Arizona's Section 1115 Waiver Demonstration Annual Report

Federal Fiscal Year 2020
October 1, 2019 – September 30, 2020

Table of Contents

		2
I.	Introduction	3
II.	Waiver Demonstration Changes	3
III.	1115 Waiver Renewal Public Forum	6
IV.	Outreach and Innovation Activities	7
V.	Enrollment Information	11
VI.	Consumer Issues	13
VII.	Individuals with Serious Mental Illness (SMI) Opt-Out for Cause Report	14
VIII.	Demonstration Operations and Policies	17
	• Legal Update	17
	• Legislative Update	22
	• Program Integrity Update	23
	• State Plan Update	30
IX.	Quality Assurance/Monitoring Activities	33
X.	Demonstration Implementation Update	56
	• Targeted Investments (TI) Program Demonstration	58
	• Waiver Evaluation Update	60
XI.	Notable Achievements	61
XII.	Appendix	
	• Appendix A: 1115 Waiver Public Forum Agenda and Slides	63

I. Introduction

Since its inception, the Arizona Health Care Cost Containment System (AHCCCS), Arizona's single state Medicaid agency, has had the unique distinction of operating a statewide managed care program under the Section 1115 Research and Demonstration Waiver. During its 38 years of operation, the program has proven to effectively deliver high-quality and cost-effective health care services to low-income populations. With a model based on competition and member choice, AHCCCS has been a pioneer in testing health care policies and financing strategies, continuously seeking to improve health care outcomes while containing costs.

On September 30, 2016, the Centers for Medicare and Medicaid Services (CMS) approved an extension of Arizona's 1115 Waiver for a five-year period from October 1, 2016 to September 30, 2021. Under the five-year waiver demonstration, Arizona continues many of the existing authorities that allow AHCCCS to maintain its unique and successful managed care model, using home and community-based services for members with long term care needs, and other innovations that make AHCCCS one of the most cost-effective Medicaid programs in the nation.

Pursuant to the Special Terms and Conditions (STCs), paragraph 41, AHCCCS is required to submit an annual progress report to CMS documenting accomplishments, project implementation status, quantitative and case study findings, utilization data, and policy and administrative updates related to Arizona's 1115 Waiver demonstration.

II. Waiver Demonstration Changes

On March 17 and March 24, 2020, AHCCCS submitted requests to the CMS administrator to waive certain Medicaid and CHIP requirements in order to combat the continued spread of 2019 novel coronavirus (COVID-19). AHCCCS sought 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:

- 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 prior authorization requirements,
- Require fee-for-service 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. Verbal consents will be obtained telephonically, where identity will be reliably established, and will be documented in the member's record,
- Waive the face-to-face requirements applicable to Home Health Services including medical supplies, equipment & appliances,

In addition to the 1135 Waiver flexibilities, Arizona received approval for the following 1115 Waiver and Appendix K authorities for the duration of the emergency period:

- Expenditure authority to pay for EPSDT covered dental services that were previously approved but postponed due to COVID-19 after a member turns 21 years old,
- Permit payment for home and community-based services (HCBS) rendered by family caregivers or legally responsible individuals,
- Authority to make retainer payments to habilitation and personal care providers.
- Authority to provide long-term care services and supports to impacted members regardless of whether timely updates are made in the plan of care, or if services are delivered in alternative settings,
- Authority to 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,
- Authority to expand the provision of home delivered meals to long term care members enrolled in the ALTCS Department of Economic Security/Division of Developmental Disabilities (DES/DDD),
- Authority to modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers,
- Allowing case management entities to provide direct services in response to COVID-19;

- Extending reassessments and reevaluations of a member's institutional level of need for up to one year past the due date, if needed,
- Allowing the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings,
- Adjusting prior approval/authorization criteria approved in the waiver,
- Adjusting assessment requirements,
- Adding 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, churches), and
- Temporarily allow for payment for services for the purpose of supporting 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 requests under the 1135 Waiver, Appendix K, and the State Plan. Information regarding the status of AHCCCS Emergency Authority Requests (for the federally declared COVID-19 emergency) can be found on the AHCCCS COVID-19 Federal Emergency Authorities Request web page.

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

- Mandatory managed care,

- Home and community-based services for individuals in the ALTCS program,
- Administrative simplifications that reduce inefficiencies in eligibility determination,
- Integrated health plans for AHCCCS members,
- Payments to providers participating in the Targeted Investments Program,
- AHCCCS Works, and
- Waiver of Prior Quarter Coverage for specific populations.

In addition to renewing current waiver and expenditure authorities, AHCCCS is seeking to implement the following:

- 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 Indian Health Service (IHS), a tribe or tribal organization, or an Urban Indian health program,
- Authority to reimburse Indian Health Services 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 age 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 AHCCCS Section 1115 Waiver Renewal Request (2021-2026) web page.

III. 1115 Waiver Renewal Public Forum

AHCCCS hosted various community meetings across the state to provide the public with information about its 1115 Waiver demonstration renewal process.

Updates on the current 1115 Waiver demonstration were provided at all quarterly Tribal consultations as well as Special Tribal consultations held in FFY 2020. Additionally, waiver updates were added to agendas for AZ Advisory Council on Indian Health Care (AACIHC), IHS area directors and CMO meetings on a quarterly basis.

On October 2, 2020, public notice of Arizona's waiver renewal request was published in the Arizona Administrative Register. The notice included a summary description of the demonstration request, the locations, dates and times of the public hearings, instructions on how to submit comments and a link to where copies of the demonstration application are available for public review and comments.

Stakeholder Meetings on Waiver Renewal:

AHCCCS presented the details about Arizona's demonstration renewal proposal to the public and solicited feedback at several agency meetings: three demonstration renewal public forum meetings held

online and attended by a variety of community stakeholders; other public meetings such as the State Medicaid Advisory Committee (SMAC); and several tribal consultations.

All public forum meetings were held via webinar and telephone to promote social distancing and to mitigate the spread of COVID-19. The public had the opportunity to review and submit comments on the proposal at the public meetings and in writing via e-mail to waiverpublicinput@azahcccs.gov or by mail to AHCCCS, c/o Division of Community Advocacy and Intergovernmental Relations, 801 E. Jefferson Street, MD 4200, Phoenix, AZ 85034. Details regarding the public forum meetings can be found in **Appendix A**.

IV. Outreach and Innovation Activities

AHCCCS conducts numerous outreach activities across Arizona to educate the community about its programs, partnerships, and policy changes. Below is a summary of the agency's outreach activities in FY 2020.

The Division of Community Advocacy and Intergovernmental Relations (DCAIR)

DCAIR interfaces with Medicaid beneficiaries and their family members, community members, and federal and state stakeholders to ensure that all perspectives and voices are considered in the health care policy and service delivery decision-making process. DCAIR's three distinct departments advocate on behalf of members and oversee federal policy relations.

The Office of Human Rights (OHR)

OHR provides a variety of advocacy services to individuals determined to have a serious mental illness to help them understand, protect, and exercise their rights; facilitate self-advocacy through education; and obtain access to behavioral health services in the Arizona Medicaid delivery system. Community engagement and advocacy activities include, but are not limited to, special assistance home visits, hospital visits, service planning meetings, provider coordination, navigating the grievance and appeals processes, Individual Service Planning (ISP) meetings, jail visits, intake appointments, general outreach, and education. OHR currently provides assistance to the largest number of individuals in the history of this office: 3,266 individuals in Arizona are identified as Special Assistance, and, as of September 2020, 797 members are assigned to a state OHR advocate to receive direct advocacy.

The OHR Community Affairs Liaison (CAL) assists the statutorily required Independent Oversight Committees for the Mentally Ill and monitors all required deliverables. These Oversight Committees are composed of community volunteers who have various educational expertise and personal experiences, as specified in Arizona Revised Statute 41-3803 and 3804. The committees review reports, make regular site visits, and hold open meetings to provide advocacy to individuals determined to have a serious mental illness. The committees also make recommendations to agency administration and the Legislature to improve the public behavioral health system.

The Office of Individuals and Family Affairs (OIFA)

OIFA promotes recovery, resiliency, and wellness for individuals with mental health and substance use challenges. OIFA builds partnerships with individuals, biological and chosen families, youth, communities, and advocacy organizations, and collaborates with key leadership and community members in the decision-making process at all levels of the behavioral health system. OIFA leverages the strategies below to advocate on behalf of members and families:

- OIFA works to ensure AHCCCS members and their families have direct and meaningful input into the behavioral health system policies, programs, and practices that affect services. For example, OIFA holds a community policy meeting to review policies that are open for public comment. This helps peers and families add their input at the policy-making level. OIFA also supports community advocacy, and regularly reviews documents intended for stakeholders.
- OIFA assists and promotes the Peer and Family Career Academy which provides quality, continuing education for peer and family support employees. The Peer and Family Career Academy offers classes that enhance and strengthen skills and knowledge (e.g., forensic, the opioid crisis, self-care, effective advocacy, leadership, and supervision).
- The OIFA Advisory Council meets monthly to allow members, families, and stakeholders to discuss system issues and advocacy opportunities.
- OIFA holds one-on-one meetings with members to address system barriers and develop strategies that improve access to Medicaid services.
- OIFA creates and distributes informational pamphlets to help members and families better understand how to access services.
- OIFA provides regular Jacob's Law training sessions for families and stakeholders to ensure that families of foster and adoptive children understand the law and that their children are able to access behavioral health care.

Federal Relations and Communications (FRAC)

The Office of Federal Relations and Communications oversees federal policy relations and external communications. The team includes:

- Federal relations administrator,
- State Plan and health policy managers,
- Waiver manager,
- Tribal liaison,
- Public information officers, and
- Graphic designer.

In these roles, FRAC staff serve as the liaison and point of contact with the CMS on Title XIX and XXI policy issues; maintain regular communication with the Office of the Governor and the State's health policy advisor; coordinate quarterly Tribal Consultation meetings and ad hoc meetings as needed with Arizona tribal communities and Indian Health Services; advise the Director and Governor's Office on issues related to health care policy. The team provides communication and graphic design services including print and digital marketing, media relations, public records requests, and social media management to meet all internal and external needs.

DCAIR coordinates efforts with a variety of committees, councils, and stakeholders, ensuring a bi-directional relationship with all stakeholders, including, but not limited to:

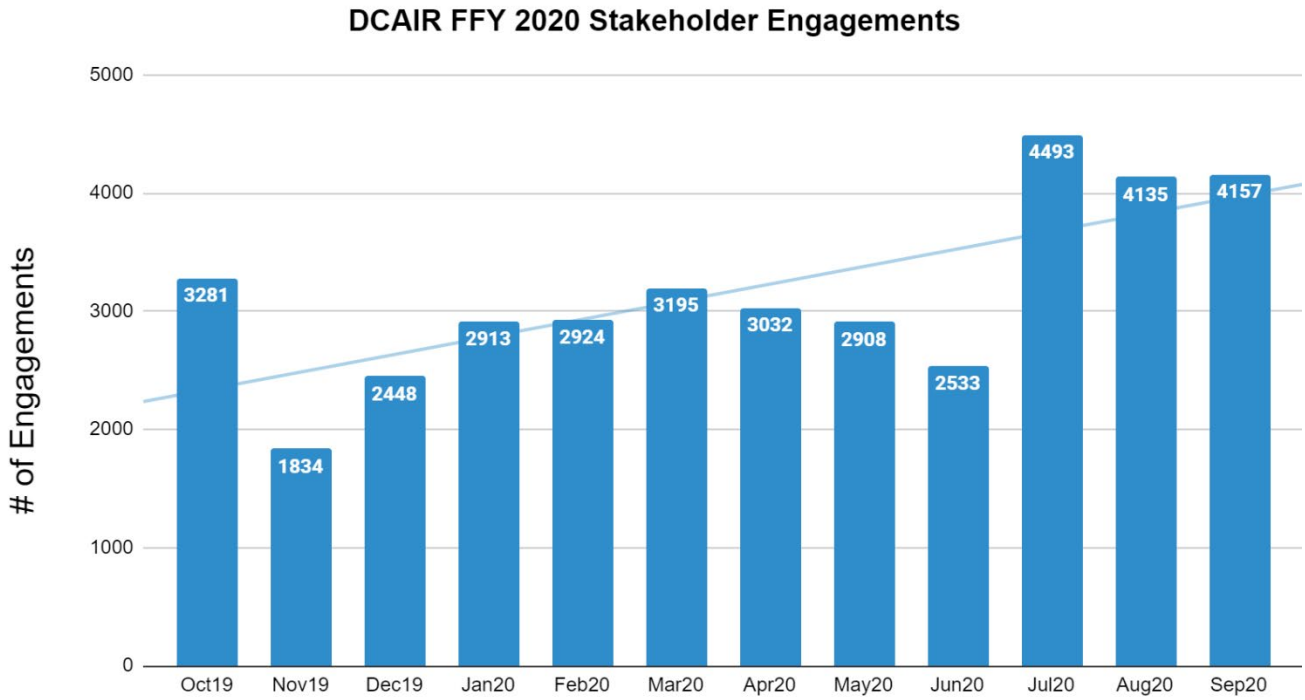
- **ALTCS Advisory Council** meets quarterly to assist the ALTCS program to develop and monitor a work plan that addresses opportunities for new service innovations or systemic issues impacting ALTCS members. The Advisory Council consists of ALTCS members and their family/representatives, Managed Care Organizations (MCOs), AHCCCS, providers, and advocacy agencies.
- **Behavioral Health Planning Council** advises AHCCCS in planning and implementing a comprehensive community-based system of behavioral health and mental health services. The Council reviews the State of Arizona's plans and suggests additions and modifications. An OIFA representative attends these meetings.
- **The State Medicaid Advisory Committee (SMAC)** provides guidance on the strategic direction of Arizona's Medicaid program and input on agency planning efforts and operational protocols that may impact the services and support offered to Medicaid beneficiaries. The SMAC advises the AHCCCS director, providing insight on a variety of topics including the 1115 waiver, system transformation efforts, and the prioritization of initiatives aimed at enhancing and/or maintaining the ongoing stability of Arizona's health care delivery system. The SMAC meets quarterly unless more frequent meetings are deemed necessary by the AHCCCS director. The SMAC is composed of ten professional members, ten members of the public, and three ex-officio members. The AHCCCS director attends these meetings.
- **Autism Advisory Committee** is charged with making recommendations to the state that strengthen the health care system's ability to respond to the needs of AHCCCS members with, or at risk for, ASD, including those with comorbid diagnoses. The committee focuses on individuals with varying levels of needs across the spectrum and addresses both the early identification of ASD and the development of person-centered care plans. DCAIR representatives attend these meetings.
- **Arizona Council of Human Services Providers** provides a collective voice for members to influence local, state, and federal public policy decisions, both legislatively and administratively. The ability of member agencies to provide high quality, evidence-based programs is dependent on ensuring that adequate funding is available to those who serve our most vulnerable citizens. Council staff establish and maintain strong relationships with elected officials, their staff, and state department staff (DES, DHS, AOC, etc.), and encourage member program staff to do the same on a local level. DCAIR facilitates this meeting.
- **Arizona Advisory Council on Indian Health Care (AACIHC),** composed of tribal stakeholders and representatives from each federally recognized tribe with land bases in Arizona, works to advocate for increased access to high-quality health care programs that meet the needs of all American Indians in Arizona. As such, the council advises the AHCCCS administration on Title XIX and XXI programs, services, policies, and funding options impacting American Indian and Alaska Native members.
- **The OIFA Advisory Council** is a monthly meeting of peers, family members, stakeholders, and other strategic partners throughout the behavioral health system. This provides an opportunity for the community to address systemic issues directly to the AHCCCS DCAIR/OIFA leadership team. The advisory council is also updated on various AHCCCS OIFA initiatives and other long-

term projects. It also provides an opportunity for educating the community about the more nuanced aspects of the AHCCCS programs.

