RBHA felt it was important to show a continued upward trend in the data from last year.

Changes in contracts and populations make direct comparisons of the populations difficult. However, HCA – RBHA noted that it is pleased that despite these limitations, the rates of electronic prescribing continue to increase.

During the reporting for Remeasurement 1, HCA – RBHA noticed a considerable error in the reporting for the number of prescribers in the previous years. HCA – RBHA was able to update this number for the interim year and has resolved the issue moving forward.

Lessons Learned:

Increasing the use of electronic prescribing across such a large and diverse GSA was a monumental effort requiring that many agencies either upgrade or update their EHRs, train providers on electronic prescribing, and ensure adequate lines of communication between EHRs and pharmacies. HCA – RBHA noted that it was pleased overall with the progress from year to year, given the complexity of making these large organizational changes.

### Strengths

HCA – RBHA was successful in increasing performance rates for Indicator 1 with a rate of 78.02 percent, an increase from Remeasurement 1 of 25.38 percent, and for Indicator 2 with a rate of 80.46 percent, an increase of 25.47 percent. HCA – RBHA demonstrated statistically significant improvements for all indicators for this PIP. In addition, HCA – RBHA identified methods to overcome the barriers many providers faced, including the lack of infrastructure needed to submit prescriptions electronically. Providing financial incentives for providers to invest in needed infrastructure ensured a long-term solution. HCA – RBHA also educated providers and provided one-on-one support throughout the PIP to further foster buy-in among providers.

### Opportunities for Improvement and Recommendations

HSAG recommends that HCA – RBHA continue to provide ongoing support to its providers in order to further increase the number of providers and sustain provider buy-in for this project.

## *Preventive Screening* PIP

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Preventive Screening* PIP for the RBHA SMI population. The CYE 2019 baseline year for this PIP will be followed by two "intervention" years in which each Contractor will implement strategies and interventions to improve performance. AHCCCS will then conduct annual measurements to evaluate Contractor performance, with the first remeasurement reflective of calendar year (CY) 2022 (January 1, 2022, through December 31, 2022) and the second remeasurement year reflective of CY 2023 (January 1, 2023, through December 31, 2023).

Early detection of breast cancer and cervical cancer is important when providing effective interventions. 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,[7-2] and accounts for 15 percent of all new cancer diagnoses in the U.S.[7-3] Ensuring that all women receive regular breast cancer screening is critically important in disease prevention, early detection, and treatment. Cervical cancer is a type of cancer that occurs in the cells of the cervix. The risk of developing cervical cancer can be reduced by having screening tests and receiving a vaccine that protects against human papillomavirus (HPV) infection.

Breast cancer 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.

The purpose of the *Preventive Screening* PIP is to increase the number and percentage of breast cancer screenings and cervical cancer screenings. The eligible population for breast cancer screening includes women, 50 to 74 years of age, who are continuously enrolled with no more than one gap in enrollment of up to 45 days during the measurement period. The eligible population for cervical cancer screenings includes women, 21 to 64 years of age, who are continuously enrolled with no more than one gap in enrollment of up to 45 days during the measurement period. AHCCCS' goal is to demonstrate a statistically significant increase in the number and percentage of breast cancer screenings and cervical cancer screenings, followed by sustained improvement for one consecutive year. CYE 2019 was the baseline measurement period for the RBHA *Preventive Screening* PIP. Table 7-3 shows the indicator, numerator, and denominator that will be used to measure the baseline of this PIP. RBHA CYE 2019 baseline rates will be detailed in next year's Annual Report.

**Table 7-3—RBHA *Preventive Screening* PIP Indicator (Breast Cancer Screening)**

| PIP Measure Indicator 1 | |
|---|---|
| Indicator 1: The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer. | Numerator: Number of women who had one or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.* |
| | Denominator: The eligible population. |

**One or more mammograms any time on or between July 1 two years prior to the measurement year and September 31 of the measurement year for CYE 2019 measurement year only.*

[7-2] Jemal A, Siegel R, Ward E, Hao Y, Xu J, Thun MJ. Cancer statistics, 2009. CA Cancer J Clin. 2009 Jul-Aug;59(4):225-49. doi: 10.3322/caac.20006. Epub 2009 May 27. PMID: 19474385.

[7-3] Howlader N, Noone AM, Krapcho M, Miller D, Brest A, Yu M, Ruhl J, Tatalovich Z, Mariotto A, Lewis DR, Chen HS, Feuer EJ, Cronin KA (eds). SEER Cancer Statistics Review, 1975-2016, National Cancer Institute. Bethesda, MD; 2016.

**Table 7-4—RBHA *Preventive Screening* PIP Indicator (Cervical Cancer Screening)**

| PIP Measure Indicator 2 | |
|---|---|
| Indicator 1: The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:<br>• Women ages 21 to 64 who had cervical cytology performed within the last 3 years<br>• Women ages 30 to 64 who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.<br>• Women ages 30 to 64 who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years. | Numerator: Number of women who were screened for cervical cancer as outlined in the associated technical specifications.*<br><br>Denominator: The eligible population. |

**Cervical cytology performed any time on or between October 1 three years prior to the measurement year and September 31 of the measurement year or hrHPV testing/cervical cytology and hrHPV cotesting any time on or between October 1 five years prior to the measurement year and September 31 of the measurement year for CYE 2019 measurement year only.*

## Recommendations

HSAG offers the following general recommendations related to the PIPs to support progress toward improved outcomes:

- RBHAs should identify and prioritize barriers to develop robust strategies and interventions for the PIP.
- RBHAs are encouraged to monitor the progress of the PIP interventions employed to increase the rate of women receiving a breast cancer screening, then adjust interventions as needed to ensure that the rates continue to increase.

# 8. Organizational Assessment and Structure Performance

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

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

## Conducting the Review

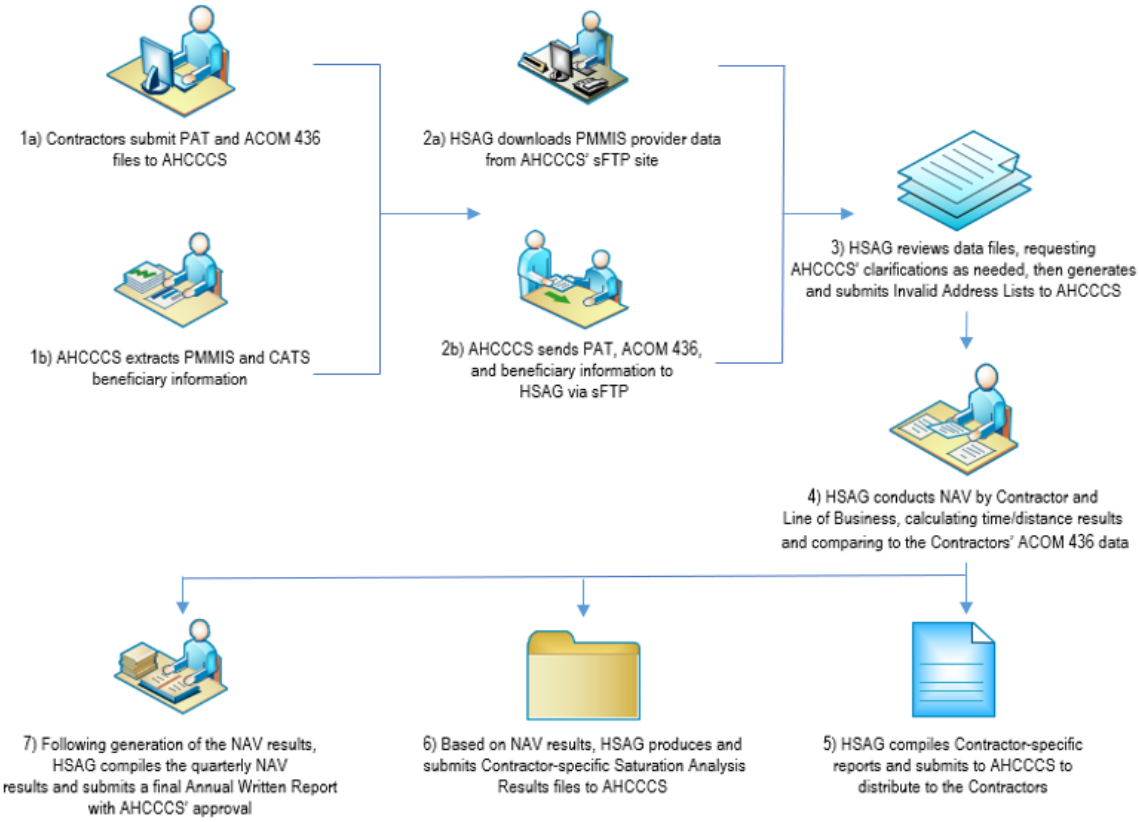
ORs were not conducted in CYE 2019 for the RBHA Contractors. AHCCCS intended to conduct ORs in CYE 2020; however, due to the COVID-19 pandemic, on-site OR reviews were postponed.