DCAIR often hosts educational forums to inform the community of the latest efforts of the state's Medicaid system. Forum topics over the past year have included, but are not limited to:

- The future of integration,
- Arizona's 1115 Waiver,
- The response to the COVID-19 pandemic,
- Grants,
- Behavioral health initiatives,
- Arizona's crisis system,
- Health equity, and
- System oversight and evaluation.

Lastly, DCAIR hosts forums and member listening sessions to receive feedback about continuous improvement, as well as recommendations for system evolution (e.g., policy changes, ways of enhancing integration, methods to simplify system navigation). In FFY 2020, DCAIR engaged with approximately 38,000 stakeholders.



The Division of Member and Provider Services (DMPS)

The Division of Member and Provider Services (DMPS) is responsible for AHCCCS eligibility, for the enrollment of members into health plans, and provider registration. DMPS is also responsible for the accuracy of eligibility determinations, including oversight of Medicaid eligibility completed at the Department of Economic Security (DES). DMPS participated in a variety of outreach activities including:

- Numerous collaborative meetings to discuss coordination, address program needs and clarify policy and processes with state and county justice system staff. Meetings are held at the request of the justice entities, and no specific data is available on average meeting length or participation.
- Ask an Expert meetings: On a monthly basis, AHCCCS holds an hour-long, Ask an Expert meeting, open to all assistors. This consists of an open Q&A session for assistors to ask questions of any type directly to a panel of agency subject matter experts. On average, meeting participation is greater than 200 assistors.
- Quarterly Information Exchange meetings: AHCCCS provides an update to Community Partner-Assistor organizations on changes to the HEAplus system and other policies or procedures over the preceding quarter. In addition to a question-and-answer session about the changes, these meetings also include an Ask the Expert segment where assistors are able to ask questions directly to a panel of agency subject matter experts. This meeting is typically two hours long with an average participation of more than 240 assistors.
- Annual Security Training 2020: In 2020, AHCCCS provided a refreshed Community Partner- New Assistor Training to refresh understanding of roles and responsibilities and educate assistors about HEAplus features and navigation.
- Joint Eligibility Appeals meetings. This joint meeting of staff involved in the eligibility appeal process from AHCCCS and Department of Economic Security was held to improve coordination, discuss policy issues, and share best practices.
- Provided LTSS financial and medical eligibility presentation materials for three events in the second quarter of FFY 2020 attended by 56 attendees from providers and provider groups.

V. Enrollment Information

Table 1 contains a summary of the number of unduplicated enrollees for FY 2020 (October 1, 2019—September 30, 2020), by population categories. The table also includes the number of voluntarily and involuntarily disenrolled members during this period.

Table 1

Population Groups	Number of Enrollees	Number Voluntarily Disenrolled	Number Involuntarily Disenrolled
Acute AFDC/SOBRA	1,285,213	10,379	79,507
Acute SSI	216,742	556	14,829
Prop 204 Restoration	427,444	3,440	46,345
Adult Expansion	161,793	1,221	16,099
LTC DD	36,664	106	628
LTC EPD	37,674	109	8,931
Non-Waiver	119,424	653	14,582
Total	**2,284,954**	**16,464**	**180,921**

Table 2 is a snapshot of the number of current enrollees (as of October 1, 2020) by funding categories as requested by CMS.

Table 2

State Reported Enrollment in the Demonstration (as requested)	Current Enrollees
Title XIX funded State Plan [1]	**1,336,748**
Title XXI funded State Plan [2]	**34,015**
Title XIX funded Expansion[3]	**387,727**
• **Prop 204 Restoration (0-100% FPL)**	310,816
• **Adult Expansion (100% - 133% FPL)**	76,911
Enrollment Current as of	10/1/2020

[1] SSI Cash and Related, 1931 Families and Children, 1931 Related, TMA, SOBRA child and pregnant, ALTCS, FTW, QMB, BCCP, SLMB, QI-1

[2] KidsCare

[3] Prop 204 Restoration & Adult Expansion

VI. Consumer Issues

Table 3 is a summary of advocacy issues received by the Office of Client Advocacy (OCA) in FY 2020.

Table 3

Advocacy Issues[4]	Quarter 1 10/01/19-12/31/20	Quarter 2 1/1/20-3/31/20	Quarter 3 4/1/20-6/30/20	Quarter 4 7/1/20-9/30/20	Total
Billing Issues ● Member reimbursements ● Unpaid bills	29	37	29	27	**122**
Cost Sharing ● Co-pays ● Share of Cost (ALTCS) ● Premiums (Kids Care, Medicare)	0	3	2	6	**11**
Covered Services	84	98	30	43	**255**
ALTCS ● Resources ● Income ● Medical	27	31	31	27	**116**
DES ● Income ● Incorrect determination ● Improper referrals	63	47	41	47	**198**
KidsCare ● Income ● Incorrect determination	9	9	1	2	**21**
SSI/Medical Assistance Only ● Income ● Not categorically linked	31	46	64	16	**157**
Information ● Status of application ● Eligibility criteria ● Community resources ● Notification (Did not receive or didn't understand)	144	121	112	112	**489**

[4] Categories of good customer service, bad customer service, documentation, policy, and process are captured under the category to which it may relate.

Medicare ● Medicare coverage ● Medicare Savings Program ● Medicare Part D	9	17	12	7	**45**
Prescriptions ● Prescription coverage ● Prescription denial	21	13	24	26	**84**
Fraud-Referred to Office of Inspector General (OIG)	0	1	0	0	**1**
Quality of Care-Referred to Division of Health Care Management (DHCM)	8	100	38	40	**186**
Total	**425**	**523**	**384**	**353**	**1685**

Table 4

Issue Originator[5]	Quarter 1 10/01/19-12/31/19	Quarter 2 1/1/20-3/31/20	Quarter 3 4/1/20-6/30/20	Quarter 4 7/1/20-9/30/20	Total
Applicant, Member or Representative	384	488	338	310	**1520**
CMS	5	6	6	11	**28**
Governor's Office	23	21	14	12	**70**
Ombudsmen/Advocates/Other Agencies	10	6	10	4	**30**
Senate & House	3	2	16	16	**37**
Total	**425**	**523**	**384**	**353**	**1685**

VII. Individuals with Serious Mental Illness (SMI) Opt-Out for Cause Report

Tables 5 through 9 below illustrate the number of the opt-out requests filed by individuals determined to have a SMI in Maricopa County and greater Arizona, broken down by months, health plans, counties, reasons for opt-out requests, opt-out outcome, and post-appeal opt-out outcomes.

[5] This data was compiled from the OCA logs by the OCA Client Advocate and the Member Liaison.

Table 5

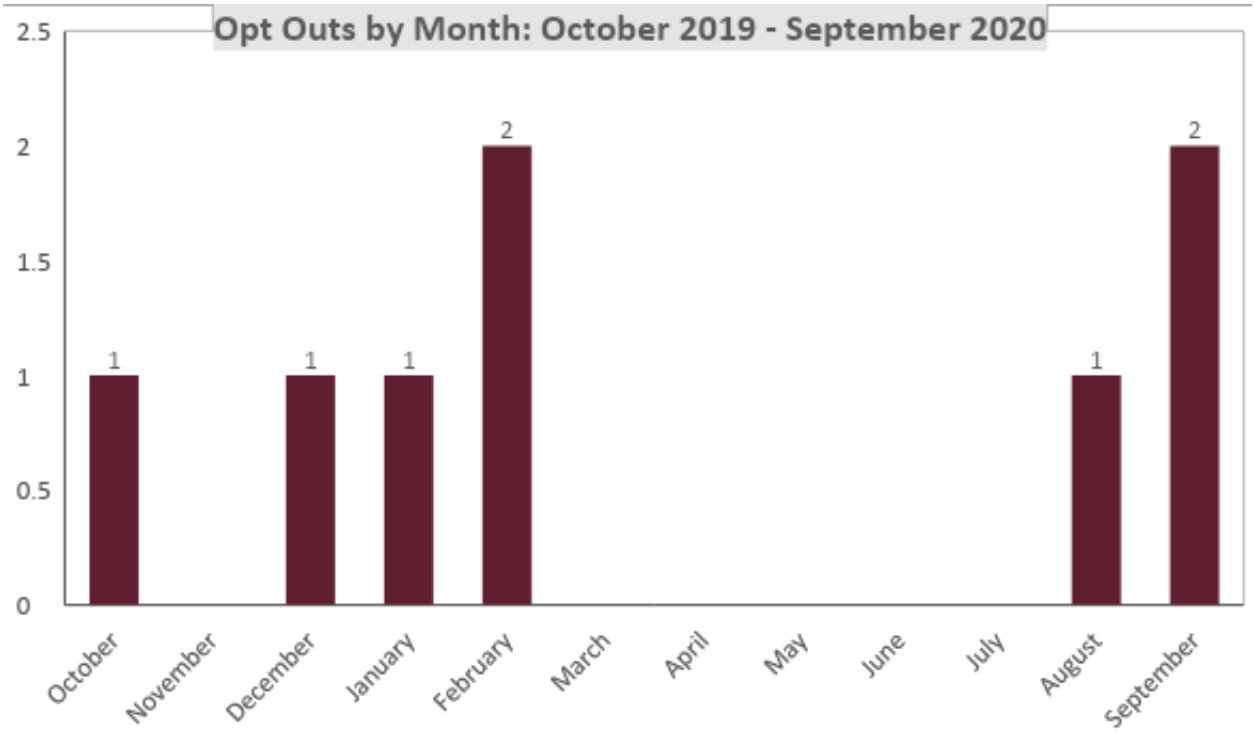


Table 6

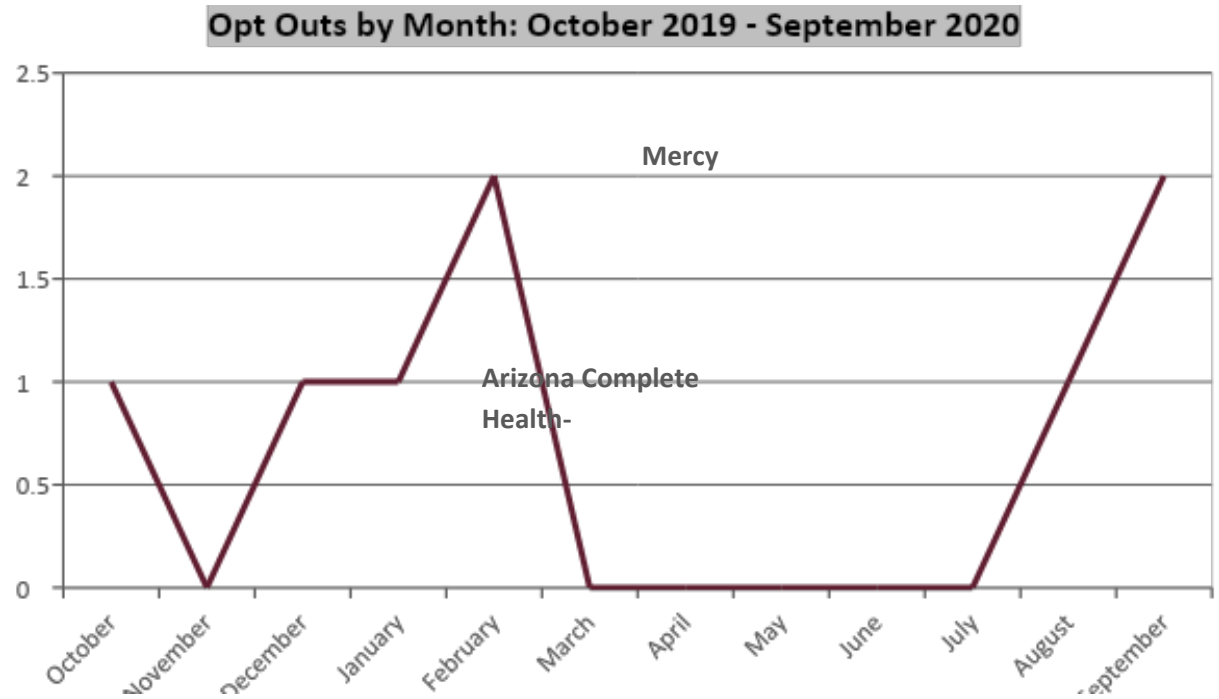


Table 7

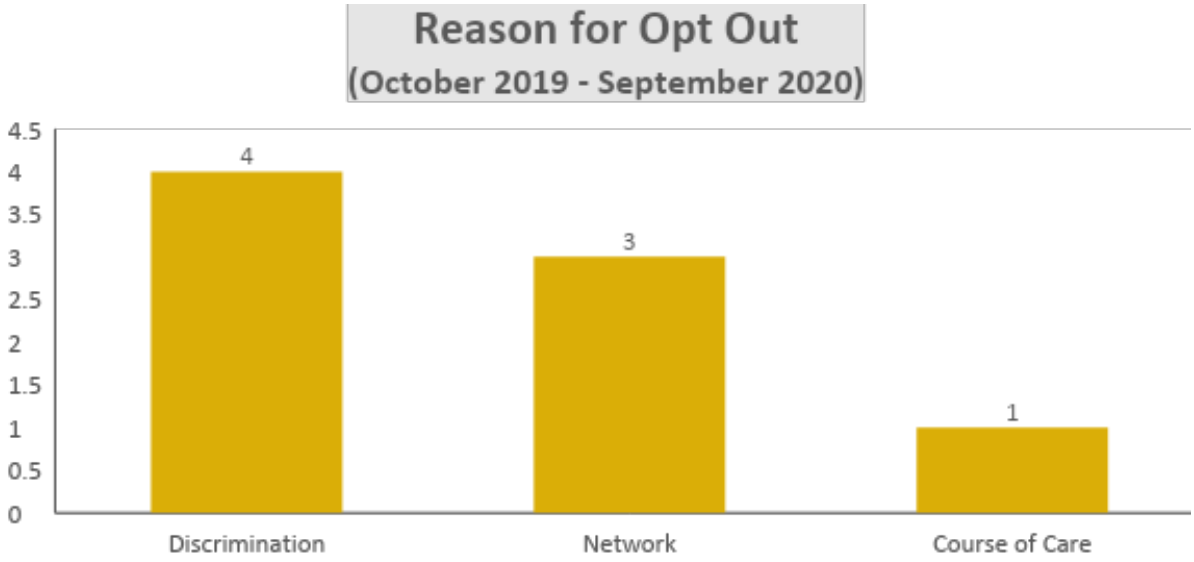
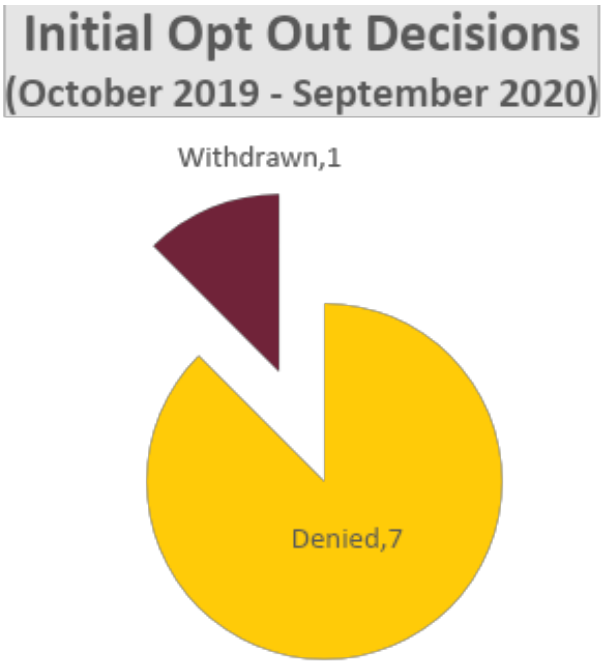


Table 8

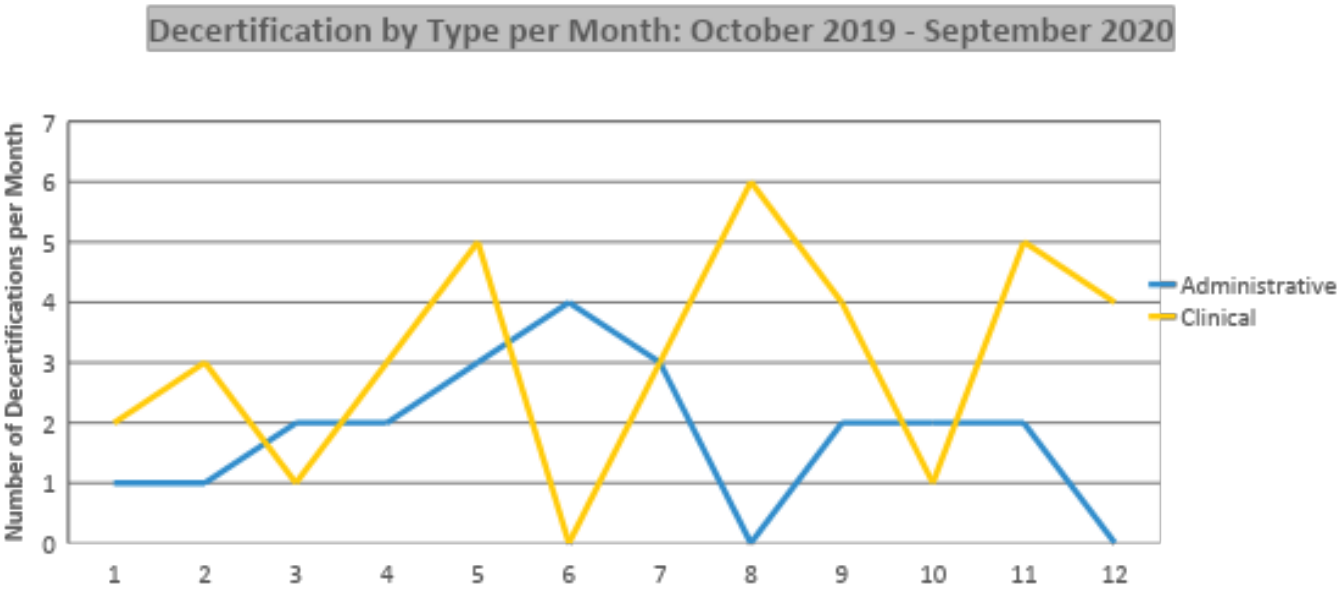


Appeal Outcomes (October 2019 - September 2020)			
Approved	**Withdrawn**	**Denied**	**Pending**
0	**0**	**1**	**0**

The following are the two established mechanisms for changing an individual's designation and service eligibility:

- Clinical decertification. Eligibility for SMI services is based upon a clinical determination as to whether a person meets a designated set of qualifying diagnostic and functional criteria. If criteria are no longer met, the individual's SMI eligibility is removed and the individual will be eligible for behavioral health services under the general mental health (GMH) program category. AHCCCS' contracted vendor, Crisis Response Network, makes these determinations.
- Administrative decertification. This administrative option, facilitated by AHCCCS, is a process that allows an individual with an SMI designation to elect to change their behavioral health category from SMI to GMH if they have not received behavioral health services for two or more years.

Table 9



VIII. Demonstration Operations and Policies

Legal Update

The Office of Administrative Legal Services (OALS) provides legal counsel to the AHCCCS administration and oversees the agency's rulemaking and Grievance and Appeals System. Major components of the Grievance and Appeals System include scheduling State Fair Hearings for disputed matters, the informal adjudication of member appeals and provider claim disputes, and the issuance of AHCCCS Hearing Decisions (also referred to as Director's Decisions). AHCCCS Hearing Decisions represent the agency's final administrative decisions and are issued subsequent to review of the Recommended Decisions made by Administrative Law Judges employed by the State Office of Administrative Hearings, an independent

office of state government. AHCCCS' General Counsel (also referred to as the Assistant Director of OALS) additionally serves as the agency's Chief Privacy Officer with oversight authority over HIPAA and Part II compliance issues.

Between October 1, 2019 and September 30, 2020, OALS received 20,528 matters, including member appeals, provider claim disputes, ALTCS trust reviews, and eligibility appeals. Of the 20,528 total cases received, 426 were member appeals, 18,069 were provider claim disputes, 256 were ALTCS trust reviews, and 1,777 were eligibility appeals. OALS issued 753 Director's Decisions after State Fair hearings were held. In addition, OALS issued 15,140 informal dispositions of disputes filed with the AHCCCS Administration. More than 97 percent of these disputes were resolved at the informal level, thus obviating the need for State Fair Hearings in these cases.

With regard to major litigation, the following is a summary of the status of major cases involving legal challenges to AHCCCS during this federal fiscal year:

1. B.K. et. al v Faust (Formerly B.K. et. al v McKay et. al; Tinsley v McKay) Lawsuit Alleging Violations of Constitutional and Statutory Rights of Foster Care Children

On February 3, 2015, a class action lawsuit in federal district court was filed against the directors of the Arizona Department of Child Safety (DCS) and Department of Health Services (ADHS) alleging violations of the constitutional and statutory rights of children in foster care custody of the State of Arizona. Plaintiffs are several children in state foster care custody, suing on behalf of themselves, a general class of children who are or will be placed in such custody, and certain subclasses, to enjoin the directors of DCS and ADHS from continuing to operate the Arizona foster care system in ways that violate plaintiffs' federal constitutional and statutory rights. Represented by Arizona Center for Law in the Public Interest, Children's Rights, Inc. and Perkins Coie LLP, Plaintiffs allege failures by DCS and ADHS to provide safe and necessary medical and behavioral health care for approximately 17,000 foster children in the custody of the State.

The AHCCCS administration was not a named defendant. However, because the injunctive and declaratory relief, including imposition of a court monitor, would impair the ability of the AHCCCS Administration to manage the Title XIX program and, in particular, the provision of EPSDT services, AHCCCS filed a Motion to Intervene on May 7, 2015 to add AHCCCS then-Director Betlach as a defendant on the EPSDT claims. Also, on May 7, Defendants DCS and ADHS jointly moved to dismiss the case on abstention grounds arguing that the federal suit would interfere with state juvenile court proceedings. Plaintiffs filed their Response to Defendants' Motion to Abstain on June 11, 2015, and on June 29, defendants filed their Joint Reply. The Court denied Defendants' Motion to Abstain on September 29, 2015. On May 19, 2015, the Plaintiffs responded by not opposing AHCCCS' Motion to Intervene, stating they would amend their complaint to add Director Betlach once the Court grants the motion. The Court granted the Motion to Intervene on June 3, 2015.

Plaintiffs then filed a Second Amended Complaint on June 8, 2015 which includes allegations specific to the AHCCCS program and the Medicaid subclass. In the Second Amended Complaint, Plaintiffs particularly allege that they have suffered physical and emotional harm and remain at risk of ongoing

harm, as a result of Defendants' long standing failures: (1) to provide adequate health care services to children in state foster care; (2) to conduct timely investigations into reports that children have been abused or neglected while in state care; (3) to provide a minimally adequate number and array of foster homes for children not placed with kin; and (4) to take minimally adequate steps to keep families together after removing children from their homes. A scheduling order was entered on December 21, 2015, and discovery began.

On February 11, 2016, Defendant Betlach filed the First Request for Production of Documents. Plaintiffs' filed Responses on March 14, 2016. The District Court issued an Order for Protection of Privileged/Confidential Material on March 15, 2016 ordering Defendants to produce redacted information regarding the named Plaintiffs no later than April 1, 2016. The Court also approved, in part, the Parties' Joint Submission of Proposed Protective Order and required the parties to comply with specified requirements concerning the production and handling of information.

After Plaintiffs filed a Motion to Amend the Court's Rule 16 Scheduling Order which was entered December 21, 2015, the Court, on May 12, 2016, extended all outstanding deadlines by 90 days in its First Amended Rule 16 Scheduling Order. On May 13, 2016, the Court approved in part Plaintiffs' Motion for Appointment, approving the appointment of 2 of the 3 individuals volunteering to serve as next friends for the minors. Because of a possible appearance of impropriety with regard to one individual, that one appointment was not approved. The parties were ordered to confer to identify a suitable individual to serve as next friend for the other minors. Expert reports of Marci White, MSW, and of Steven Blatt, MD, both retained by Plaintiffs, were submitted on September 15, 2016. The Plaintiffs filed their Motion for Class Certification on November 29, 2016. The Defendants responded on December 22, 2016.

Plaintiffs' Reply was filed on January 5, 2017. The parties engaged in mediation on May 18th which was unsuccessful. Discovery resumed. On September 30, 2017, the District Court issued an Order granting Plaintiffs' Motion for Class Certification of a General Class and two subclasses consisting of the Non-Kinship Subclass and the Medicaid Subclass. The General Class consists of "all children who are or will be in the legal custody of DCS due to a report or suspicion of abuse or neglect." The Non-Kinship Subclass consists of "all members in the General Class who are not placed in the care of an adult relative or person who has a significant relationship with the child." The Medicaid Subclass is comprised of "all members of the General Class who are entitled to early and periodic screening, diagnostic, and treatment services under the federal Medicaid statute." Additionally, the Court granted Plaintiffs' request to appoint Perkins Coie, the Arizona Center for Law in the Public Interest, and Children's Rights, Inc. as class counsel. Petitions by Defendants to the Ninth Court appealing the ruling will be filed.

On October 16, 2017, Defendants filed a Petition to the Ninth Circuit Court of Appeals challenging the ruling on an immediate interlocutory basis. Plaintiffs filed a Response to the Petitions on October 25, 2017, and the Ninth Circuit granted the Petitions on December 19, 2017. Defendants filed a Motion to Stay the case pending the outcome of the appeal which was denied by the District Court Judge on February 13, 2018. Shortly thereafter, Defendants filed a Motion to Stay with the Ninth Circuit which was granted on February 27, 2018. Events in the district court will not stop while the Ninth Circuit

decides the class certification issue. Defendants filed their Joint Opening Brief on April 30, and on June 29, Plaintiffs filed their Answering Brief opposing Defendants' appeal of the class certification Order. Meanwhile, Defendants filed a Motion with the Ninth Circuit on June 26, 2018 requesting en banc review of the class certification issue rather than review by the 3-judge panel in light of the importance of the issue. The Court of Appeals denied the Motion without comment.

On January 17, 2019, the case was argued at the Court of Appeals, and on April 26, 2019, the Court of Appeals vacated the Medicaid subclass certification. However, the Court of Appeals upheld class certification in the counts against DCS. The Ninth Circuit lifted the Stay on June 11, 2019. An expedited new scheduling order was issued by the District Court on July 18, 2019. Plaintiffs filed a renewed Motion to certify a Medicaid Subclass on July 31, 2019, and the District Court granted the Motion on October 11, 2019. As part of the ruling, the District Court appointed B.K. as the class representative of the Medicaid subclass and appointed Perkins Coie, LLP, Arizona Center for Law in the Public Interest, and Children's Rights, Inc. as class counsel for the Medicaid Subclass. Defendants filed a Joint Petition to the Ninth Circuit Court of Appeals for permission to appeal the District Court ruling recertifying the Medicaid subclass, seeking an order to decertify the Medicaid subclass. Defendants argued that the District Court erred by premising class certification upon per se State liability created whenever a child fails to receive an EPSDT service, regardless of the reasons for failure to receive the service. Defendants maintain that there is no basis for the per se liability theory in Medicaid statutes, regulations or case law.

On October 12, 2019, the Court granted the renewed Motion to certify a Medicaid Subclass, and Defendants filed a joint petition to the Ninth Circuit for permission to appeal this ruling on October 28, 2019. Plaintiffs responded on November 7, 2019, and Defendants filed a Motion for Leave to File a Reply on November 14, 2019. The Ninth Circuit denied the Petition on February 28, 2020. Defendants then moved for en banc reconsideration on March 11, 2020 which was denied on May 4, 2020. Defendants filed a Motion to exclude five of Plaintiffs' experts on January 10, 2020 which the Court denied.

Settlement discussions took place in summer 2020, and the parties ultimately reached a settlement. The settlement proposal was filed with the Court on August 31, 2020, along with a request for preliminary approval from the Court. The agreement does not require actions by AHCCCS, but it does require actions by DCS. On October 14, the Judge issued preliminary approval of the settlement, and a final approval hearing is scheduled for February 12, 2021.

2. CMS Disallowance of Medicaid School-Based Administrative Claims

On October 20, 2016, CMS issued its final disallowance of school-based administrative claims that AHCCCS submitted for the period of January 1, 2004 through September 30, 2008. CMS disallowed $5,421,711 for failure of the AHCCCS contractor, Maximus, Inc., to retain documentation to support claims in two fiscal quarters and disallowed an additional $6,295,139 because Maximus and AHCCCS used a sampling methodology that was disapproved by CMS. On December 14, 2016, AHCCCS sent a Request for Reconsideration to the Secretary of HHS. By letter dated February 14, 2017, but received by AHCCCS on March 6, 2017, CMS denied AHCCCS' Request for Reconsideration. AHCCCS filed a Notice of Appeal to the Departmental Appeals Board (DAB) on April 3, 2017, and AHCCCS' Opening Brief was filed on May 5, 2017. CMS filed its Response on June 5, 2017, and AHCCCS filed its Reply on June 20, 2017.

On October 2, 2017, the DAB denied AHCCCS' appeal. AHCCCS filed a Complaint in the U.S. District Court in Phoenix on December 1, 2017, appealing the DAB ruling. On February 8, 2018, the Federal Government filed its Answer. The administrative record was filed on March 30, 2018. AHCCCS filed its Opening Brief on May 11, 2018. The Federal Government filed its Response June 18, 2018, and AHCCCS filed its Reply on July 9, 2018. After an extended delay, the District Court upheld the DAB Decision on February 18, 2020. AHCCCS filed an appeal on April 3, 2020, and the Opening Brief was filed July 12, 2020. CMS filed its response on September 11, 2020, and AHCCCS' reply was submitted by November 2, 2020.