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

# 9. Network Adequacy Update

CYE 2020 is the second year in which AHCCCS contracted HSAG to support quarterly analyses and validation of healthcare provider networks subcontracted to AHCCCS' RBHA Contractors for all beneficiary coverage areas.[9-1] HSAG's quarterly NAV considered each RBHA Contractor's compliance with 12 AHCCCS-established time/distance standards for specific provider types and populations during the July 1, 2019, through June 30, 2020, measurement period.[9-2] Figure 9-1 summarizes the quarterly network adequacy data process and reporting products.

**Figure 9-1—CYE 2020 Quarterly Network Adequacy Validation Process Flow**




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

[9-1] Validation of network adequacy is a mandatory EQR activity, and states must begin conducting this activity, described in CMS rule 438.358(b)(1)(iv), no later than one year from the issuance of the associated EQR protocol. While the protocol has not yet been released as of the publication of this report, HSAG's analysis of the Contractor's time/distance results aligns with current federal regulations.

[9-2] The AHCCCS Contractor Operations Manual (ACOM), Section 436—Network Standards defines time/distance standards, as well as provider identification and beneficiaries' county assignment criteria. The ACOM is available at: https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/436_Network_Standards.pdf.

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

HSAG's validation of the RBHA Contractors' quarterly ACOM 436 reports indicated that the Contractors' self-reported time/distance calculations were accurate across counties and network standards. AHCCCS suspended the CYE 2020 Quarter 2 ACOM 436 data reporting during the COVID-19 public health emergency, and RBHA Contractors' ACOM 436 results were not available for comparison to HSAG's CYE 2020 Quarter 2 time/distance calculation results.

Table 9-1 summarizes HSAG's assessment of each RBHA Contractor's compliance with AHCCCS' minimum time/distance network standards. A check mark indicates that the RBHA Contractor met the minimum network standard for each Arizona county during each of the four quarterly assessments.

**Table 9-1—Summary of RBHA Contractors' CYE 2020 Compliance With Minimum Time/Distance Network Requirements**

| Minimum Network Requirement | AzCH – CCP – RBHA | HCA – RBHA | Mercy Care – RBHA |
|---|---|---|---|
| Behavioral Health Outpatient and Integrated Clinic, Adult | ✔ | ✔ | ✔ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric[1] | ✔ | ✔ | ✔ |
| Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)* | ✔ | Not Applicable | ✔ |
| Cardiologist, Adult | ✔ | ✔ | ✔ |
| Cardiologist, Pediatric | ✔ | ✔ | ✔ |
| Crisis Stabilization Facility | ✔ | ✔ | ✔ |
| Dentist, Pediatric[3] | Met all standards across all counties, except the Dentist, Pediatric standard in Graham County for CYE 2019 Quarter 4 and CYE 2020 Quarter 1[2] | ✔ | ✔ |
| Hospital | ✔ | ✔ | ✔ |
| Obstetrics/Gynecology (OB/GYN) | ✔ | ✔ | ✔ |
| Pharmacy | ✔ | ✔ | ✔ |
| PCP, Adult | ✔ | ✔ | ✔ |
| PCP, Pediatric | ✔ | ✔ | ✔ |

1) HSAG's validation identified no RBHA beneficiaries under 18 years of age for consideration in the Behavioral Health Outpatient and Integrated Clinic, Pediatric standard in all counties and quarters, except Maricopa County for CYE 2019 Quarter 1 and CYE 2020 Quarter 1.
2) HSAG's time/distance calculation results for AzCH – CCP – RBHA's compliance with the Dentist, Pediatric standard included fewer than five beneficiaries younger than 21 years in Graham County during the measurement period.
3) HSAG identified one instance in which the RBHA Contractor's self-reported ACOM 436 results failed to meet the minimum network requirement, but HSAG's calculations indicated that the standard was met: AzCH – CCP – RBHA's CYE 2019 Quarter 4 Dentist, Pediatric result in Greenlee County.

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

## Recommendations

As of CYE 2020 Quarter 3, Mercy Care – RBHA and HCA – RBHA met all standards and did not receive saturation analysis results. Although AzCH – CCP – RBHA failed to meet the minimum network requirement for the Dentist, Pediatric standard in CYE 2019 Quarter 4 and CYE 2020 Quarter 1, it met the requirement starting in CYE 2020 Quarter 2. As of CYE 2020 Quarter 3, all RBHA Contractors should continue to monitor and maintain their existing provider networks.

# Appendix A. Validation of Performance Measure Methodology and Additional Results

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

As permitted by 42 CFR §438.358(a), AHCCCS elected to conduct the functions associated with the mandatory activity of validating performance measures. In accordance with and satisfying the requirements of 42 CFR §438.364(a)(1–5), AHCCCS contracted with HSAG as an EQRO to use the information that AHCCCS obtained from the performance measure calculations and data validation activities to prepare this CYE 2020 annual report.

## Conducting the Review

HSAG calculates and reports rates on AHCCCS' behalf for a variety of Contractor-specific and statewide aggregate performance measures to address different quality initiatives. HSAG calculated the measure rates for CYE 2019.

Using the results and statistical analysis of Contractors' performance measure rates, HSAG organized, aggregated, and analyzed the performance data. From the analysis, HSAG was able to draw conclusions about Contractor-specific and statewide aggregate performance related to the quality of, access to, and timeliness of care and services provided to AHCCCS members for CYE 2019.

### *Objectives for Conducting the Review*

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

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

### *Methodology for Conducting the Review*

For the CYE 2019 (October 1, 2018–September 30, 2019) reporting period, AHCCCS conducted the following activities:

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

CAPs, key components of the AHCCCS Quality Strategy, are used as foundational elements to improve performance measure rates that fall below the contractual MPS. During CYE 2020, AHCCCS required Contractors to propose and implement CAPs for CYE 2018 performance measures that did not meet the MPS. The Contractors then submitted CAP proposals. Once a CAP proposal is submitted to and approved by AHCCCS, the Contractors implement the CAP and are required to provide CAP updates as required by AHCCCS.

HSAG calculated results on AHCCCS' behalf for a variety of performance measures to address different quality initiatives using the following technical specifications: NCQA's HEDIS and CMS Adult Core Set. The Contractors' performance rates were calculated for AHCCCS-selected measures using administrative data collected from the automated managed care data system known as the Prepaid Medical Management Information System (PMMIS). NCQA and CMS update their respective methodologies annually to add new codes to better identify the eligible populations and/or services being measured or to delete codes retired from standardized coding sets used by providers.

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

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

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

| Performance Measure | Quality | Timeliness | Access |
|---|---|---|---|
| **Behavioral Health** | | | |
| *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* | ✓ | ✓ | ✓ |
| **Preventive Screening** | | | |
| *Breast Cancer Screening—Total* | ✓ | | |
| *Cervical Cancer Screening* | ✓ | | |

| Performance Measure | Quality | Timeliness | Access |
|---|---|---|---|
| **Utilization** | | | |
| *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* | N/A | N/A | N/A |
| *Plan All-Cause Readmissions—Observed Readmissions—Total* | ✓ | | |

*N/A indicates Not Applicable.*

## Performance Measure Results—RBHA Integrated SMI Contractors

The following tables include performance measure results for the RBHA Integrated SMI Contractors. The tables display the following information: CYE 2018 performance, where available; CYE 2019 performance; the relative percentage change between CYE 2018 and CYE 2019 rates, where available; the statistical significance of the relative percentage change, where available; and the AHCCCS MPS, where available. Performance measure rate cells shaded green indicate that performance met or exceeded the CYE 2019 MPS established by AHCCCS. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the established MPS are shaded green.