3. Arizona Alliance of Community Health Centers et al. v AHCCCS-Lawsuit regarding FQHC Reimbursement.

Several federally qualified health centers (FQHCs) and their trade association filed a lawsuit in federal district court against AHCCCS on October 29, 2019, seeking declaratory and injunctive relief. Plaintiffs maintain that AHCCCS is required to pay for "physicians' services" (including services by dentists, optometrists, podiatrists, and chiropractors) pursuant to 42 U.S.C. § 254b(k)(3)(F) and (G). Plaintiffs' position is that Defendants must cover, and may not limit, certain optional Medicaid services if they are provided in a FQHC. Plaintiffs seek to enforce what they interpret as clear statutory language and binding Ninth Circuit precedent, California Association of Rural Health Clinics v. Douglas, which, according to Plaintiffs, requires States to cover and pay for dental, podiatry, optometry, and chiropractic services as mandatory "FQHC services" in accordance with their FQHC payment obligation (42 U.S.C. § 1396a(bb)).

On November 21, 2019, Plaintiffs filed a Motion for Preliminary Injunction, and AHCCCS filed its Response on January 10, 2020. Plaintiffs filed their Reply in Support of the Motion for Preliminary Injunction on January 31, 2020. Earlier, on November 25, 2019, AHCCCS filed a Motion to Dismiss for failure to state a claim. Oral argument was held on September 4, 2020, and the Court required further submissions from the parties by September 22, 2020. The Court has not issued a ruling to date.

4. D.H. and John Doe v Snyder- Lawsuit Alleging Violations of Civil Rights on behalf of Transgender Individuals under 21 Years of Age

The D.H. litigation is a putative class action seeking declaratory and injunctive relief on behalf of "all transgender individuals under age 21 who are or will be enrolled in AHCCCS, have or will have a diagnosis of gender dysphoria, and are seeking or will seek coverage for male chest reconstruction surgery following a determination by their respective health care providers that the procedure is necessary to treat their gender dysphoria." Plaintiffs are represented by the National Health Law Program, the National Center for Lesbian Rights, Perkins Coie, and King & Spalding.

Both the Complaint and the Motion for Preliminary Injunction were filed in federal court in Tucson, Arizona, on August 6, 2020. The two named Plaintiffs, teenagers who identified at birth as females who self-identify as males, allege that A.A.C. R9-22-205B.4(a), which excludes coverage of gender reassignment surgeries, violates their equal protection rights, constitutes sex discrimination, and

violates Medicaid's EPSDT and comparability requirements. Specifically, they assert that the AHCCCS rule violates the Plaintiffs' civil rights under: Section 1557 of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18116 (prohibiting discrimination on the basis of sex); the 14th Amendment (requiring equal protection under the law); the EPSDT requirements of the federal Medicaid Act, 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B),1396d(r) (requiring services for individuals under 21 years of age); and Medicaid's comparability provision at 42 U.S.C. § 1396a(a)(10)(B) ("the medical assistance made available to any individual . . . shall not be less in amount, duration or scope than the medical assistance made available to any other such individual.") Plaintiffs seek male chest reconstruction surgery to relieve both physical and behavioral symptoms of gender dysphoria.

Also, Plaintiffs filed a Motion to Transfer the Case to Judge Marquez on August 11, 2020 which was denied on October 19, 2020. On September 28, 2020, AHCCCS filed its Opposition to Plaintiffs' August 6, 2020 Motion for Preliminary Injunction, and on October 26, 2020, Plaintiffs filed their Reply.

Legislative Update

The legislature passed several bills in the 2020 Legislative session that have impacts on the agency including:

- **SB 1244** (caregivers; assisted living; training) was an agency-supported bill which aligns the training and testing requirements for direct care workers with the training and testing requirements of assisted living caregivers. This alignment allows for easier transitions for workers between in-home care and caregiving in an assisted living facility.
- **SB 1246 (**behavioral health; foster children) allowed for the integration of physical and behavioral health under a single plan (the Comprehensive Medical and Dental Program) for foster children across the state.
- **SB 1535 (**AHCCCS; opioid treatment programs; requirements) required opioid treatment programs to submit a series of reports to ensure community engagement and adherence to best practices in order to qualify for AHCCCS reimbursement. SB 1535 also created a new process for the establishment of criteria regarding Opioid Treatment Program centers of excellence and creates the Opioid Use Disorder Review Council.
- **HB 2754/HB 2747** (budget bills) contained appropriations for state agencies and programs. Specific to the AHCCCS administration, the budget included the following items:

    1. Eliminated a mandatory enrollment freeze on the KidsCare program due to declining federal funding participation and fully funds the program;
    2. Created a licensure type for Secure Behavioral Health residential facilities;
    3. Provided additional state funds for Graduate Medical Education; and
    4. Provided additional funding for long term care providers.

Program Integrity Update

The Office of Inspector General (OIG) is responsible for and must coordinate activities that promote accountability, integrity, and the detection of fraud, mismanagement, abuse, and waste within the Medicaid program. The AHCCCS OIG is a criminal justice agency as defined by Arizona state law.

AHCCCS continues to increase its commitment of resources and the development of programs to implement internal controls throughout the Medicaid system to detect, prevent, and investigate cases of suspected fraud, waste, and abuse (FWA).

The OIG include four divisions that accomplish different, but interrelated, functions:

Member Compliance Section (MCS)

MCS is divided in two subsections: the Member Criminal Investigations Unit (MCIU); and the Fraud Prevention Unit (FPU). Each unit plays a distinctive role in fraud cases involving applicants and enrolled Medicaid members.

Program Integrity Team (PIT)

The PIT performs data mining, audits payment data, and conducts periodic utilization reviews of target providers to identify trends and determine potential fraudulent billing practices.

Performance Improvement and Audits Section (PIAS)

PIAS oversees the Corporate Compliance Program as required by federal law and as established in the AHCCCS contracts with MCOs and has four units: an Audit unit; a Post Pay Interoperability unit; Collections unit; and a Referral Administrative team. PIAS conducts performance improvement projects independent provider audits.

In the Federal Fiscal Year (FFY) 2020, OIG achieved a total of $46,662,348 in savings and recoveries for all programs.

Provider Compliance Section (PCS) -

PCS conducts investigations of external referrals and internally detected cases using data mining (Program Integrity audits) activities. PCS has three components: Provider Compliance Unit (PCU); Pharmacy Fraud Investigative team; and a Fee- for- Service (FFS) team (newly created). However, the Forensic Accountant Unit that provides financial fraud assistance in cases related to Health Care Corporate Compliance Fraud and Health Care Financial Frauds and their statistics is reported as Provider Compliance. This section also makes independent referrals to the State Medicaid Fraud Control Unit (MFCU) and other city, state, and federal law enforcement authorities.

The OIG works to continually increase its associations with federal, state, and local law enforcement. To support this effort, the Provider Compliance Section has developed relationships with several county prosecutors who successfully prosecuted cases involving health care theft, fraudulent schemes, and/or elder abuse prosecutions. PCS's primary goal is to identify the subjects who accept plea deals, are convicted, and are sentenced in order to report those individuals to the US Department of Health and

Human Services (HHS), OIG, for potential exclusions. The secondary goal is to increase associations with county prosecutors in order to create joint initiatives between agencies. AHCCCS OIG has submitted county prosecutions to HHS OIG for review of potential exclusions.

This year, OIG PCS developed successful partnerships with law enforcement as well as other areas of program integrity, including:

- Phoenix Police Department, Family Investigations Bureau, Crimes Against Children Unit
  Once MFCU introduced this partnership to PCS, OIG PCU successfully connected the Phoenix Police Department with AHCCCS Clinical Quality Management and Fee-For-Service Quality teams for matters regarding quality of care that officers encountered during field calls. OIG was able to connect and open cases for potential FWA due to information shared through this new partnership.

- ASU, Edson College of Nursing and Health Innovation
  OIG participates in a new, undergraduate ASU Health Care Compliance and Regulations degree program as a member of the Advisory Board Committee. The degree program strives to develop health care compliance professionals with competencies that providers, regulators, investigators, government programs, and enforcement agencies would find relevant to their work, and graduates will have job-ready skills, knowledge, and abilities.

- CVS Caremark
  OIG successfully partnered with CVS Caremark, a subcontractor of several AHCCCS MCOs, to provide direct and timely audit permissions in a consolidated process. This partnership has significantly reduced the number of redundant steps between the OIG and MCOs. CVS looks to extend this process to compliance audits in every state where they collaborate on Medicaid audits.

- LexisNexis
  PCU successfully leveraged the Provider Compliance Section's partnership with LexisNexis to perform an independent data review of several behavioral health providers involved in a fraud ring case. The output was shared with both OIG and the Arizona State Attorney General's Office (AGO) MFCU.

- New Internal Workflow
  OIG is strengthening its internal workflow processes in order to educate internal AHCCCS partners about the roles and responsibilities regarding Medicaid fraud, waste, and abuse and program integrity. OIG is developing a new team of seven investigators and one supervisor to lead, develop, and support fraud, waste, abuse identification among unique programs.

- Qlarant
  Under the CMS Unified Program Integrity contractors (UPIC) program, OIG is working with Qlarant, the southwest regional UPIC, to develop viable cases to support the Medicare and Medicaid (Medi-Medi) initiative.

The OIG Self Disclosure Program, updated in SFY 2019, continues to be an AHCCCS OIG success. Because of the 2019 update, providers have the ability to reimburse overpayments directly to the OIG while ensuring access to service for members and maintaining a cost-effective program for Arizona's taxpayers.

In FFY 2020, the OIG:

- Accepted 1,494 cases for prosecution,
- Achieved a total of 194 convictions,
- Achieved total asset forfeitures of $2,645,859,
- Accomplished $9,783,452 in program savings, and
- Achieved $3,923,165 in total recoveries.

Wrongful billing under an incorrect provider ID is a consistent error found across several provider types. OIG actively pursues recoupments of overpayments related to wrongful billing. Case examples include, but are not limited to, the following:

- The PCS initiated a high-profile case involving a conspiracy ring involving Behavioral Health Residential Facilities (BHRFs), in collusion with Behavioral Health Outpatient Clinics, fraudulently billing the state Medicaid program. This investigation was a joint effort with the AGO and MFCU.
- Stemming from a Credible Allegation of Fraud (CAF), PCS continues to institute a current and ongoing partial suspension of new patient admissions on an entity that was unable to produce complete records and ensure patient safety. Additional providers involved in the oversight of the facility were also suspended.

PCS has also instituted several credible allegations of fraud payment suspensions this year:

- Two payment suspensions of therapy companies for providing services to our members through unlicensed/unqualified personnel; billing for services not provided; failing to adhere to the requirements of our provider agreements; creating false documentation; failing to adhere to medical documentation requirements; etc.
- Three payment suspensions of Non-Emergency Medical Transportation (NEMT) companies who billed for services the company knew and/or should have known could not have been provided as claimed.
- Three payment suspensions for companies operating as though they were NEMT and billing for services they knew and/or should have known could not have been provided as claimed.
- One payment suspension for a provider operating and billing for services provided to members in an unlicensed BHRF.
- One payment suspension of a provider who billed for COVID testing, whole body assessments, and other items that never occurred.

PCS incorporates coding algorithms and flags data to identify cases. Recoveries include:

- $30,030 for the first nine cases identified and opened from patients receiving outpatient services while hospitalized in inpatient treatment facilities. There are 50 more cases that have been opened as a result.
- Although not initially data mined as a distinct initiating referral, OIG used additional data mining techniques to identify, based on cataract surgery codes, prior patient diagnosis, and eye exams, a full fraud scheme run by an ophthalmologist and eye surgery group. The case is not complete, but final records reviews, criminal charges, and criminal information documents indicate a preliminary loss of $450,000. AHCCCS OIG information and data mining led to the indictment of more than 47 people involved in this fraud scheme.
- The OIG conducted a Date of Death (DOD) audit of claims processed for members who had died before the claims were provided to AHCCCS. This audit is on-going and OIG has initiated approximately 40 cases.

The OIG NEMT project has one, dedicated full-time investigator and has yielded the following:

56 referrals specific to NEMT received with $1,781,922 in recoveries and $891,292 in program savings.

AHCCCS OIG has expanded beyond the Statute of Limitation Tolling Agreement developed last year; and this year has incorporated Notices of Intent to Offset. AHCCCS OIG has the authorities, pursuant to Provider Participation Agreements, A.R.S. 36-2903.01 (L), AAC R9-22-703(F) and AAC R9-22-713(B) to recoup, withhold, and offset against current or future payments for overpayment amounts, expenses, and costs determined by a post payment review. These notices include appeal rights and the chance to request any informal settlement conferences pursuant to A.R.S. 41-1092 et.seq. AHCCCS OIG is currently performing offsets on five different providers throughout the MCO and FFS populations.

A decision rendered by the Arizona Court of Appeals in the Sunflower Adult Day Care Corporation v. AHCCCS Administration Decision affirmed that the extrapolation process used by AHCCCS OIG is based upon valid statistical methods. Furthermore, AHCCCS OIG was able to obtain a judgment and record it with the County Recorder's Office. This judgment will be re-recorded in five years if there are still monies owed at that time. This judgment upholds that Sunflower NEMT owes AHCCCS $701,550.14 and was furthered ordered interest at the rate of 5.75 percent per annum from the date of judgment.

As this is a shared provider/owner between Arizona and Alaska, Arizona was able to connect and share information with Alaska Medicaid to inform Alaska's program integrity reviews and potential actions.

Cases of particular interest this past year include:

- Over 400 hours spent reviewing medical records, attending meetings, and providing input for the case against Paul Petersen, the Maricopa County property assessor. Reviews of the records provided relevant and pertinent information outlining payments made, recruiting efforts, and witness statements that helped support the AHCCCS OIG member case and loss of over $850,000. The member case led to a $650,000 recovery and a potential spin off case to PCS.

- $297,000 Civil Monetary Penalty (CMP) imposed against an Arizona doctor who refused to provide any documentation for any claims billed and paid by AHCCCS for medical and pharmacy related scripts.
- $100,000 recovered from fraudulent timesheets billed for excessive units from a HCBS provider.
- $1,115,260 forfeiture award on a case several years in the making against a pain management doctor who billed AHCCCS for patients he never saw.

Pharmacy Fraud Investigative Team (PFIT)

In FFY 2020, the PFIT, as part of PCS, continues its Pharmacy Intelligence Project to drive casework. PFIT investigates matters related to opioid and prescription fraud, waste, and abuse. The PFIT consists of four investigators with provider and member fraud experience. The PFIT also has three pharmacists on the team. The PFIT continues to work closely with local police departments, MFCU, and federal agencies in working joint investigations.

- 30 referrals reviewed,
- 4 outbound referrals,
- 56 cases opened,
- 1 new joint case with MFCU,
- 3 lock-down requests,
- 4 approved lockdowns,
- 11 case management requests,
- 4 case management requests granted,
- Zero search warrants issued,
- Zero indictments, and
- 2 convictions.

Member Compliance Section (MCS)

The MCS includes two units: Criminal Investigative Units (CIU) and the Fraud Prevention Units (FPU). Combined, these units handled 5,555 cases in FFY 2020 with total recovery and savings of $22,020,091.

With units in Tucson and Phoenix, FPUs closed a total of 4,148 cases with a total savings of $14,110,458 in FFY 2020.

With units in Tucson and Phoenix, CIU closed a total of 1,407 cases, with total savings and recoveries of $7,909,633 in FFY 2020.