### *Arizona Complete Health – Complete Care Plan – Regional Behavioral Health Authority (AzCH – CCP – RBHA)*

**Table A-2—CYE 2018 and CYE 2019 Performance Measure Results—AzCH – CCP – RBHA**

| Performance Measure | CYE 2018 Performance | CYE 2019 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| **Medication Management** | | | | | |
| ***Use of Opioids at High Dosage in Persons Without Cancer*** | | | | | |
| *Total** | 12.9% | 12.5% | -3.2% | *p*=0.793 | — |
| **Preventive Screening** | | | | | |
| ***Breast Cancer Screening*** | | | | | |
| *Total* | 38.2% | 38.5% | 0.8% | *p*=0.830 | 55.0% |
| ***Cervical Cancer Screening*** | | | | | |
| *Cervical Cancer Screening* | 45.7% | 43.9% | -3.9% | *p*=0.069 | 53.0% |
| **Behavioral Health** | | | | | |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | | |
| *7-Day Follow-Up—Total* | 62.9% | 63.3% | 0.6% | *p*=0.806 | 60.0% |
| *30-Day Follow-Up—Total* | 83.9% | 83.6% | -0.3% | *p*=0.807 | 85.0% |
| **Utilization** | | | | | |
| ***Ambulatory Care (per 1,000 Member Months)*** | | | | | |

| Performance Measure | CYE 2018 Performance | CYE 2019 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| *ED Visits—Total** | 105.0 | 111.7 | 6.4% | — | 150.0 |
| ***Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total†*** | | | | | |
| *Days per 1,000 Member Months (Total Inpatient)—Total* | 62.0 | 73.0 | 17.7% | — | — |
| ***Mental Health Utilization†*** | | | | | |
| *Any Service—Total* | 86.7% | 85.7% | -1.2% | — | — |
| ***Plan All-Cause Readmissions[2]*** | | | | | |
| *Observed Readmissions—Total** | — | 12.9% | — | — | 23.0% |

** A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance.*
*[1] Significance levels (p values) noted in the table were calculated by HSAG on behalf of AHCCCS and demonstrate whether the differences in performance between CYE 2018 and CYE 2019 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.*
*[2] Due to changes in the technical specifications for this measure, a break in trending between CYE 2019 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.*
*— Indicates that the CYE 2018 rate was not displayed due to technical specification changes, that a comparison of performance between CYE 2018 and CYE 2019 was not possible or appropriate, or that an MPS had not been established by AHCCCS.*
*† Lower or higher rates are not considered to be an appropriate measure of care for this measure.*
*Cells shaded green indicate that the rate met or exceeded the CYE 2019 MPS established by AHCCCS.*

## Health Choice Arizona – Regional Behavioral Health Authority (HCA – RBHA)

**Table A-3—CYE 2018 and CYE 2019 Performance Measure Results—HCA – RBHA**

| Performance Measure | CYE 2018 Performance | CYE 2019 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| **Medication Management** | | | | | |
| ***Use of Opioids at High Dosage in Persons Without Cancer*** | | | | | |
| *Total** | 13.8% | 9.3% | -32.3% | ***p*=0.023** | — |
| **Preventive Screening** | | | | | |
| ***Breast Cancer Screening*** | | | | | |
| *Total* | 31.8% | 36.6% | 14.8% | ***p*=0.022** | 55.0% |
| ***Cervical Cancer Screening*** | | | | | |
| *Cervical Cancer Screening* | 40.7% | 41.0% | 0.8% | *p*=0.820 | 53.0% |
| **Behavioral Health** | | | | | |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | | |
| *7-Day Follow-Up—Total* | 64.4% | 64.5% | 0.2% | *p*=0.967 | 60.0% |
| *30-Day Follow-Up—Total* | 81.2% | 81.2% | 0.0% | *p*=0.990 | 85.0% |

| Performance Measure | CYE 2018 Performance | CYE 2019 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| **Utilization** | | | | | |
| ***Ambulatory Care (per 1,000 Member Months)*** | | | | | |
| *ED Visits—Total** | 128.2 | 120.0 | -6.4% | — | 150.0 |
| ***Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total†*** | | | | | |
| *Days per 1,000 Member Months (Total Inpatient)—Total* | 61.5 | 56.2 | -8.6% | — | — |
| ***Mental Health Utilization†*** | | | | | |
| *Any Service—Total* | 83.9% | 83.7% | -0.2% | — | — |
| ***Plan All-Cause Readmissions[2]*** | | | | | |
| *Observed Readmissions—Total** | — | 11.5% | — | — | 23.0% |

** A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance.*
*[1] Significance levels (p values) noted in the table were calculated by HSAG on behalf of AHCCCS and demonstrate whether the differences in performance between CYE 2018 and CYE 2019 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.*
*[2] Due to changes in the technical specifications for this measure, a break in trending between CYE 2019 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.*
*— Indicates that the CYE 2018 rate was not displayed due to technical specification changes, that a comparison of performance between CYE 2018 and CYE 2019 was not possible or appropriate, or that an MPS had not been established by AHCCCS.*
*† Lower or higher rates are not considered to be an appropriate measure of care for this measure.*
*Cells shaded green indicate that the rate met or exceeded the CYE 2019 MPS established by AHCCCS.*

## Mercy Care – Regional Behavioral Health Authority (Mercy Care – RBHA)

**Table A-4—CYE 2018 and CYE 2019 Performance Measure Results—Mercy Care – RBHA**

| Performance Measure | CYE 2018 Performance | CYE 2019 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| **Medication Management** | | | | | |
| ***Use of Opioids at High Dosage in Persons Without Cancer*** | | | | | |
| *Total** | 12.7% | 11.9% | -6.2% | *p*=0.526 | — |
| **Preventive Screening** | | | | | |
| ***Breast Cancer Screening*** | | | | | |
| *Total* | 38.1% | 35.8% | -5.9% | *p*=0.057 | 55.0% |
| ***Cervical Cancer Screening*** | | | | | |
| *Cervical Cancer Screening* | 45.5% | 43.5% | -4.4% | ***p*=0.011** | 53.0% |
| **Behavioral Health** | | | | | |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | | |

| Performance Measure | CYE 2018 Performance | CYE 2019 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| *7-Day Follow-Up—Total* | 71.2% | 71.3% | 0.1% | *p*=0.925 | 60.0% |
| *30-Day Follow-Up—Total* | 86.7% | 86.6% | -0.2% | *p*=0.809 | 85.0% |
| **Utilization** | | | | | |
| ***Ambulatory Care (per 1,000 Member Months)*** | | | | | |
| *ED Visits—Total** | 51.5 | 119.6 | 132.4% | — | 150.0 |
| ***Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total†*** | | | | | |
| *Days per 1,000 Member Months (Total Inpatient)—Total* | 89.8 | 83.1 | -7.4% | — | — |
| ***Mental Health Utilization†*** | | | | | |
| *Any Service—Total* | 96.8% | 97.2% | 0.5% | — | — |
| ***Plan All-Cause Readmissions[2]*** | | | | | |
| *Observed Readmissions—Total** | — | 14.3% | — | — | 23.0% |

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

*[1] Significance levels (p values) noted in the table were calculated by HSAG on behalf of AHCCCS and demonstrate whether the differences in performance between CYE 2018 and CYE 2019 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.*

*[2] Due to changes in the technical specifications for this measure, a break in trending between CYE 2019 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.*

*— Indicates that the CYE 2018 rate was not displayed due to technical specification changes, that a comparison of performance between CYE 2018 and CYE 2019 was not possible or appropriate, or that an MPS had not been established by AHCCCS.*

*† Lower or higher rates are not considered to be an appropriate measure of care for this measure.*

*Cells shaded green indicate that the rate met or exceeded the CYE 2019 MPS established by AHCCCS.*

## RBHA Integrated SMI Aggregate

**Table A-5—CYE 2018 and CYE 2019 Performance Measure Results—RBHA Integrated SMI Contractors**

| Performance Measure | CYE 2018 Performance | CYE 2019 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| **Medication Management** | | | | | |
| ***Use of Opioids at High Dosage in Persons Without Cancer*** | | | | | |
| *Total** | 13.0% | 11.5% | -11.0% | *p*=0.103 | — |
| **Preventive Screening** | | | | | |
| ***Breast Cancer Screening*** | | | | | |
| *Total* | 37.3% | 36.9% | -1.0% | *p*=0.655 | 55.0% |
| ***Cervical Cancer Screening*** | | | | | |
| *Cervical Cancer Screening* | 44.8% | 43.2% | -3.5% | ***p*=0.005** | 53.0% |

| Performance Measure | CYE 2018 Performance | CYE 2019 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| **Behavioral Health** | | | | | |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | | |
| *7-Day Follow-Up—Total* | 68.5% | 68.6% | 0.2% | *p*=0.847 | 60.0% |
| *30-Day Follow-Up—Total* | 85.6% | 85.4% | -0.2% | *p*=0.716 | 85.0% |
| **Utilization** | | | | | |
| ***Ambulatory Care (per 1,000 Member Months)*** | | | | | |
| *ED Visits—Total** | 122.1 | 117.1 | -4.1% | — | 150.0 |
| ***Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total†*** | | | | | |
| *Days per 1,000 Member Months (Total Inpatient)—Total* | 76.6 | 76.1 | -0.7% | — | — |
| ***Mental Health Utilization†*** | | | | | |
| *Any Service—Total* | 90.8% | 90.6% | -0.2% | — | — |
| ***Plan All-Cause Readmissions[2]*** | | | | | |
| *Observed Readmissions—Total** | — | 13.6% | — | — | 23.0% |

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

*[1] Significance levels (p values) noted in the table were calculated by HSAG on behalf of AHCCCS and demonstrate whether the differences in performance between CYE 2018 and CYE 2019 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.*

*[2] Due to changes in the technical specifications for this measure, a break in trending between CYE 2019 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.*

*— Indicates that the CYE 2018 rate was not displayed due to technical specification changes, that a comparison of performance between CYE 2018 and CYE 2019 was not possible or appropriate, or that an MPS had not been established by AHCCCS.*

*† Lower or higher rates are not considered to be an appropriate measure of care for this measure.*

*Cells shaded green indicate that the rate met or exceeded the CYE 2019 MPS established by AHCCCS.*

# Appendix B. Validation of Performance Improvement Project Methodology

## Performance Improvement Project Design

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

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

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

## Data Collection Methodology

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

## Measurement of Significant Improvement

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

evidenced in repeated measurements of the quality indicators specified for each PIP undertaken by the Contractors.

AHCCCS determines a Contractor has demonstrated significant improvement when the Contractor achieves any one of the following three conditions:

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

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

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

## Performance Improvement Project Time Frames

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

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

AHCCCS will conduct annual measurements to evaluate Contractor performance and may conduct interim measurements, depending on the resources required, to collect and analyze data. Contractors must include internal annual measurements/rates and results, used as the basis for analysis (both

quantitative and qualitative) and selection/modification of interventions, within the Contractors' annual PIP report submissions.

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

# Appendix C. Validation of Organizational Assessment and Structure Performance Methodology

## Objectives for Conducting the Review

AHCCCS' objectives for conducting ORs are to:

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

## Methodology for Conducting the Review

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

AHCCCS' methodology for conducting the OR included the following:

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

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

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

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

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

Using the verified results that AHCCCS obtained from conducting the OR, HSAG organized and aggregated the performance data for each Contractor. HSAG then analyzed the data by focus area.

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

## Scoring Methodology

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

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

## Corrective Action Statements

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

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

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

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

# Appendix D. Validation of Network Adequacy Methodology and Detailed Results

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

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

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

1. Applies only to Maricopa and Pima counties.
2. Applies only to RBHA Contractors.

## Data Sources

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

1. Prepaid Medical Management Information System (PMMIS) provider data—Data files maintained by AHCCCS that list all AHCCCS-registered providers and their corresponding addresses.
2. AHCCCS beneficiary data—A data file compiled by AHCCCS from the PMMIS and Client Assessment and Tracking System (CATS) data.
   a. PMMIS data elements include the addresses and pertinent demographic information for AHCCCS beneficiaries.[D-1]
   b. CATS data elements identify AHCCCS beneficiaries that live in their own home, for calculation of the Nursing Facility time/distance standard.
3. Provider Affiliation Transmission (PAT) file—A data file listing each Contractor's contracted providers.
4. ACOM Policy 436 (ACOM 436) submission—A Microsoft (MS) Excel workbook with a tab listing the quarterly results for compliance with county-level time/distance standards.
   a. AHCCCS did not require Contractors to submit CYE 2020 Quarter 2 ACOM 436 data reporting due to the COVID-19 public health emergency.

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

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

| Data Source | CYE 2019 Quarter 4 | CYE 2020 Quarter 1 | CYE 2020 Quarter 2 | CYE 2020 Quarter 3 |
|---|---|---|---|---|
| **Measurement Period** | July 1, 2019 – September 30, 2019 | October 1, 2019 – December 31, 2019 | January 1, 2020 – March 31, 2020 | April 1, 2020 – June 30, 2020 |
| **PMMIS Providers** | Data as of November 21, 2019 | Data as of January 9, 2020 | Data as of April 2, 2020 | Data as of July 9, 2020 |
| **AHCCCS Beneficiaries** | Active Enrollment as of October 1, 2019 | Active Enrollment as of January 1, 2020 | Active Enrollment as of April 1, 2020 | Active Enrollment as of July 1, 2020 |
| **Contractor-Specific PAT Providers** | Due to AHCCCS on October 15, 2019 | Due to AHCCCS on January 15, 2020 | Due to AHCCCS on April 15, 2020 | Due to AHCCCS on July 15, 2020 |
| **Contractor-Specific ACOM 436 Submissions** | Due to AHCCCS on October 15, 2019 | Due to AHCCCS on January 15, 2020 | Reporting Waived by AHCCCS* | Due to AHCCCS on July 15, 2020 |

* AHCCCS suspended the CYE 2020 Quarter 2 ACOM 436 data reporting during CYE 2020 Quarter 2 in response to the COVID-19 public health emergency.

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

## Study Indicators

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

1. **Time/Distance Calculation**: HSAG's calculation of results for all applicable AHCCCS-established time/distance standards by Contractor, line of business, and county, using beneficiary and PAT data.
   - Study indicators show the percent of beneficiaries assigned by AHCCCS to the specified county, with access to any provider location serving the line of business within the time/distance standard.
2. **Time/Distance Validation**: Validation of each Contractor's compliance with the time/distance standards, based on HSAG's time/distance calculation results from #1 above.
   - Study indicators validate each Contractor's reported compliance with each time/distance standard applicable to the line of business and county.
     - A score of "*met*" indicates that HSAG's time/distance results show a percentage of beneficiaries at or above the time/distance standard.
     - A score of "not met" indicates that HSAG's time/distance results show a percentage of beneficiaries below the time/distance standard.
     - The value "NA" identifies standards not applicable to the line of business and/or geography.
     - The value "NR" identifies standards for which no beneficiaries met the network requirement denominator for the line of business and geography; therefore, HSAG calculated no corresponding time/distance result.
   - Study indicators also consider the degree to which HSAG's time/distance results align with the time/distance values reported in each Contractor's ACOM 436 submission.
     - Shaded cells in the Findings tables identify notable differences between each Contractor's ACOM 436 time/distance calculation results and HSAG's results for all quarters except CYE 2020 Q2.
3. **Provider Saturation Analysis**: HSAG's assessment of the degree to which each Contractor's provider network reflects available AHCCCS-contracted providers.
   - Study indicators include the number of AHCCCS-contracted provider locations not reflected in each Contractor's quarterly PAT file for each applicable time/distance standard scored as *"not met."*

## Analytic Process

HSAG used the Quest Analytics Suite software, version 2019.3 (Quest) to geocode the PAT and PMMIS addresses for beneficiaries and providers, assigning each address to an exact geographic location (i.e., latitude and longitude). To facilitate geocoding, HSAG standardized beneficiary and provider address data to align with the United States Postal Service Coding Accuracy Support System (USPS CASS) to ensure consistent address formatting across data files.

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

To assess the validity of each RBHA Contractor's quarterly ACOM 436 submission, HSAG compared the time/distance results calculated from the PMMIS and PAT data against the quarterly ACOM 436 time/distance results submitted to AHCCCS by each RBHA Contractor. Quarterly analyses reflect the measurement periods defined in Table D-2.

## Analytic Considerations

AHCCCS does not define the software or process by which each RBHA Contractor calculates the quarterly ACOM 436 time/distance results. HSAG uses Quest to calculate time/distance results based on driving distances, and additional discrepancies may result if Contractors use different versions of Quest during each of the different data network validations.[D-2] Table D-3 describes each RBHA Contractor's self-reported methods for calculating the ACOM 436 results, as of January 2020.