- In a joint investigation with the DES Office of Special Investigations (OSI), the MCS investigated allegations that a member failed to report marital status, and that the member's husband worked for the Maricopa County Sheriff's office. This case was prosecuted by the Arizona Attorney General's Office, and the member was convicted and ordered to serve probation for three years and three months' probation and pay $49,574 in restitution.
- The MCS investigated allegations that a member earned approximately $60,000 per year working as a prostitute at Sheri's Ranch in Pahrump, Nevada and advertising adult services on Backpage.com. This investigation revealed that the member failed to report correct income. The member pled guilty to a class 6 felony and was sentenced to pay $79,115 in restitution and serve three years of supervised probation.

- An investigation into allegations of a member who stated he was unable to work due to disability and therefore eligible for Social Security Administration's (SSA) Title XVI benefits determined that the member's cognitive and physical ability was reported incorrectly. Finding the fraudulent application saved AHCCCS $17,295.
- The MCS' Tucson Task Force conducted a joint investigation with the Federal Bureau of Investigations (FBI) of allegations that a member and her spouse were involved in money laundering and drug trafficking and had failed to report all income to AHCCCS. The investigation determined that the member and her spouse had more than ten bank accounts with deposits totaling $451,242. The member's two businesses, where most of the illegal activity occurred, were shut down, and the member was convicted and sentenced to serve 2.5 years in prison and pay AHCCCS $47,482 in restitution.
- The same team, with the FBI, investigated allegations of a member's involvement with drug trafficking, money laundering, and false income reporting, and found that the member was receiving payroll checks from employers located in Miami, Florida and had bank accounts totaling $192,298. The member was convicted and sentenced to 2.5 years in prison and pay $52,069 in restitution to AHCCCS.

Program Integrity Team (PIT)

The PIT handles high-volume data requests from internal and external customers. In FFY 2020, PIT received 35 data requests per month and maintained an average two-day turnaround time. The National Association of Medicaid Fraud Control Units (NAMFCU) data requests are invariably more complex and require more time to process, but PIT rarely requires a deadline extension. PIT received $2,331,832 in global settlements from eight cases in FFY 2020. PIT currently has 63 pending global settlement cases and two active cases.

- In addition to fulfilling data requests, PIT analysts conducted investigations resulting in $26,035 in recoveries and $3.8 million in program savings.
- Due to staff shortages, Program Integrity Audits and Provider Self-Audits were suspended for much of FFY 2020 due to the COVID-19 public health emergency.
- Efforts to resolve the Medi-Medi T-MSIS data issues across the country are pending, yet PIT continues to support Qlarant, the United Program Integrity Contractor (UPIC), with their data needs (including reports to help identify data issues that are preventing T-MSIS use for program integrity). Meanwhile, the PIT will continue to process Medi-Medi data requests for Qlarant. PIT helped Qlarant investigate six cases and received $88,146 in FFY 2020. As of the end of FFY 2020, Qlarant had 28 active cases and nine cases pending at the Attorney General's Office.
- A new case management system went live in FY 2020.
- The PIT tracks the provider board terminations which totaled 338 providers and $7,564.682 in program savings.
- PIT continues to work closely with LexisNexis to enhance our data analytic activities and identify quality investigation leads. Recent developments include a deployment report (significant change in provider claim/patient numbers each quarter) and COVID-19 reports (COVID DX and Telemed analysis).

Performance Improvement and Audit Section (PIAS)

PIAS maintains monthly charts and graphs that track OIG key performance indicators and creates new charts for OIG as needed. At the end of FFY 2020, OIG monthly metrics included a 133-page report of Fraud Prevention, Member Criminal Investigations, Program Integrity, Provider Compliance, Forensic Accounting, Pharmacy Fraud Intelligence, Collections, Audits, Referrals, and more.

In FFY 2020, the Collections team focused on the 1,197 cases that were 60 days or more past due, an increase of 18 percent since FFY 2019.

Additional statistical accomplishments include:

- $5,835,408 total collections (on-time & past-due),
- 1,871 payments received (on-time & past-due),
- 1,197 60-day+ past-due cases identified, and
- 229 60-day+ past-due cases collected.

In FFY 2020, the OIG Audit Team completed the following Audits:

- 4 Operational Reviews,
- 18 Deficit Reduction Act (DRA) audits,
- 116 MCO deliverable reviews, and
- 1 FQHC audit pending.

The EHR Post Pay Audit Team completed the following EHR post pay audits in SFY 2020:

- 15 Eligible Hospitals (EH) meaningful use (MU) audits,
- 120 Adapt, Implement, and Upgrade (AIU) audits completed,
- 218 Meaningful Use (MU) audits completed,
- 1 Eligible Professional (EP) appeal,
- $1,094,140 in recoupments from EH and providers collected, and
- $151,419 in recoupments from EH and providers determined.

State Plan Update

During the reporting period, the following State Plan Amendments (SPA) were filed and/or approved:

SPA #	*Description*	*Filed*	*Approved*	*Effective Date*
Title XIX				
SPA 18-010 – GME 2019	Updates the State Plan to continue the GME program for FY2019.	*9/27/2018*	*1/22/2020*	*9/30/2020*
SPA 19-004 - Pharmacy Value Based Purchasing (VBP)	Provides the state the authority to enter into value-based payment (outcome-based) agreements with pharmacy drug manufacturers.	*9/5/2019*	*4/28/2020*	*7/1/2020*
SPA 19-005 Advanced Directives	Updates the advanced directives section of the State Plan to ensure the advanced directives brochure is always current.	*9/30/2019*	*10/17/2019*	*7/1/2019*
SPA 19-006 - Census Wage Eligibility Groups	Updates the eligibility groups for which wages related to census activities are excluded.	*9/30/2019*	*12/26/2019*	*7/1/2019*
19-007 - DSH Pool 5	Updates the State Plan to reflect DSH Pool 5 funding and participating hospitals for FY 2020.	*9/30/2019*	*5/13/2020*	*10/1/2020*
19-007 - DSH Pool 5A	In response to COVID-19, SPA 19-007 was split into two SPAs to allow the state to make interim payments to Pool 5 facilities equal to FY 2019 amounts.	*5/1/2020*	*N/A*	*10/1/2020*
19-008 - DSH Budget 2020	Updates the State Plan to reflect DSH funding for SFY 2020 in response to budget changes passed by the Arizona State Legislature.	*9/30/2019*	*5/13/2020*	*10/1/2020*
19-012 - OP Hospital Rates	Revises Outpatient Hospital Rates effective 10/1/2019.	*11/15/2019*	*12/16/2019*	*10/1/2019*
SPA 19-013 - Dental AIR	Reflect the emergency dental benefit cap as being the higher of $1,000, or the full AIR complete payment methodology in accordance with the OMB rate for IHS/638 facilities.	*12/02/2019*	*N/A*	*10/1/2019*
SPA 19-014 - DRG Rates	Updates the State Plan DRG Rates, effective October 1, 2019.	*12/30/2019*	*2/12/2020*	*10/1/2019*
SPA 19-015 - NF DAP	Updates the State Plan to update the NF DAP program.	*12/30/2019*	*2/12/2020*	*10/1/2019*

SPA 19-016 - EMS Rates	Updates the State Plan EMS rates, effective October 1, 2019.	*12/30/2019*	*3/12/2020*	*10/1/2019*
SPA 19-017 - NF Rates	Updates the State Plan to reflect updated nursing facility rates, effective October 1, 2019.	*12/30/2019*	*2/14/2020*	*10/1/2019*
SPA 19-018 - Other Provider Rates	Updates the State Plan Other Provider rates, effective October 1, 2019.	*12/30/2019*	*2/25/2020*	*10/1/2019*
SPA 19-019 - LTC & Rehab Rates	Updates the State Plan long-term care and rehabilitation rates, effective October 1, 2019.	*12/30/2019*	*1/28/2020*	*10/1/2019*
SPA 19-020 - Opioid DUR	Updates the State Plan to comply with SUPPORT Act requirements regarding opioid drug utilization reviews.	*12/30/2019*	*2/12/2020*	*10/1/2019*
SPA 19-021 - IP DAP	Updates the IP DAP program, effective October 1, 2019.	*12/30/2019*	*3/2/2020*	*10/1/2019*
SPA 19-022 - OP DAP	Updates the State Plan OP DAP program, approved February 3, 2020 effective October 1, 2019.	*12/30/20*	*3/12/2020*	*10/1/2020*
SPA 19-023- MACPro Eligibility	Updates the MACPro system to reflect the Arizona eligibility criteria.	*12/30/2019*	*5/1/2020*	*10/1/2019*
SPA 20-001 - COVID-19	Amends the State Plan to provide the state discretion to waive copayments and other cost sharing requirements for a specified period of time in response to COVID-19.	*3/24/2020*	*4/1/2020*	*3/1/2020*
SPA 20-002 "CHIP COVID-19"	Updates the CHIP State Plan to provide the state flexibility to waive cost sharing requirements and to provide additional flexibilities around enrollment and renewal timeframes in response to COVID-19.	*3/16/2020*	*4/24/2020*	*1/27/2020*
SPA 20-003 "Jan NF Rates"	Updates the State plan to update the NF rates.	*3/30/2020*	*4/9/2020*	*1/1/2020*
SPA 20-004 "COVID-19 2"	Amends the disaster relief SPA template to provide the state additional flexibilities to address the COVID-19 pandemic.	*4/2/2020*	*4/9/2020*	*3/1/2020*
SPA 20-005 "COVID-19 3"	Amends the disaster relief SPA template to provide the state additional flexibilities to address the COVID-19 pandemic	*2/13/2020*	*5/22/2020*	*3/1/2020*

20-007 "COVID-19 6"	Amends the disaster relief SPA template to provide the state additional flexibilities to address the COVID-19 pandemic.	*6/11/2020*	*Withdrawn*	*N/A*
20-008 "Tribal Dental Limit"	Removes the $1,000 dental benefit limit for members served in IHS/Tribal facilities as passed in House Bill 2244.	*6/30/2020*	*N/A*	*10/1/2020*
20-012 "CHIP SUPPORT Act BH Services"	Brings the CHIP state plan into compliance with provisions of the SUPPORT Act that require Behavioral Health (BH) services to be explicitly detailed in the CHIP State Plan document.	*6/30/2020*	*9/3/2020*	*7/1/2019*
SPA 20-006 COVID-19 5	Updates the state plan to provide additional flexibilities to allow the state to adequately respond to the COVID-19 pandemic.	*6/11/2020*	*8/4/2020*	*3/1/2020*
SPA 20-009 - COVID 4	Removes the indication that the state covers the optional COVID testing group.	*6/30/2020*	*7/28/2020*	*3/1/2020*
SPA 20-010 - EPSDT ND	Clarifies the coverage of Naturopathic Physicians under the EPSDT benefit.	*6/30/2020*	*7/14/2020*	*4/1/2020*
SPA 20-011 - IHS/638 NF AIR	Changes the reimbursement for nursing facility services provided to American Indians by facilities owned or operated by the Indian Health or tribes under PL 93-638 to reflect the outpatient All-Inclusive Rate (AIR) as published in the Federal Register.	*6/30/2020*	*8/17/2020*	*10/1/2020*
SPA 20-013 - IHS/638 DAP	Updates the IP and OP DAP programs to include IHS/638 facilities for FFY 2021.	*8/18/2020*	*10/6/2020*	*10/1/2020*
SPA 20-014 - COVID-19 7	Clarifies approved language in AZ-20-0004 and further increases bed hold days in response to the COVID-19 pandemic.	*8/19/2020*	*9/3/2020*	*3/1/2020*
SPA 20-015 - DSH Budget 2021	Updates the State Plan to reflect DSH funding for SFY 2021.	*9/30/2020*	*N/A*	*10/1/2020*
SPA 20-016 - 2021 DSH Pool 5	Updates the State Plan to reflect DSH Pool 5 funding and participating hospitals for FY 2021.	*9/30/2020*	*N/A*	*9/30/2020*
SPA 20-017 - DSH Pool 4 Reallocation	Updates the State Plan to detail the reallocation of excess Pool 4 funding.	*9/30/2020*	*N/A*	*9/30/2020*

SPA 20-018 - GME 2021	Updates the State Plan to continue the GME program for FY 2021.	*9/30/2020*	*N/A*	*9/30/2020*
SPA 20-019 - General Fund GME	Updates the State Plan to detail amounts and methodology related to the GME program General Fund dollars approved by the Arizona State Legislature.	*9/30/2020*	*N/A*	*9/30/2020*
SPA 20-020 - Vaccination Rate Increase	Updates the State Plan to reflect a rate increase for vaccination and vaccination administration codes, and to change the VFC administration rate.	*9/30/2020*	*N/A*	*9/1/2020*

IX. Quality Assurance/Monitoring Activities

AHCCCS is committed to the development of a thoughtful, data-informed delivery system that incorporates CMS' priorities and AHCCCS' business needs and promotes optimal health outcomes for all members. AHCCCS has undertaken extensive efforts related to the Quality Strategy and other quality improvement activities over the past year. With the Chief Medical Officer's (CMO) leadership, the Quality Improvement team conducted extensive research and review of performance measure related language found in AHCCCS contracts and policies. They established a workgroup with External Quality Review Organization (EQRO) and MCOs to augment communication about efforts to operationalize the agency's Performance Measure strategy. These efforts continue into CYE 2021 and AHCCCS has outlined a clear vision that promotes alignment with National Medicaid Quality Performance and Scorecard Measures as well as enhanced engagement of contracted MCOs and the EQRO.

a) PERFORMANCE MEASURES

During CYE 2020, AHCCCS further advanced its quality steering committee by establishing an AHCCCS MCO Quality Performance Measure workgroup aimed at operationalizing the agency Performance Measure transitions. AHCCCS worked to strategically align its statewide performance measures with the CMS Child and Adult Core Sets prior to implementation of mandatory child and behavioral health measure reporting. As a result, substantial updates were made to the Performance Measure sets found within the MCO contracts starting with CYE 2020. AHCCCS will prioritize focus on meaningful measures that align with high priority agency initiatives. Beginning with its CYE 2021 contract amendments, AHCCCS transitioned from its use of internally established Minimum Performance Standards (MPS) to the use of national benchmark data (i.e., CMS Medicaid Median and NCQA HEDIS® Medicaid Mean). In addition, AHCCCS also intends to utilize Line of Business specific historical performance data to evaluate MCO, Line of Business, and agency performance.

AHCCCS Performance Measure tables are included below. Performance measure rates are reflective of CMS Child and Adult Core methodologies, except where otherwise indicated. The tables include the relative percent of change and statistical significance of the rate change from the current

reporting year compared to the previous year, where possible. Rates are reported for the CYE 2018 measurement period (October 1, 2017 to September 30, 2018)* by the following lines of business:

1. Arizona Acute Care Program, AHCCCS Complete Care (ACC),
2. Arizona CHIP Program (KidsCare),
3. Comprehensive Medical Dental Program (CMDP),
4. Children's Rehabilitation Services (CRS),
5. Arizona Long Term Care System/Elderly Physically Disabled (ALTCS E/PD),
6. Arizona Long Term Care System/Division of Developmental Disabilities (ALTCS DD),
7. Serious Mentally Ill (SMI), and
8. General Mental Health/Substance Use (GMH/SU).

**CYE 2019 Performance Measure rates anticipated to be available in June 2021*

Acute Care

Historically, AHCCCS Acute Care contractors provided physical health services to members enrolled in Arizona's Medicaid program. However, beginning October 1, 2018, AHCCCS implemented ACC, a delivery system reform that provides physical and behavioral health services through a single integrated health plan.