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

| Contractor | ACOM 436 Calculation Method |
|---|---|
| **AzCH – CCP – RBHA** | Calculates time/distance results based on driving distances using Quest version 2018.4 |
| **HCA – RBHA** | Calculates time/distance results based on driving distances using Quest version 2019.3 |
| **Mercy Care – RBHA** | Calculates time/distance results based on driving distances using Quest version 2019.3 |

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

[D-2] AHCCCS' beneficiary address data may not always reflect a beneficiary'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 beneficiaries to geographic coordinates, these coordinates may not align with the beneficiary's exact residential location for records that do not use a standard street address.

Additionally, HSAG's time/distance calculations did not include some facilities available to American Indian beneficiaries enrolled with a RBHA Contractor. American Indian beneficiaries, Title XIX and Title XXI, on- or off-reservation, and eligible to receive services, may choose to receive services at any time from an American Indian Health Facility, IHS Facility, a Tribally-Operated 638 Health Program, or an Urban Indian Health Program (I/T/U) (American Reinvestment and Recovery Act of 2009 [ARRA] Section 5006(d), and State Medicaid Director Letter [SMDL] 10-001). These facilities are not included in the calculations in this report. As a result, beneficiary access may be under-reported, particularly in areas with high concentrations of these facilities.

Similarly, HSAG's validation included 12 time/distance standards that do not reflect all potential healthcare needs or service delivery options for AHCCCS' RBHA beneficiaries. Selected time/distance standards may be addressed through telehealth, mobile service providers, mail delivery for prescriptions, or other emerging service delivery approaches that may be evaluated using metrics other than time/distance calculation results.

Finally, the RBHA population includes children in foster care enrolled in the Comprehensive Medical and Dental Program (CMDP). However, these children may not have accurate ZIP Code information in the PMMIS beneficiary data, resulting in inaccurate time/distance results for the three behavioral health-related standards for which the RBHAs serve these children. While RBHA compliance results for minimum network requirements may align between HSAG and each Contractor, the Contractors' time/distance results for these children may not be based on the child's actual place of residence.

## Detailed Validation of Network Adequacy Results

Table D-4 presents the total AHCCCS RBHA beneficiary enrollment for each county as of July 1, 2020 (i.e., the day after the end of the CYE 2020 Quarter 3 measurement period). The total numbers represent all Contractors with RBHA beneficiaries residing in the county.

**Table D-4—AHCCCS' RBHA Beneficiary Enrollment by County, as of July 1, 2020**

| County | RBHA Beneficiary Enrollment |
|---|---|
| Apache | 208 |
| Cochise | 806 |
| Coconino | 744 |
| Gila | 409 |
| Graham | 196 |
| Greenlee | 25 |
| La Paz | 63 |
| Maricopa | 24,329 |
| Mohave | 2,116 |
| Navajo | 657 |

| County | RBHA Beneficiary Enrollment |
|---|---|
| Pima | 10,110 |
| Pinal | 1,343 |
| Santa Cruz | 229 |
| Yavapai | 1,875 |
| Yuma | 1,000 |

Table D-5 presents the counts of RBHA Contractors' provider locations[D-3] identified for each time/distance network standard for CYE 2020 Quarter 3 (i.e., the April 1, 2020–June 30, 2020 measurement period).

**Table D-5—Summary of RBHA Provider Locations by Time/Distance Network Standard and Contractor, CYE 2020 Quarter 3**

| Minimum Network Requirement | Count of AzCH – CCP – RBHA Provider Locations | Count of HCA – RBHA Provider Locations | Count of MC – RBHA Provider Locations |
|---|---|---|---|
| Behavioral Health Outpatient and Integrated Clinic, Adult | 566 | 396 | 330 |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 566 | 396 | 330 |
| Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)* | 206 | 199 | 194 |
| Cardiologist, Adult | 1,234 | 1,735 | 1,093 |
| Cardiologist, Pediatric | 1,374 | 2,113 | 1,236 |
| Crisis Stabilization Facility | 951 | 593 | 441 |
| Dentist, Pediatric | 1,746 | 1,841 | 228 |
| Hospital | 312 | 158 | 88 |
| Obstetrics/Gynecology (OB/GYN) | 1,249 | 2,045 | 1,367 |
| Pharmacy | 1,094 | 1,178 | 967 |
| PCP, Adult | 22,706 | 18,289 | 19,878 |
| PCP, Pediatric | 18,402 | 14,546 | 16,218 |

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

The remainder of this section presents RBHA Contractors' quarterly validation findings, with one results table for each of the following counties by region:

1. Central Region: Maricopa
2. North Region: Apache, Coconino, Gila, Mohave, Navajo, Yavapai
3. South Region: Cochise, Graham,[D-4] Greenlee, La Paz, Pima, Pinal, Santa Cruz, Yuma

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

The value, "NA," is shown for time/distance standards that do not apply to the county or RBHA line of business.

The value, "NR," is shown for time/distance standards in which no beneficiaries met the network requirement denominator for the ACC line of business and county; therefore, HSAG calculated no corresponding time/distance result.

Yellow color-coding identifies instances in which HSAG's time/distance results differed from the Contractor's ACOM 436 results, but still met the minimum network requirement. Yellow color-coding does not appear for time/distance results for CYE 2020 Quarter 2, as AHCCCS suspended Contractors' ACOM 436 quarterly reporting due to the COVID-19 public health emergency.

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

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

[D-4] Graham County includes the 85542, 85192, and 85550 ZIP Codes representing the San Carlos Tribal area; these ZIP Codes are physically located in Gila or Pinal County.

## Central Region: Maricopa County

**Table D-6—RBHA Time/Distance Validation Results for Maricopa County—Percent of Beneficiaries Meeting Minimum Network Requirements**

| Minimum Network Requirement | Mercy Care – RBHA | | | |
|---|---|---|---|---|
| | Q4 | Q1 | Q2 | Q3 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 97.8 | 98.5 | 98.4 | 98.8 |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 100.0* | 100.0* | NR | NR |
| Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)* | 98.9 | 98.9 | 98.9 | 99.1 |
| Cardiologist, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| Cardiologist, Pediatric | 100.0 | 100.0 | 100.0 | 100.0 |
| Crisis Stabilization Facility *(Only RBHA Contractors)* | 98.6 | 99.2 | 99.3 | 99.4 |
| Dentist, Pediatric | 97.7 | 96.2 | 96.6 | 96.6 |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 |
| Obstetrics/Gynecology (OB/GYN) | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 99.5 | 99.5 | 99.6 | 99.6 |
| PCP, Adult | 99.8 | 99.7 | 99.8 | 99.8 |
| PCP, Pediatric | 100.0 | 100.0 | 100.0 | 100.0 |

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

Contractor reported results were unavailable in CYE 2020 Q2 as AHCCCS suspended ACOM 436 quarterly reporting due to the COVID-19 public health emergency.

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

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

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

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

| Minimum Network Requirement | HCA – RBHA | | | |
|---|---|---|---|---|
| | Q4 | Q1 | Q2 | Q3 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 96.9 | 96.4 | 96.5 | 96.2 |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | NR | NR | NR | NR |
| Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)* | NA | NA | NA | NA |
| Cardiologist, Adult | 97.4 | 97.9 | 98.5 | 98.1 |
| Cardiologist, Pediatric | 100.0* | 100.0* | NR | NR |
| Crisis Stabilization Facility *(Only RBHA Contractors)* | 100.0 | 100.0 | 100.0 | 100.0 |
| Dentist, Pediatric | 100.0* | 100.0* | NR | NR |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 |
| Obstetrics/Gynecology (OB/GYN) | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 95.9 | 96.4 | 96.5 | 96.2 |
| PCP, Adult | 99.5 | 99.0 | 99.5 | 98.6 |
| PCP, Pediatric | 100.0* | 100.0* | NR | NR |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
Contractor reported results were unavailable in CYE 2020 Q2 as AHCCCS suspended ACOM 436 quarterly reporting due to the COVID-19 public health emergency.

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

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

NA indicates results are not applicable to the county.

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

| Minimum Network Requirement | HCA – RBHA | | | |
|---|---|---|---|---|
| | Q4 | Q1 | Q2 | Q3 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 99.4 | 99.5 | 99.4 | 99.5 |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | NR | NR | NR | NR |
| Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)* | NA | NA | NA | NA |
| Cardiologist, Adult | 100.0 | 99.6 | 99.6 | 99.6 |
| Cardiologist, Pediatric | 100.0 | 100.0 | 100.0 | 100.0 |
| Crisis Stabilization Facility *(Only RBHA Contractors)* | 100.0 | 99.9 | 99.9 | 99.3 |
| Dentist, Pediatric | 100.0 | 100.0 | 100.0 | 100.0 |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 |
| Obstetrics/Gynecology (OB/GYN) | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 97.0 | 97.3 | 96.8 | 97.8 |
| PCP, Adult | 100.0 | 98.9 | 98.0 | 98.4 |
| PCP, Pediatric | 100.0 | 100.0 | 100.0 | 100.0 |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
Contractor reported results were unavailable in CYE 2020 Q2 as AHCCCS suspended ACOM 436 quarterly reporting due to the COVID-19 public health emergency.

NR represents instances in which HSAG identified no beneficiaries meeting the network requirements for the county and time/distance standard.
NA indicates results are not applicable to the county.

**Table D-9—RBHA Time/Distance Validation Results for Gila County—Percent of Beneficiaries Meeting Minimum Network Requirements**

| Minimum Network Requirement | HCA – RBHA | | | |
|---|---|---|---|---|
| | Q4 | Q1 | Q2 | Q3 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | NR | NR | NR | NR |
| Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)* | NA | NA | NA | NA |
| Cardiologist, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| Cardiologist, Pediatric | 100.0* | 100.0* | 100.0* | 100.0* |
| Crisis Stabilization Facility *(Only RBHA Contractors)* | 100.0 | 100.0 | 100.0 | 100.0 |
| Dentist, Pediatric | 100.0* | 100.0* | 100.0* | 100.0* |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 |
| Obstetrics/Gynecology (OB/GYN) | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 100.0 | 100.0 | 100.0 | 100.0 |
| PCP, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| PCP, Pediatric | 100.0* | 100.0* | 100.0* | 100.0* |

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

Contractor reported results were unavailable in CYE 2020 Q2 as AHCCCS suspended ACOM 436 quarterly reporting due to the COVID-19 public health emergency.

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

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

NA indicates results are not applicable to the county.

**Table D-10—RBHA Time/Distance Validation Results for Mohave County—Percent of Beneficiaries Meeting Minimum Network Requirements**

| Minimum Network Requirement | HCA – RBHA | | | |
|---|---|---|---|---|
| | Q4 | Q1 | Q2 | Q3 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | NR | NR | NR | NR |
| Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)* | NA | NA | NA | NA |
| Cardiologist, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| Cardiologist, Pediatric | 100.0 | 100.0 | 100.0 | 100.0 |
| Crisis Stabilization Facility *(Only RBHA Contractors)* | 99.8 | 99.9 | 99.3 | 99.3 |
| Dentist, Pediatric | 100.0 | 100.0 | 100.0 | 100.0 |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 |
| Obstetrics/Gynecology (OB/GYN) | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 99.1 | 99.1 | 99.1 | 99.1 |
| PCP, Adult | 100.0 | 100.0 | 99.9 | 100.0 |
| PCP, Pediatric | 100.0 | 100.0 | 100.0 | 100.0 |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
Contractor reported results were unavailable in CYE 2020 Q2 as AHCCCS suspended ACOM 436 quarterly reporting due to the COVID-19 public health emergency.

NR represents instances in which HSAG identified no beneficiaries meeting the network requirements for the county and time/distance standard.
NA indicates results are not applicable to the county.

**Table D-11—RBHA Time/Distance Validation Results for Navajo County—Percent of Beneficiaries Meeting Minimum Network Requirements**

| Minimum Network Requirement | HCA – RBHA | | | |
|---|---|---|---|---|
| | Q4 | Q1 | Q2 | Q3 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 99.1 | 99.1 | 98.8 | 98.9 |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | NR | NR | NR | NR |
| Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)* | NA | NA | NA | NA |
| Cardiologist, Adult | 99.4 | 99.1 | 98.8 | 98.8 |
| Cardiologist, Pediatric | 100.0* | 100.0 | 100.0 | 100.0 |
| Crisis Stabilization Facility *(Only RBHA Contractors)* | 99.4 | 99.5 | 99.4 | 99.4 |
| Dentist, Pediatric | 100.0* | 100.0 | 100.0 | 100.0 |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 |
| Obstetrics/Gynecology (OB/GYN) | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 98.7 | 98.9 | 98.8 | 98.9 |
| PCP, Adult | 100.0 | 100.0 | 99.8 | 100.0 |
| PCP, Pediatric | 100.0* | 100.0 | 100.0 | 100.0 |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
Contractor reported results were unavailable in CYE 2020 Q2 as AHCCCS suspended ACOM 436 quarterly reporting due to the COVID-19 public health emergency.

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

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

NA indicates results are not applicable to the county.

**Table D-12—RBHA Time/Distance Validation Results for Yavapai County—Percent of Beneficiaries Meeting Minimum Network Requirements**

| Minimum Network Requirement | HCA – RBHA | | | |
|---|---|---|---|---|
| | Q4 | Q1 | Q2 | Q3 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | NR | NR | NR | NR |
| Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)* | NA | NA | NA | NA |
| Cardiologist, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| Cardiologist, Pediatric | 100.0 | 100.0 | 100.0 | 100.0 |
| Crisis Stabilization Facility *(Only RBHA Contractors)* | 99.4 | 99.5 | 99.5 | 99.5 |
| Dentist, Pediatric | 100.0 | 100.0 | 100.0 | 97.0 |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 |
| Obstetrics/Gynecology (OB/GYN) | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 98.9 | 98.9 | 99.0 | 98.9 |
| PCP, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| PCP, Pediatric | 100.0 | 100.0 | 100.0 | 100.0 |

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

Contractor reported results were unavailable in CYE 2020 Q2 as AHCCCS suspended ACOM 436 quarterly reporting due to the COVID-19 public health emergency.

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

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

NA indicates results are not applicable to the county.

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

**Table D-13—RBHA Time/Distance Validation Results for Cochise County—Percent of Beneficiaries Meeting Minimum Network Requirements**

| Minimum Network Requirement | AzCH – CCP – RBHA | | | |
|---|---|---|---|---|
| | Q4 | Q1 | Q2 | Q3 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | NR | NR | NR | NR |
| Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)* | NA | NA | NA | NA |
| Cardiologist, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| Cardiologist, Pediatric | 100.0* | 100.0* | 100.0 | 100.0 |
| Crisis Stabilization Facility *(Only RBHA Contractors)* | 99.7 | 99.9 | 99.7 | 99.8 |
| Dentist, Pediatric | 100.0* | 100.0* | 100.0 | 100.0 |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 |
| Obstetrics/Gynecology (OB/GYN) | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 99.6 | 99.6 | 99.5 | 99.5 |
| PCP, Adult | 99.7 | 99.7 | 99.6 | 99.6 |
| PCP, Pediatric | 100.0* | 100.0* | 100.0 | 100.0 |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
Contractor reported results were unavailable in CYE 2020 Q2 as AHCCCS suspended ACOM 436 quarterly reporting due to the COVID-19 public health emergency.

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

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

NA indicates results are not applicable to the county.

**Table D-14—RBHA Time/Distance Validation Results for Graham County—Percent of Beneficiaries Meeting Minimum Network Requirements**

| Minimum Network Requirement | AzCH – CCP – RBHA | | | |
|---|---|---|---|---|
| | Q4 | Q1 | Q2 | Q3 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | NR | NR | NR | NR |
| Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)* | NA | NA | NA | NA |
| Cardiologist, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| Cardiologist, Pediatric | 100.0* | 100.0* | 100.0* | 100.0* |
| Crisis Stabilization Facility *(Only RBHA Contractors)* | 100.0 | 100.0 | 100.0 | 100.0 |
| Dentist, Pediatric | 50.0* | 50.0* | 100.0* | 100.0* |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 |
| Obstetrics/Gynecology (OB/GYN) | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 99.5 | 98.4 | 98.4 | 99.0 |
| PCP, Adult | 99.5 | 98.4 | 98.4 | 99.0 |
| PCP, Pediatric | 100.0* | 100.0* | 100.0* | 100.0* |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
Contractor reported results were unavailable in CYE 2020 Q2 as AHCCCS suspended ACOM 436 quarterly reporting due to the COVID-19 public health emergency.