	CYE 2018 Rates	CYE 2017 Rates	Relative Percent Change	Statistical Significance	FFY 2019 CMS Median	2018 Medicaid Mean	CYE 2018 MPS
Acute Care Performance Measures							
Adolescent Well-care Visits	40.6%	39.2%	3.6%	**P<.001**	50.6%	n/a	41%
Adults Access to Preventive/ Ambulatory Health Services	76.2%	75.6%	0.8%	**P<.001**	n/a	n/a	75%
Ambulatory Care: ED Visits (Total HEDIS)	54.8	53.4	2.6%	n/a	n/a	n/a	55
Annual Dental Visits (HEDIS®)	61.1%	60.8%	0.5%	**P=.002**	n/a	55.9%	60%
Annual Monitoring for Patients on Persistent Medications (Total)	87.6%	87.8%	-0.2%	P=.430	87.4%	n/a	n/a
Asthma in Younger Adults Admissions[1]	7.1	7	1.4%	n/a	6.1	n/a	n/a
Asthma Medication Ratio: 19-64 Years (Total)	50.2%	n/a	n/a	n/a	57.0%	n/a	n/a
Asthma Medication Ratio: 5-18 Years (Total)	67.1%	n/a	n/a	n/a	69.4%	n/a	n/a
Breast Cancer Screening	54.9%	54.4%	0.9%	**P=.035**	53.4%	n/a	50%
Cervical Cancer Screening	50.8%	50.5%	0.6%	**P=.025**	55.1%	n/a	64%
Children's and Adolescents' Access to PCPs, 12 – 19 Years	86.1%	86.4%	-0.3%	**P=.003**	90.3%	n/a	82%
Children's and Adolescents' Access to PCPs, 12 – 24 Months	94.8%	93.1%	1.8%	**P<.001**	95.5%	n/a	93%
Children's and Adolescents' Access to PCPs, 25 Months – 6 Years	84.2%	82.9%	1.6%	**P<.001**	87.7%	n/a	84%

Children's and Adolescents' Access to PCPs, 7 – 11 Years	88.4%	89.0%	-0.7%	**P<.001**	91.1%	n/a	83%
Chlamydia Screening in Women (Child and Adult Combined)	49.4%	48.3%	2.3%	**P<.001**	n/a	58.1%	63%
Concurrent Use of Opioids and Benzodiazepines (Total) Cross LOB	12.0%	15.1%	-20.5%	**P<.001**	n/a	n/a	n/a
Contraceptive Care – Postpartum Women LARC within 3 Days of Delivery Ages 15-20	1.1%	0.6%	83.3%	**P=.021**	2.0%	n/a	n/a
Contraceptive Care – Postpartum Women LARC within 3 Days of Delivery Ages 21-44	0.5%	0.2%	150.0%	**P<.001**	1.6%	n/a	n/a
Contraceptive Care – Postpartum Women LARC within 60 Days of Delivery Ages 15-20	11.4%	10.7%	6.5%	P=.354	15.8%	n/a	n/a
Contraceptive Care – Postpartum Women LARC within 60 Days of Delivery Ages 21-44	9.3%	9.0%	3.3%	P=.293	12.6%	n/a	n/a
Contraceptive Care – Postpartum Women Most or Moderately Effective FDA-Approved within 3 Days of Delivery Ages 15-20	1.7%	1.1%	54.5%	P=.064	4.1%	n/a	n/a
Contraceptive Care – Postpartum Women Most or Moderately Effective FDA-Approved within 3 Days of Delivery Ages 21-44	7.3%	7.6%	-3.9%	P=.143	11.3%	n/a	n/a
Contraceptive Care – Postpartum Women Most or Moderately Effective FDA-Approved within 60 Days of Delivery Ages 15-20	28.6%	31.4%	-8.9%	**P=.013**	41.8%	n/a	n/a
Contraceptive Care – Postpartum Women Most or Moderately Effective FDA-Approved within 60 Days of Delivery Ages 21-44	30.5%	33.4%	-8.7%	**P<.001**	40.2%	n/a	n/a
COPD or Asthma in Older Adults Admissions[1]	43.8	49.5	-11.5%	n/a	71.9	n/a	n/a
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	22.7%	23.8%	-4.6%	**P<.001**	22.7%	n/a	Baseline Year
Developmental Screening in the First Three Years of Life (Total)	29.9%	26.2%	14.1%	**P<.001**	32.7%	n/a	55%
Diabetes Short-Term Complications Admissions[1]	13	12.7	2.4%	n/a	19.1	n/a	n/a
Heart Failure Admissions[1]	29.6	23.6	25.4%	n/a	26.4	n/a	n/a
Inpatient Utilization: Total Days per 1,000 MM (HEDIS®)	32.8	26.5	24.0%	n/a	n/a	n/a	33
Metabolic Monitoring for Children and Adolescents on Antipsychotics (Total) Cross LOB	44.0%	43.9%	0.2%	P=.933	n/a	35.3%	n/a
Plan All-Cause Readmissions: Total[2]	14.4%	12.0%	n/a	n/a	n/a	n/a	11%

Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Total) Cross LOB	0.6%	0.8%	-25.0%	P=.246	2.6%	n/a	n/a
Use of Opioids at High Dosage in Persons Without Cancer (Total)	12.4%	51.7	n/a	n/a	6.4%	n/a	Baseline Year
Use of Opioids from Multiple Providers - Multiple Pharmacies	9.1%	111.7	n/a	n/a	n/a	8.3%	Baseline Year
Use of Opioids from Multiple Providers - Multiple Prescribers	31.2%	350.1	n/a	n/a	n/a	23.2%	Baseline Year
Use of Opioids from Multiple Providers - Multiple Prescribers and Multiple Pharmacies	5.6%	77.3	n/a	n/a	n/a	4.8%	Baseline Year
Well-child Visits in the First 15 Months of Life	61.5%	59.5%	3.4%	**P<.001**	64.0%	n/a	65%
Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life	61.4%	60.7%	1.2%	**P<.001**	69.0%	n/a	66%

Significance levels (p values) noted in the table demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.

n/a = Rate, relative percent of change, statistical significance, or minimum performance standard was not measured, not applicable, or not appropriate for the specific reporting period.

While the relative percent of change and statistical significance are provided, trending across years should be considered with caution or a break in trending recommended, in alignment with measure steward recommendations.

Medicaid Mean included for measures calculated using NCQA HEDIS® methodology; whereas CMS Median included for measures calculated using CMS Core (Adult and/or Child) Measure methodology.

[1] *CYE 2017 PQI rates have been updated as a result of a data issue identified within the previous year reporting.*

[2] *Due to changes in the calculation methodology used for this measure in CYE 2018, comparison to the MPS was not made and statistical significance testing not included.*

Acute Care Performance Summary

The Acute Care program demonstrated strength when compared to the Minimum Performance Standard (MPS) and demonstrated a statistically significant improvement from the previous year's performance for the following CYE 2018 performance measures:

- Adults Access to Preventive/Ambulatory Health Services,
- Annual Dental Visits (HEDIS®),
- Breast Cancer Screening,
- Cervical Cancer Screening,
- Children's and Adolescents' Access to PCPs, 12 – 24 Months, and
- Children's and Adolescents' Access to PCPs, 25 Months – 6 Years.

Acute Care program demonstrated a statistically significant improvement from the previous year's performance in the following CYE 2018 performance measures:

- Adolescent Well-care Visits,
- Chlamydia Screening in Women (Child and Adult Combined),

- Developmental Screening in the First Three Years of Life (Total),
- Well-child Visits in the First 15 Months of Life, and
- Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life.

Additionally, when compared to the FFY 2019 CMS Median, the Acute Care program demonstrated strength in the following measures:

- Breast Cancer Screening,
- Dental Sealants for 6-9-Year-Old Children at Elevated Caries Risk,
- Inpatient Hospital Admissions for Diabetes Short-Term Complications,
- Inpatient Hospital Admissions for Chronic Obstructive Pulmonary Disease (COPD) or Asthma,
- Metabolic Monitoring for Children and Adolescents on Antipsychotics - (Total), and
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents - (Total) Cross LOB.

AHCCCS identified an opportunity for improvement in well-child, adolescent well-care, and dental visit rates for contractors providing care and services to children. As such, AHCCCS implemented a "Back to Basics" Performance Improvement Project (PIP) in CYE 2019 aimed at improving the overall well-being of children and adolescents. This PIP focuses on improving the rates of Well-Child Visits in the First 15 Months of Life (W15); Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34); Adolescent Well-Care Visits (AWC); and Annual Dental Visits (ADV). Increasing the rates for these measures impacts other measures and focus areas, including, but not limited to, childhood and adolescent immunizations, dental sealants for children at elevated caries risk, and developmental screenings. Additionally, AHCCCS required individual contractors to implement Corrective Action Plans (CAPs) for measures not meeting the MPS to promote improvement in performance measure rates.

- Acute Care contractors have focused efforts on improving performance measure rates for the Cervical Cancer Screening and Chlamydia Screening in Women. Contractors have implemented interventions such as:
- Providing gaps-in-care reports to providers that identify members who are in need of preventive screenings,
- Assisting providers with streamlining workflows, as well as identifying and overcoming barriers/challenges,
- Enhancing member and provider outreach related to the importance of preventive screenings, including offering three-way calls for appointment scheduling,
- Offering member incentives for the completion of cervical cancer and chlamydia screenings,
- Creating automated reminder programs to outreach members via phone call or text message, and
- Improving member focused education to diminish misconceptions and promote the benefits of preventive screenings.

KidsCare

In 2016, the enrollment freeze on the Arizona CHIP program (KidsCare) ended, allowing children up to age 19 to be enrolled in the KidsCare program. The table below includes performance measure data for CYE 2018.

	CYE 2018 Rates	CYE 2017 Rates	Relative Percent Change	Statistical Significance	FFY 2019 CMS Median	2018 Medicaid Mean	CYE 2018 MPS
KidsCare Performance Measure Rates							
Adolescent Well-care Visits	59.3%	61.1%	-2.9%	P=.269	50.6%	n/a	41%
Annual Dental Visits (HEDIS®)	74.1%	74.3%	-0.3%	P=.847	N/A	55.9%	60%
Children's and Adolescents' Access to PCPs, 12 – 19 Years	95.4%	95.1%	0.3%	P=.851	90.3%	n/a	82%
Children's and Adolescents' Access to PCPs, 12 – 24 Months	98.6%	97.4%	1.2%	P=.610	95.5%	n/a	93%
Children's and Adolescents' Access to PCPs, 25 Months – 6 Years	93.1%	92.3%	0.9%	P=.499	87.7%	n/a	84%
Children's and Adolescents' Access to PCPs, 7 – 11 Years	95.7%	100.0%	-4.3%	P=.388	91.1%	n/a	83%
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	28.0%	n/a	n/a	n/a	22.7%	n/a	Baseline Year
Developmental Screening in the First Three Years of Life (Total)	34.2%	39.1%	-12.5%	P=.502	32.7%	n/a	55%
Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life	75.7%	75.8%	-0.1%	P=.977	69.0%	n/a	66%

Significance levels (p values) noted in the table demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.

n/a = Rate, relative percent of change, statistical significance, or minimum performance standard was not measured or applicable for the specific reporting period.

While the relative percent of change and statistical significance are provided, trending across years should be considered with caution or a break in trending recommended, in alignment with measure steward recommendations.

Medicaid Mean included for measures calculated using NCQA HEDIS® methodology; whereas CMS Median included for measures calculated using CMS Core (Adult and/or Child) Measure methodology.

KidsCare Performance Summary

The KidsCare aggregate rates demonstrated overall strength in CYE 2018, as all performance measure rates exceeded the established Minimum Performance Standard (MPS) and associated 2018 NCQA Medicaid Mean.

The KidsCare population is included within the Back-to-Basics Performance Improvement Project (PIP) that is aimed at improving the rates of Well-Child Visits in the First 15 Months of Life (W15); Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34); Adolescent Well-Care Visits (AWC); and Annual Dental Visits (ADV). As with the Acute Care (ACC) children, AHCCCS required individual contractors to implement Corrective Action Plans (CAPs) for measures not meeting the MPS to promote improvement in performance measure rates.

Comprehensive Medical and Dental Program

Arizona children involved in the foster care system receive physical health care and services through the CMDP and receive their behavioral health care through the Regional Behavioral Health Authorities (RBHAs). Beginning in CYE 2021, it is anticipated that children in foster care will receive care and services through an integrated delivery model under CMDP.

	CYE 2018 Rates	CYE 2017 Rates	Relative Percent Change	Statistical Significance	CYE 2018 MPS
CMDP Performance Measure Rates					
Adolescent Well-care Visits	72.4%	72.3%	0.1%	P=.954	41%
Ambulatory Care: ED Visits (Total HEDIS)	43.1	n/a	n/a	n/a	43
Annual Dental Visits (HEDIS®)	75.4%	73.8%	2.2%	**P=.034**	60%
Asthma Medication Ratio: 5-18 Years (Total)	76.6%	n/a	n/a	n/a	n/a
Children's and Adolescents' Access to PCPs, 12 – 19 Years	96.4%	97.1%	-0.7%	P=.337	82%
Children's and Adolescents' Access to PCPs, 12 – 24 Months	97.7%	97.9%	-0.2%	P=.804	93%
Children's and Adolescents' Access to PCPs, 25 Months – 6 Years	92.9%	91.8%	1.2%	P=.196	84%
Children's and Adolescents' Access to PCPs, 7 – 11 Years	96.2%	96.8%	-0.6%	P=.447	83%
Chlamydia Screening in Women (Child and Adult Combined)	54.6%	54.6%	0.0%	P=.994	n/a
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	27.1%	27.1%	0.0%	P=.952	Baseline Year
Developmental Screening in the First Three Years of Life (Total)	37.7%	34.4%	9.6%	**P=.032**	55%
Inpatient Utilization: Total Days per 1,000 MM (HEDIS®)	15.1	12.5	20.8%	n/a	23
Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life	72.6%	74.5%	-2.6%	P=.197	66%
30 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined)	84.0%	82.8%	1.4%	P=.599	95%

7 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined)	66.5%	63.4%	4.9%	P=.314	85%
Follow-Up Care for Children Prescribed ADHD Medication (Continuation and Maintenance Phase) Cross LOB	92.4%	n/a	n/a	n/a	n/a
Follow-Up Care for Children Prescribed ADHD Medication (Initiation Phase) Cross LOB	90.2%	n/a	n/a	n/a	n/a
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of AOD (Total)	15.1%	23.1%	-34.6%	P=.067	n/a
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of AOD (Total)	55.1%	56.6%	-2.7%	P=.785	n/a
Mental Health Utilization - Any Service (Total)	64.1%	51.9%	23.3%	**P<.001**	Baseline Year
Metabolic Monitoring for Children and Adolescents on Antipsychotics	61.2%	58.8%	4.1%	P=.368	n/a
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total) Cross LOB[1]	90.3%	86.6%	n/a	n/a	n/a
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	0.3%	0.5%	-40.0%	P=.470	n/a

Significance levels (p values) noted in the table demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.

n/a = Rate, relative percent of change, statistical significance, or minimum performance standard was not measured, not applicable, or not appropriate for the specific reporting period.

While the relative percent of change and statistical significance are provided, trending across years should be considered with caution or a break in trending recommended, in alignment with measure steward recommendations.

[1] CYE 2018 rate was calculated using a different methodology than in CYE 2017; as such, statistical significance testing was not included.

Comprehensive Medical and Dental Program Performance Summary

CMDP demonstrated strength in all CYE 2018 performance measures. CMDP also demonstrated strength when compared to the Acute Care performance for all measures, as all performance measure rates were at or above the Acute Care aggregate (GMH/SU aggregate, when applicable). CMDP was not required to implement a Corrective Action Plan (CAP) as all CYE 2018 performance measures were above the Minimum Performance Standard (MPS). Of note, the following performance measure rate demonstrated significant improvements from CYE 2017 to CYE 2018:

- Annual Dental Visits
- Developmental Screening in the First Three Years of Life (Total)

The CMDP population is included in the Back-to-Basics Performance Improvement Project (PIP) that is aimed at improving the rates of Well-Child Visits in the First 15 Months of Life (W15); Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34); Adolescent Well-Care Visits (AWC); and Annual Dental Visits (ADV).

Children's Rehabilitative Services

In October 2013, children enrolled in the Acute Care program who had a CRS qualifying diagnosis were enrolled into one integrated CRS contractor. Beginning October 1, 2018, the CRS program was integrated into the ACC program and CRS-eligible members now receive integrated care and services through an ACC contractor.

	CYE 2018 Rates	CYE 2017 Rates	Relative Percent Change	Statistical Significance	CYE 2018 MPS
CRS Performance Measure Rates					
Adolescent Well-care Visits	48.1%	48.9%	-1.6%	P=.409	41%
Ambulatory Care: ED Visits Total (HEDIS®)	55.2	55.4	-0.4%	n/a	43
Annual Dental Visits (HEDIS®)	67.7%	67.4%	0.4%	P=.606	60%
Asthma Medication Ratio: 19-64 Years (Total)	61.8%	n/a	n/a	n/a	n/a
Asthma Medication Ratio: 5-18 Years (Total)	68.7%	n/a	n/a	n/a	n/a
Children's and Adolescents' Access to PCPs, 12 – 19 Years	95.1%	95.1%	0.0%	P=.912	82%
Children's and Adolescents' Access to PCPs, 12 – 24 Months	99.1%	96.9%	2.3%	**P=.042**	93%
Children's and Adolescents' Access to PCPs, 25 Months – 6 Years	92.2%	92.7%	-0.5%	P=.422	84%
Children's and Adolescents' Access to PCPs, 7 – 11 Years	95.8%	95.8%	0.0%	P=.981	83%
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	22.1%	23.1%	-4.3%	P=.446	Baseline Year
Developmental Screening in the First Three Years of Life (Total)	37.3%	33.1%	12.7%	**P=.024**	55%
Inpatient Utilization: Total Days per 1,000 MM (HEDIS®)	88.4	78.5	12.6%	n/a	51
Mental Health Utilization - Any Service (Total)	12.9%	12.4%	4.0%	P=.256	Baseline Year
Plan All-Cause Readmissions: Total	22.2%	n/a	n/a	n/a	Baseline Year
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	0.7%	0.7%	0.0%	P=1.000	n/a

Use of Opioids at High Dosage in Persons Without Cancer (Total)	10.0%	n/a	n/a	n/a	Baseline Year
Use of Opioids from Multiple Providers - Multiple Pharmacies	15.4%	n/a	n/a	n/a	Baseline Year
Use of Opioids from Multiple Providers - Multiple Prescribers	43.6%	n/a	n/a	n/a	Baseline Year
Use of Opioids from Multiple Providers - Multiple Prescribers and Multiple Pharmacies	5.1%	n/a	n/a	n/a	Baseline Year
Well-child Visits in the First 15 Months of Life	47.3%	49.2%	-3.9%	P=.690	65%
Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life	63.8%	65.8%	-3.0%	P=.137	66%

Significance levels (p values) noted in the table demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.

n/a = Rate, relative percent of change, statistical significance, or minimum performance standard was not measured, not applicable, or not appropriate for the specific reporting period.

While the relative percent of change and statistical significance are provided, trending across years should be considered with caution or a break in trending recommended, in alignment with measure steward recommendations.

Due to program close out and integration of this population into AHCCCS Complete Care (ACC), the following measure rates are not available for CYE 2018 nor included within the above table: Follow-Up After Hospitalization for Mental Illness, Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics, and Metabolic Monitoring for Children and Adolescents Prescribed Antipsychotics.

The CRS program demonstrated strength when compared to the Minimum Performance Standard (MPS) in the following CYE 2018 performance measure:

- Children and Adolescents' Access to Primary Care Practitioners (with statistically significant improvement in performance noted for members 12-24 months),
- Adolescent Well-Care Visits, and
- Annual Dental Visits.

The CRS program demonstrated a statistically significant improvement from the previous year's performance for the following CYE 2018 performance measure:

- Developmental Screening in the First Three Years of Life (Total).

Because the CRS program was integrated into ACC beginning October 1, 2018, the CRS population was not included as part of the Back-to-Basics Performance Improvement Project (PIP). However, AHCCCS has enhanced its requirements for the ACC contractors' subpopulation analysis. As part of this subpopulation analysis, ACC contractors will be required to monitor the care and services received by members and identify any disparities. AHCCCS reserves the right to require contractors to implement Corrective Action Plans (CAPs) for any noted disparities or gaps in care.

Arizona Long Term Care System (Elderly/Physically Disabled)

The ALTCS E/PD program delivers long-term, acute, behavioral health, and case management services to eligible members who are elderly and/or who have physical disabilities.

	CYE 2018 Rates	CYE 2017 Rates	Relative Percent Change	Statistical Significance	CYE 2018 MPS
ALTCS E/PD Performance Measure Rates					
30 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined)	52.4%	51.0%	2.7%	P=.810	95%
7 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined)	34.6%	30.3%	14.2%	P=.415	85%
Adults Access to Preventive/ Ambulatory Health Services	91.8%	91.8%	0.0%	P=.807	75%
Ambulatory Care: ED Visits (HEDIS®)	69.9	66.7	4.7%	n/a	80
Annual Monitoring for Patients on Persistent Medications (Total)	91.7%	90.8%	1.0%	P=.373	75%
Breast Cancer Screening	34.0%	34.0%	0.0%	P=.983	n/a
Concurrent Use of Opioids and Benzodiazepines (Total)	27.6%	32.1%	-14.0%	**P=.015**	n/a
COPD or Asthma in Older Adults Admissions[1]	95.2	147.3	-35.4%	n/a	n/a
Diabetes Short-Term Complications Admissions[1]	10.9	11.3	-3.5%	n/a	15
Heart Failure Admissions[1]	175.1	157.4	11.2%	n/a	n/a
Inpatient Utilization: Total Days per 1,000 MM (HEDIS®)	284.4	194.4	46.3%	n/a	95
Mental Health Utilization - Any Service (Total)	22.9%	19.6%	16.8%	**P<.001**	n/a
Plan All-Cause Readmissions: Total[2]	18.7%	15.9%	n/a	n/a	17%
Use of Opioids at High Dosage in Persons Without Cancer (Total)	21.3%	85.6	n/a	n/a	Baseline Year
Use of Opioids from Multiple Providers - Multiple Pharmacies	4.7%	72.5	n/a	n/a	Baseline Year
Use of Opioids from Multiple Providers - Multiple Prescribers	31.6%	348.3	n/a	n/a	Baseline Year
Use of Opioids from Multiple Providers - Multiple Prescribers and Multiple Pharmacies	3.4%	54.7	n/a	n/a	Baseline Year

Significance levels (p values) noted in the table demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.

n/a = Rate, relative percent of change, statistical significance, or minimum performance standard was not measured, not applicable, or not appropriate for the specific reporting period.

While the relative percent of change and statistical significance are provided, trending across years should be considered with caution or a break in trending recommended, in alignment with measure steward recommendations.

[1] CYE 2017 PQI rates have been updated as a result of a data issue identified within the previous year reporting.

[2] Due to changes in the calculation methodology used for this measure in CYE 2018, comparison to the MPS was not made and statistical significance testing not included.

Arizona Long Term Care System (Elderly/Physically Disabled) Performance Summary

The ALTCS E/PD program demonstrated strength when compared to the Minimum Performance Standard in the following CYE 2018 performance measures:

- Adults Access to Preventive/Ambulatory Health Services;
- Ambulatory Care (per 1,000 Member Months) – ED Visits (Total); and
- Annual Monitoring for Patients on Persistent Medications (Total).

The ALTCS E/PD program demonstrated a statistically significant improvement from the previous year's performance for the following CYE 2018 performance measure:

Concurrent Use of Opioids and Benzodiazepines (Total).

While not statistically significant, an increase in performance from the previous year's reporting was noted for the "Follow-Up After Hospitalization for Mental Illness (7 Day and 30 Day)" measures**.** ALTCS E/PD contractors have focused efforts on improving these rates through the implementation of Corrective Action Plans (CAPs). Contractors have implemented interventions such as:

- Increasing care coordination,
- Assisting members in scheduling follow-up appointments,
- Implementing a health app which assists members who have health related questions, offers appointment reminders, and connects members with assistance should a need arise prior to a scheduled appointment,
- Enhancing education and outreach to members and providers detailing the importance of follow-up visits, and
- Implementing a self-selected Performance Improvement Project (PIP) focused on improving performance measure rates for Follow-Up After Hospitalization for Mental Illness (7 Day and 30 Day).

AHCCCS identified an opportunity for improvement in the Breast Cancer Screening performance measure rates. As such, AHCCCS has implemented a Breast Cancer Screening Performance Improvement Project for the ALTCS E/PD program aimed at improving the rates of breast cancer screening in women.

Arizona Long Term Care System (Division of Developmental Disabilities)

The ALTCS/DDD program delivers long-term, acute, and case management services to eligible members with developmental disabilities (DD). ALTCS/DDD members have historically received their acute care services through DDD-subcontracted health plans and their behavioral health care through the Regional Behavioral Health Authorities (RBHAs). As of October 1, 2019, DDD members receive integrated care and services through DDD-subcontracted health plans which are responsible for physical and behavioral health care. DDD has maintained responsibility for case management, Home and Community Based Services (HCBS), and therapy services for members under the age of 21.

	CYE 2018 Rates	CYE 2017 Rates	Relative Percent Change	Statistical Significance	CYE 2018 MPS
ALTCS DD Performance Measure Rates					
Adolescent Well-care Visits	45.8%	43.4%	5.5%	**P=.001**	41%
Adults Access to Preventive/ Ambulatory Health Services	87.3%	85.8%	1.7%	**P<.001**	75%
Ambulatory Care: ED Visits (HEDIS®)	44.0	39.1	12.6%	N/A	43
Annual Dental Visits (HEDIS®)	56.9%	56.5%	0.7%	P=.444	60%
Annual Monitoring for Patients on Persistent Medications (Total)	76.7%	80.9%	-5.2%	P=.136	75%
Asthma in Younger Adults Admissions[1]	1.5	1.6	-6.30%	n/a	n/a
Asthma Medication Ratio: 19-64 Years (Total)	75.4%	n/a	n/a	n/a	n/a
Asthma Medication Ratio: 5-18 Years (Total)	77.0%	n/a	n/a	n/a	n/a
Breast Cancer Screening	45.1%	45.9%	-1.7%	P=.698	50%
Cervical Cancer Screening	16.3%	16.6%	-1.8%	P=.711	64%
Children's and Adolescents' Access to PCPs, 12 – 19 Years	89.8%	89.6%	0.2%	P=.677	82%
Children's and Adolescents' Access to PCPs, 12 – 24 Months	100.0%	96.2%	4.0%	P=.238	93%
Children's and Adolescents' Access to PCPs, 25 Months – 6 Years	87.4%	89.2%	-2.0%	**P=.030**	84%
Children's and Adolescents' Access to PCPs, 7 – 11 Years	92.2%	92.1%	0.1%	P=.918	83%
Chlamydia Screening in Women (Child and Adult Combined)	12.1%	10.5%	15.2%	P=.311	63%
COPD or Asthma in Older Adults Admissions[1]	11.1	26.5	-58.1%	n/a	n/a
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	15.30%	18.0%	-15.0%	**P=.036**	Baseline Year
Developmental Screening in the First Three Years of Life (Total)	25.1%	20.4%	23.0%	P=.142	5%
Diabetes Short-Term Complications Admissions[1]	3.8	4.0	-5.0%	n/a	n/a
Heart Failure Admissions[1]	5.4	5.1	5.9%	n/a	n/a
Inpatient Utilization: Total Days per 1,000 MM (HEDIS®)	61.5	43.4	41.7%	n/a	51
Plan All-Cause Readmissions: Total[2]	13.1%	11.3%	n/a	n/a	11%
Use of Opioids at High Dosage in Persons Without Cancer (Total)	8.9%	7.8	n/a	n/a	Baseline Year
Use of Opioids from Multiple Providers - Multiple Pharmacies	4.4%	36.8	n/a	n/a	Baseline Year
Use of Opioids from Multiple Providers - Multiple Prescribers	20.2%	198.5	n/a	n/a	Baseline Year
Use of Opioids from Multiple Providers - Multiple Prescribers and Multiple Pharmacies	2.6%	7.4	n/a	n/a	Baseline Year
Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life	55.2%	53.4%	3.4%	P=.154	66%

	CYE 2018 Rates	CYE 2017 Rates	Relative Percent Change	Statistical Significance	CYE 2018 MPS
ALTCS DD GMH/SU Performance Measure Rates					
30 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined)	92.7%	91.3%	1.5%	P=.467	n/a
7 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined)	73.5%	73.9%	-0.5%	P=.899	n/a
Antidepressant Medication Management - Effective Acute Phase Treatment (Total) Cross LOB	44.7%	n/a	n/a	n/a	n/a
Antidepressant Medication Management - Effective Continuation Phase Treatment (Total) Cross LOB	34.2%	n/a	n/a	n/a	n/a
Concurrent Use of Opioids and Benzodiazepines (Total) Cross LOB	17.00%	16.1%	5.6%	P=.858	n/a
Follow-Up Care for Children Prescribed ADHD Medication (Continuation and Maintenance Phase) Cross LOB	47.9%	n/a	n/a	n/a	n/a
Follow-Up Care for Children Prescribed ADHD Medication (Initiation Phase) Cross LOB	51.4%	n/a	n/a	n/a	n/a
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of AOD (Total)	11.4%	10.5%	8.6%	P=1.000	n/a
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of AOD (Total)	45.5%	44.7%	1.8%	P=.948	n/a
Mental Health Utilization - Any Service (Total)	34.9%	33.8%	3.3%	**P=.031**	Baseline Year
Metabolic Monitoring for Children and Adolescents on Antipsychotics Cross LOB	34.0%	36.9%	-7.9%	P=.123	n/a
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total) Cross LOB[3]	25.3%	27.2%	n/a	n/a	n/a
Use of Multiple Concurrent Antipsychotics in Children and Adolescents Cross LOB	2.4%	2.6%	-7.7%	P=.731	n/a

Significance levels (p values) noted in the table demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.

n/a = Rate, relative percent of change, statistical significance, or minimum performance standard was not measured, not applicable, or not appropriate for the specific reporting period.

While the relative percent of change and statistical significance are provided, trending across years should be considered with caution or a break in trending recommended, in alignment with measure steward recommendations

[1] CYE 2017 PQI rates have been updated as a result of a data issue identified within the previous year reporting

[2] Due to changes in the calculation methodology used for this measure in CYE 2018, comparison to the MPS was not made and statistical significance testing not included.