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 beneficiaries meeting the network requirements for the county and time/distance standard.

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

NA indicates results are not applicable to the county.

**Table D-15—RBHA Time/Distance Validation Results for Greenlee County—Percent of Beneficiaries Meeting Minimum Network Requirements**

| Minimum Network Requirement | AzCH – CCP – RBHA | | | |
|---|---|---|---|---|
| | Q4 | Q1 | Q2 | Q3 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | NR | NR | NR | NR |
| Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)* | NA | NA | NA | NA |
| Cardiologist, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| Cardiologist, Pediatric | 100.0* | NR | 100.0* | 100.0* |
| Crisis Stabilization Facility *(Only RBHA Contractors)* | 100.0 | 100.0 | 100.0 | 100.0 |
| Dentist, Pediatric | 100.0* | NR | 100.0* | 100.0* |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 |
| Obstetrics/Gynecology (OB/GYN) | 100.0 | 100.0* | 100.0* | 100.0* |
| Pharmacy | 100.0 | 100.0 | 100.0 | 100.0 |
| PCP, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| PCP, Pediatric | 100.0* | 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.

Contractor reported results were unavailable in CYE 2020 Q2 as AHCCCS suspended ACOM 436 quarterly reporting due to the COVID-19 public health emergency.

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

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

NA indicates results are not applicable to the county.

**Table D-16—RBHA Time/Distance Validation Results for La Paz County—Percent of Beneficiaries Meeting Minimum Network Requirements**

| Minimum Network Requirement | AzCH – CCP – RBHA | | | |
|---|---|---|---|---|
| | Q4 | Q1 | Q2 | Q3 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | NR | NR | NR | NR |
| Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)* | NA | NA | NA | NA |
| Cardiologist, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| Cardiologist, Pediatric | NR | NR | NR | NR |
| Crisis Stabilization Facility *(Only RBHA Contractors)* | 100.0 | 100.0 | 100.0 | 100.0 |
| Dentist, Pediatric | NR | NR | NR | NR |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 |
| Obstetrics/Gynecology (OB/GYN) | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 98.3 | 98.2 | 96.6 | 96.8 |
| PCP, Adult | 100.0 | 100.0 | 100.0 | 96.8 |
| PCP, Pediatric | NR | NR | NR | NR |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
Contractor reported results were unavailable in CYE 2020 Q2 as AHCCCS suspended ACOM 436 quarterly reporting due to the COVID-19 public health emergency.

NR represents instances in which HSAG identified no beneficiaries meeting the network requirements for the county and time/distance standard.
NA indicates results are not applicable to the county.

**Table D-17—RBHA Time/Distance Validation Results for Pima County—Percent of Beneficiaries Meeting Minimum Network Requirements**

| Minimum Network Requirement | AzCH – CCP – RBHA | | | |
|---|---|---|---|---|
| | Q4 | Q1 | Q2 | Q3 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 98.3 | 98.2 | 99.2 | 97.9 |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | NR | NR | NR | NR |
| Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)* | 95.6 | 95.5 | 95.6 | 95.6 |
| Cardiologist, Adult | 99.5 | 99.5 | 99.5 | 99.5 |
| Cardiologist, Pediatric | 100.0 | 100.0 | 99.2 | 99.1 |
| Crisis Stabilization Facility *(Only RBHA Contractors)* | 98.7 | 98.7 | 99.4 | 98.7 |
| Dentist, Pediatric | 92.2 | 92.2 | 93.4 | 93.9 |
| Hospital | 99.7 | 99.7 | 99.7 | 99.7 |
| Obstetrics/Gynecology (OB/GYN) | 99.6 | 99.6 | 99.6 | 99.6 |
| Pharmacy | 98.7 | 98.8 | 98.8 | 98.8 |
| PCP, Adult | 99.9 | 99.9 | 99.9 | 99.9 |
| PCP, Pediatric | 100.0 | 99.0 | 99.2 | 99.1 |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results. Contractor reported results were unavailable in CYE 2020 Q2 as AHCCCS suspended ACOM 436 quarterly reporting due to the COVID-19 public health emergency.

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

**Table D-18—RBHA Time/Distance Validation Results for Pinal County—Percent of Beneficiaries Meeting Minimum Network Requirements**

| Minimum Network Requirement | AzCH – CCP – RBHA | | | |
|---|---|---|---|---|
| | Q4 | Q1 | Q2 | Q3 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | NR | NR | NR | NR |
| Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)* | NA | NA | NA | NA |
| Cardiologist, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| Cardiologist, Pediatric | 100.0 | 100.0 | 100.0 | 100.0 |
| Crisis Stabilization Facility *(Only RBHA Contractors)* | 100.0 | 100.0 | 100.0 | 100.0 |
| Dentist, Pediatric | 100.0 | 100.0 | 100.0 | 100.0 |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 |
| Obstetrics/Gynecology (OB/GYN) | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 100.0 | 100.0 | 100.0 | 100.0 |
| PCP, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| PCP, Pediatric | 100.0 | 100.0 | 100.0 | 100.0 |

Contractor-reported CYE 2020 Q2 results were unavailable for comparison to HSAG's results, as AHCCCS suspended ACOM 436 quarterly reporting due to the COVID-19 public health emergency.

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

NA indicates results are not applicable to the county.

**Table D-19—RBHA Time/Distance Validation Results for Santa Cruz County—Percent of Beneficiaries Meeting Minimum Network Requirements**

| Minimum Network Requirement | AzCH – CCP – RBHA | | | |
|---|---|---|---|---|
| | Q4 | Q1 | Q2 | Q3 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | NR | NR | NR | NR |
| Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)* | NA | NA | NA | NA |
| Cardiologist, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| Cardiologist, Pediatric | 100.0* | 100.0* | 100.0* | 100.0* |
| Crisis Stabilization Facility *(Only RBHA Contractors)* | 100.0 | 100.0 | 100.0 | 100.0 |
| Dentist, Pediatric | 100.0* | 100.0* | 100.0* | 100.0* |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 |
| Obstetrics/Gynecology (OB/GYN) | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 100.0 | 100.0 | 100.0 | 100.0 |
| PCP, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| PCP, Pediatric | 100.0* | 100.0* | 100.0* | 100.0* |

Contractor-reported CYE 2020 Q2 results were unavailable for comparison to HSAG's results, as AHCCCS suspended ACOM 436 quarterly reporting due to the COVID-19 public health emergency.

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

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

NA indicates results are not applicable to the county.

**Table D-20—RBHA Time/Distance Validation Results for Yuma County—Percent of Beneficiaries Meeting Minimum Network Requirements**

| Minimum Network Requirement | AzCH – CCP – RBHA | | | |
|---|---|---|---|---|
| | Q4 | Q1 | Q2 | Q3 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 99.8 | 99.8 | 99.8 | 99.8 |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | NR | NR | NR | NR |
| Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)* | NA | NA | NA | NA |
| Cardiologist, Adult | 100.0 | 100.0 | 100.0 | 100.0 |
| Cardiologist, Pediatric | 100.0 | 100.0 | 100.0 | 100.0 |
| Crisis Stabilization Facility *(Only RBHA Contractors)* | 99.8 | 99.8 | 99.8 | 99.8 |
| Dentist, Pediatric | 100.0 | 100.0 | 100.0 | 100.0 |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 |
| Obstetrics/Gynecology (OB/GYN) | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 99.8 | 99.8 | 99.8 | 99.8 |
| PCP, Adult | 99.8 | 99.8 | 99.8 | 99.8 |
| PCP, Pediatric | 100.0 | 100.0 | 100.0 | 100.0 |

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

Contractor reported results were unavailable in CYE 2020 Q2 as AHCCCS suspended ACOM 436 quarterly reporting due to the COVID-19 public health emergency.

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

NA indicates results are not applicable to the county.

# Appendix E. Network Adequacy Report

The following pages contain the 2020 AHCCCS Network Adequacy Report.

HSAG HEALTH SERVICES ADVISORY GROUP

AHCCCS
Arizona Health Care Cost Containment System

# 2020 AHCCCS NETWORK ADEQUACY REPORT

PREPARED BY
DIVISION OF HEALTH CARE MANAGEMENT, OPERATIONS

## CONTENTS

## Purpose

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

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

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

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

## Program Description

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

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

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

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

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

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

- ***Arizona Long Term Care System Arizona Department of Economic Security/Division of Developmental Disabilities (ALTCS/DDD)*** is a contracted

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

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

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

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

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

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

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

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

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

## Deliverables Demonstrating Network Adequacy

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

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

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

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

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

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

***Minimum Network Requirements Verification*** – Each quarter, health plans[2] are required to submit a completed Minimum Network Requirement Verification Report (Verification Report). The requirements for this report are outlined in ACOM Policy 436. In the Verification Report health plans describe their compliance with minimum network requirements, including time and distance requirements (*See Attachment C ACOM 436 Verification Report*). These requirements identify thirteen provider types for which AHCCCS

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

has developed minimum time and distance standards to ensure geographic access to services. The Verification Report includes standards specific to all health plans, as well as some standards specific to RBHA and ALTCS/EPD health plans. Moreover, some standards are measured against specific member populations and the standards vary by county. These standards are identified in Table 1, below:

**Table 1 - AHCCCS Minimum Time and Distance Standards**

| Provider Type | Beneficiary Population | Network Standard Maricopa and Pima Counties | Network Standard All Other Arizona Counties |
|---|---|---|---|
| 1. Behavioral Health Outpatient and Integrated Clinic, Adult | Beneficiaries aged 18 years and older | 90 percent of beneficiaries within 15 minutes or 10 miles | 90 percent of beneficiaries within 60 miles |
| 2. Behavioral Health Outpatient and Integrated Clinic, Pediatric | Beneficiaries younger than 18 years | 90 percent of beneficiaries within 15 minutes or 10 miles | 90 percent of beneficiaries within 60 miles |
| 3. Behavioral Health Residential Facility *(Applies to Maricopa and Pima Counties Only)* | All beneficiaries | 90 percent of beneficiaries within 15 minutes or 10 miles | Not Applicable |
| 4. Cardiologist, Adult | Beneficiaries aged 21 years and older | 90 percent of beneficiaries within 30 minutes or 20 miles | 90 percent of beneficiaries within 75 minutes or 60 miles |
| 5. Cardiologist, Pediatric | Beneficiaries younger than 21 years | 90 percent of beneficiaries within 60 minutes or 45 miles | 90 percent of beneficiaries within 110 minutes or 100 miles |
| 6. Crisis Stabilization Facility *(Applies to RBHAs only)* | All beneficiaries | 90 percent of beneficiaries within 15 minutes or 10 miles | 90 percent of beneficiaries within 45 miles |
| 7. Dentist, Pediatric | Beneficiaries younger than 21 years | 90 percent of beneficiaries within 15 minutes or 10 miles | 90 percent of beneficiaries within 40 minutes or 30 miles |
| 8. Hospital | All beneficiaries | 90 percent of beneficiaries within 45 minutes or 30 miles | 90 percent of beneficiaries within 95 minutes or 85 miles |
| 9. Nursing Facility *(Applies to ALTCS/EPD Plans Only)* | All beneficiaries currently residing in their own home | 90 percent of beneficiaries within 45 minutes or 30 miles | 90 percent of beneficiaries within 95 minutes or 85 miles |
| 10. Obstetrics/Gynecology (OB/GYN) | Female beneficiaries aged 15 to 45 years | 90 percent of beneficiaries within 45 minutes or 30 miles | 90 percent of beneficiaries within 90 minutes or 75 miles |
| 11. Pharmacy | All beneficiaries | 90 percent of beneficiaries within 12 minutes or 8 miles | 90 percent of beneficiaries within 40 minutes or 30 miles |
| 12. PCP, Adult | Beneficiaries aged 21 years and older | 90 percent of beneficiaries within 15 minutes or 10 miles | 90 percent of beneficiaries within 40 minutes or 30 miles |
| 13. PCP, Pediatric | Beneficiaries younger than 21 years | 90 percent of beneficiaries within 15 minutes or 10 miles | 90 percent of beneficiaries within 40 minutes or 30 miles |

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

health plan, HSAG produces a report comparing the Verification Report submissions with its validation.

To ensure health plans have the resources to address discrepancies found in the validation process, AHCCCS provides the following information to the health plans:

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

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

After completion of the individual quarterly reports, HSAG also generated an annual validation report which is attached with this Network Adequacy Report (*See Attachment A HSAG Validation Report)*. This report covers Contract Year Ending (CYE) 2019 Quarter 4 through CYE 2020 Quarter 3.

AHCCCS identified a number of areas where health plans appear to struggle to meet the minimum network requirements. For example, the validation of both ACC contractors serving Apache County shows difficulty in meeting the time and distance requirements for several provider types. Specifically, Pediatric Dentists, and Pharmacies. Compliance with these standards is complicated by the extremely rural nature of significant parts of these counties, as well as the presence of tribal providers that have been excluded from these time and distance calculations. Previously, both ACC contractors struggled with Outpatient and Integrated Clinics (Adult and Pediatric). However, in the past year Care1st Health Plan has addressed this gap.

Also, during CYE 2020 Quarters 2 and 3, Banner University Family Care's (Banner UFC) PAT file submission reported a significantly reduced number of provider records measured under Outpatient and Integrated Clinic (Adult and Pediatric), Behavioral Health Residential Facility, and Hospital standards for its ACC program. This was due to an error in the submission of its PAT files that was unable to be corrected until Quarter 4. This reporting error impacted Banner UFC's calculated compliance with these standards in several counties.

The process of reviewing and validating the health plans' progress towards compliance with minimum network requirements is underscoring the relative lack of providers in some of Arizona's more rural counties. ACOM Policy 436 does include an exception process for health plans to request an exception from any minimum network standard that cannot be met after all efforts are exhausted. AHCCCS will review certain criteria to determine if an exception will be allowed, these criteria include but are not limited to; the number of providers available in the area, provider willingness to contract with a health plan, the availability of IHS/638 facilities[3] to serve the American Indian population, and the availability of alternate service delivery mechanisms. Plans are then required to monitor member access

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

to the services covered by the exception while the exception is in place. In CYE 2020 there were no exemptions in place.

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

- ALTCS/EPD and ALTCS/DDD health plans report compliance with requirements for long term care facilities in specific areas of any county served.
- All health plans report compliance with network requirements related to Multi-Specialty Interdisciplinary Clinics (MSICs).
- RBHA health plans report compliance with Mobile Behavioral Health Crisis Team response time requirements.

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

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

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

***Material Changes to the Provider Network*** – AHCCCS has established reporting requirements for when a significant change is made to a health plan's provider network in order to evaluate the impact of the change. As outlined in ACOM Policy 439, AHCCCS requires health plans to evaluate changes made to their provider network for materiality. A material change to provider network is defined as any change in the composition of or payments to the health plan's provider network that would cause or is likely to cause more than five percent of its members in a GSA to change where they receive services, or any

change impacting fewer than five percent of members but involves a provider or provider group who is the sole source of a service, or operates in an area with limited alternate sources.

When the health plan identifies a material change to provider network, it submits an assessment of the impact of the change, how the health plan will transition members, a communication plan regarding the change, and how the health plan will monitor the impact of the change after transition (*See Attachment E ACOM 439 Material Change Checklist*). After approval of a material change in provider network, AHCCCS commonly requires periodic reports on the status of transitioning members. In CYE 2020, AHCCCS approved and monitored six material changes from contracted health plans.

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

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

***Gap in Critical Services Reporting*** – AHCCCS has established reporting requirements for gaps in the provision of specific Home and Community Based (HCBS) services provided to ALTCS/EPD and ALTCS/DDD members. Under ACOM Policy 413, each quarter these health plans must report their 'gap hours', or the number of hours of scheduled Attendant Care, Personal Care, Homemaker and Respite care services that were not delivered to members without being replaced by another paid caregiver (*See Attachment G ACOM 413 Gap Reporting Template*). Plans also report the percent of gap hours compared to total authorized hours for these services. In CYE 2020, AHCCCS health plans typically reported .05% or less of their authorized hours were gap hours.

This reporting was instituted as a part of a settlement agreement for a class action lawsuit. While the lawsuit has since been dismissed, AHCCCS retains this report and continues to monitor it as a measure of member access to HCBS services deemed critical under the lawsuit. Starting in 2021, AHCCCS will be replacing this reporting with an automated method through its planned Electronic Visit Verification program.