[3] CYE 2018 rate was calculated using a different methodology than in CYE 2017; as such, statistical significance testing was not included.

Arizona Long Term Care System (Division of Developmental Disabilities) Performance Summary

The ALTCS/DDD program demonstrated strength when compared to the Minimum Performance Standard (MPS) in the following CYE 2018 performance measures:

- Adolescent Well-Care Visits (statistically significant improvement noted when compared to previous year performance);
- Adults Access to Preventive/Ambulatory Health Services (statistically significant improvement noted when compared to previous year performance); and
- Children and Adolescents' Access to Primary Care Practitioners (All Age Ranges).

The ALTCS/DDD program also demonstrated strength in the following CYE 2018 performance measures when compared to GMH/SU aggregate performance:

- 7 Day Follow-Up After Hospitalization for Mental Illness, and
- 30 Day Follow-Up After Hospitalization for Mental Illness.

Additionally, the ALTCS/DDD program demonstrated improvement in the rates when compared to CYE 2017 performance for the following measures:

- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, and
- Annual Dental Visits performance measures.

AHCCCS identified an opportunity for improvement in well-child and dental visit rates for contractors providing care and services to children. As such, The ALTCS DD population is included within the Back-to-Basics Performance Improvement Project (PIP) that is aimed at improving the rates of Well-Child Visits in the First 15 Months of Life (W15); Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34); Adolescent Well-Care Visits (AWC); and Annual Dental Visits (ADV). As with other lines of business, increasing the rates for these measures also impacts other measures and focus areas, including, but not limited to childhood and adolescent immunizations, dental sealants for children at elevated caries risk, and developmental screenings.

General Mental Health/Substance Use

General Mental Health/Substance Use (GMH/SU) members received behavioral health care through the Regional Behavioral Health Authorities (RBHAs) until September 30, 2018. As of October 1, 2018, GMH/SU members (not enrolled in CMDP or ALTCS/DDD) receive integrated services through ACC contractors.

	CYE 2018 Rates	CYE 2017 Rates	Relative Percent Change	Statistical Significance	FFY 2019 CMS Median	2018 Medicaid Mean	CYE 2018 MPS
GMH/SU Performance Measure Rates							
30 Day Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (Total)	27.8%	31.4%	-11.5%	**P=.033**	21.7%	n/a	Baseline Year
30 Day Follow-Up After ED Visit for Mental Illness (Total)	58.5%	51.6%	13.4%	**P=.035**	52.1%	n/a	Baseline Year
30 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined)	67.1%	67.2%	-0.1%	P=.971	N/A	56.8%	95%
7 Day Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (Total)	20.5%	24.2%	-15.3%	**P=.017**	13.9%	n/a	Baseline Year
7 Day Follow-Up After ED Visit for Mental Illness (Total)	47.4%	41.3%	14.8%	P=.062	38.4%	n/a	Baseline Year
7 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined)	49.4%	48.1%	2.7%	**P=.034**	N/A	35.8%	85%
Antidepressant Medication Management - Effective Acute Phase Treatment (Total) Cross LOB	41.9%	n/a	n/a	n/a	51.3%	n/a	n/a
Antidepressant Medication Management - Effective Continuation Phase Treatment (Total) Cross LOB	22.8%	n/a	n/a	n/a	34.4%	n/a	n/a
Concurrent Use of Opioids and Benzodiazepines (Total) Cross LOB	12.0%	15.1%	-20.5%	**P<.001**	n/a	n/a	n/a
Follow-Up Care for Children Prescribed ADHD Medication (Continuation and Maintenance Phase) Cross LOB	68.1%	n/a	n/a	n/a	58.6%	n/a	n/a
Follow-Up Care for Children Prescribed ADHD Medication (Initiation Phase) Cross LOB	59.8%	n/a	n/a	n/a	48.6%	n/a	n/a
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of AOD (Total)	28.3%	26.9%	5.2%	**P=.001**	11.2%	n/a	n/a
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of AOD (Total)	60.4%	58.7%	2.9%	**P=.001**	39.9%	n/a	n/a
Mental Health Utilization - Any Service (Total)	11.3%	9.8%	15.3%	**P<.001**	n/a	n/a	Baseline Year
Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS®) Cross LOB	42.4%	42.7%	-0.7%	P=.704	N/A	35.3%	n/a
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics Cross LOB[1]	71.3%	68.5%	n/a	n/a	62.8%	n/a	n/a
Use of Multiple Concurrent Antipsychotics in Children and Adolescents Cross LOB	0.9%	1.1%	-18.2%	P=.318	2.6%	n/a	Baseline Year

Significance levels (p values) noted in the table demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.

n/a = Rate, relative percent of change, statistical significance, or minimum performance standard was not measured, not applicable, not appropriate for the specific reporting period.

While the relative percent of change and statistical significance are provided, trending across years should be considered with caution or a break in trending recommended, in alignment with measure steward recommendations.

Medicaid Mean included for measures calculated using NCQA HEDIS® methodology; whereas CMS Median included for measures calculated using CMS Core (Adult and/or Child) Measure methodology.

[1] CYE 2018 rate was calculated using a different methodology than in CYE 2017; as such, statistical significance testing not included.

General Mental Health/Substance Use Performance Summary

The GMH/SU program demonstrated strength when compared to the Minimum Performance Standard (MPS) and demonstrated a statistically significant improvement from the previous year's performance for the CYE 2018 performance measure 7 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined).

The GMH/SU program demonstrated a statistically significant improvement from the previous year's performance for the CYE 2018 performance measure Concurrent Use of Opioids and Benzodiazepines (Total) Cross LOB

The GMH/SU program demonstrated strength when compared to the 2018 NCQA HEDIS® Medicaid Mean in the following CYE 2018 performance measures:

- 30 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined),
- 7 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined), and
- Metabolic Monitoring for Children and Adolescents on Antipsychotics.

Additionally, the GMH/SU program demonstrated strength when compared to the FFY 2019 CMS Median for the following CYE 2018 performance measures:

- 30 Day Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (Total),
- 30 Day Follow-Up After ED Visit for Mental Illness (Total) (statistically significant improvement noted when compared to previous year performance),
- 7 Day Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (Total),
- 7 Day Follow-Up After ED Visit for Mental Illness (Total),
- Follow-Up Care for Children Prescribed ADHD Medication (Continuation and Maintenance Phase) Cross LOB,
- Follow-Up Care for Children Prescribed ADHD Medication (Initiation Phase) Cross LOB,

- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of AOD (Total) (statistically significant improvement noted when compared to previous year performance),
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of AOD (Total) (statistically significant improvement noted when compared to previous year performance),
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (statistically significant improvement noted when compared to previous year performance), and
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents.

With the integration of the GMH/SU program into ACC as of October 1, 2018, AHCCCS enhanced its requirements for the ACC contractors' subpopulation analysis. As part of this subpopulation analysis, ACC contractors are required to monitor the care and services received by the GMH/SU population and identify any disparities. AHCCCS reserves the right to require contractors to implement Corrective Action Plans (CAPs) for any noted disparities or gaps in care.

Members Determined to have a Serious Mental Illness

Members determined to have a SMI receive integrated physical and behavioral health services through the RBHAs.

	CYE 2018 Rates	CYE 2017 Rates	Relative Percent Change	Statistical Significance	CYE 2018 MPS
SMI Performance Measures					
30 Day Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence	28.7%	27.1%	5.9%	P=.381	n/a
30 Day Follow-Up After ED Visit for Mental Illness	77.8%	79.9%	-2.6%	P=.166	n/a
30 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined)	85.6%	87.7%	-2.4%	**P<.001**	95%
7 Day Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence	20.8%	19.9%	4.5%	P=.609	n/a
7 Day Follow-Up After ED Visit for Mental Illness	61.1%	63.1%	-3.2%	P=.263	n/a
7 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined)	68.5%	71.8%	-4.6%	**P<.001**	85%
Adults' Access to Preventive/ Ambulatory Health Services	91.2%	92.2%	-1.1%	**P<.001**	75%
Ambulatory Care: ED Visits (HEDIS®)	122.1	133.1	-8.3%	N/A	Baseline Year
Annual Monitoring for Patients on Persistent Medications (Total)	91.7%	92.1%	-0.4%	P=.577	75%
Asthma in Younger Adults Admissions[1]	17.1	15.2	12.5%	n/a	Baseline Year
Asthma Medication Ratio: 19-64 Years (Total)	51.3%	n/a	n/a	n/a	n/a
Breast Cancer Screening	37.3%	38.7%	-3.6%	P=.170	50%

Cervical Cancer Screening	44.8%	46.0%	-2.6%	**P=.030**	64%
Chlamydia Screening in Women (Child and Adult Combined)	51.3%	51.5%	-0.4%	P=.946	63%
Concurrent Use of Opioids and Benzodiazepines (Total)	20.6%	27.6%	-25.4%	**P<.001**	n/a
Contraceptive Care – Postpartum Women LARC within 3 Days of Delivery Ages 21-44	0.4%	n/a	n/a	n/a	n/a
Contraceptive Care – Postpartum Women LARC within 60 Days of Delivery Ages 21-44	5.4%	n/a	n/a	n/a	n/a
Contraceptive Care – Postpartum Women Most or Moderately Effective FDA-Approved within 3 Days of Delivery Ages 21-44	11.2%	n/a	n/a	n/a	n/a
Contraceptive Care – Postpartum Women Most or Moderately Effective FDA-Approved within 60 Days of Delivery Ages 21-44	29.7%	n/a	n/a	n/a	n/a
COPD or Asthma in Older Adults Admissions[1]	63.7	87.6	-27.3%	n/a	Baseline Year
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	75.0%	76.3%	-1.7%	**P=.031**	Baseline Year
Diabetes Short-Term Complications Admissions[1]	35.2	38.1	-7.6%	n/a	Baseline Year
Heart Failure Admissions[1]	38.2	31.0	23.2%	n/a	Baseline Year
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of AOD (Total)	10.8%	9.2%	17.4%	**P=.013**	n/a
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of AOD (Total)	44.5%	42.5%	4.7%	**P=.044**	n/a
Inpatient Utilization: Total Days per 1,000 MM (HEDIS®)	76.6	72.8	5.2%	N/A	Baseline Year
Mental Health Utilization - Any Service (Total)	90.8%	90.1%	0.8%	P=.267	Baseline Year
Plan All-Cause Readmissions: Total[2]	25.1%	22.7%	n/a	n/a	Baseline Year
Use of Opioids at High Dosage in Persons Without Cancer (Total)	13.0%	63.5	n/a	n/a	Baseline Year
Use of Opioids from Multiple Providers - Multiple Pharmacies	11.3%	143.1	n/a	n/a	Baseline Year
Use of Opioids from Multiple Providers - Multiple Prescribers	33.6%	413.9	n/a	n/a	Baseline Year
Use of Opioids from Multiple Providers - Multiple Prescribers and Multiple Pharmacies	7.5%	104.3	n/a	n/a	Baseline Year

Significance levels (p values) noted in the table demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.

n/a = Rate, relative percent of change, statistical significance, or minimum performance standard was not measured, not applicable, or not appropriate for the specific reporting period.

While the relative percent of change and statistical significance are provided, trending across years should be considered with caution or a break in trending recommended, in alignment with measure steward recommendations.

[1] CYE 2017 PQI rates have been updated as a result of a data issue identified within the previous year reporting.

[2] Due to changes in the calculation methodology used for this measure in CYE 2018, comparison to the MPS was not made and statistical significance testing not included.

Serious Mental Illness Performance Summary

The SMI program demonstrated strength when compared to the Minimum Performance Standard (MPS) for the measure Adults' Access to Preventive/Ambulatory Health Services.

The following performance measures demonstrated improvement between CYE 2017 and CYE 2018:

- Ambulatory Care: ED Visits,
- 7 Day Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence, and
- 30 Day Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence.

The SMI program demonstrated a statistically significant improvement from the previous year's performance for the following CYE 2018 performance measures:

- Concurrent Use of Opioids and Benzodiazepines,
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation (Total), and
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement (Total).

RBHA contractors have focused efforts on improving rates for the Follow-Up After Hospitalization for Mental Illness (7 Day and 30 Day) measures through the implementation of Corrective Action Plans (CAPs). Contractors have implemented interventions such as:

- Increasing care coordination,
- Enhancing outreach and education to members and providers detailing the importance of follow-up visits,
- Improving communication with health homes to assist in scheduling follow-up appointments,
- Incentivizing providers through Value Based Purchasing programs,
- Identification of best practices from contracted providers, and
- Implementing interdepartmental coordination processes to assist in identifying and addressing provider barriers, ensure consistent messaging, and providing technical assistance.

SMI contractors have also focused efforts on improving rates for the Breast Cancer Screening, Cervical Cancer Screening, and Chlamydia Screening in Women measures through the implementation of interventions such as:

- Enhancing member and provider education and outreach detailing the importance of preventive screenings,
- Creating automated reminder programs to outreach members via phone call, text message, and email,
- Offering member incentives for completing preventive screenings,
- Improving communication with health homes to assist in the identification of members in need of preventive screenings,

- Streamlining processes between imaging clinics and provider offices to assist with ordering and scheduling mammogram appointments,
- Increasing utilization of and data capture within the Health Information Exchange (HIE),
- Conducting provider site visits and providing gaps in care reports, and
- Incentivizing providers through Value Based Purchasing programs.

AHCCCS identified an opportunity for improvement in the Breast Cancer Screening and Cervical Cancer Screening performance measure rates. As such, AHCCCS has implemented a Preventive Screening Performance Improvement Project for the SMI Integrated population aimed at improving the rates of breast cancer screenings and cervical cancer screenings.

b) FORM CMS-416

AHCCCS Medicaid and KidsCare rates for EPSDT Participation, Total Eligibles Receiving Preventive Dental Services, and Total Eligibles Receiving Any Dental Services are included in table below. This data is reflective of CYE 2019 (October 1, 2018 to September 30, 2019) and are inclusive of the information reported to CMS on the annual Form CMS-416 Report. Please note that although KidsCare is not formally reported to CMS via the CMS-416 Report, AHCCCS monitors this population using the same methodology as the Form CMS-416 Report for comparison purposes.

	CYE 2019 Rates	CYE 2019 MPS
Acute Care CMS-416 Rates		
EPSDT Participation (%)	51.0%	68%
Total Eligibles Receiving Preventive Dental Services (%)	48.6%	46%
Total Eligibles Receiving Any Dental Services (%)	49.5%	n/a
KidsCare CMS-416 Rates		
EPSDT Participation (%)	66.5%	68%
Total Eligibles Receiving Preventive Dental Services (%)	53.8%	46%
Total Eligibles Receiving Any Dental Services (%)	56.4%	n/a

PERFORMANCE IMPROVEMENT PROJECTS (PIPS)

AHCCCS had the following Performance Improvement Projects in place during CYE 2019 (October 1, 2018 to September 30, 2019):

E-Prescribing PIP

Population(s): RBHA SMI Integrated*

The purpose of this Performance Improvement Project is to increase provider utilization of electronic prescribing practices. The goal is to demonstrate a statistically significant increase in the number of providers submitting electronic prescriptions and the number of electronic prescriptions submitted followed by increased sustainment for one year.

Line of Business	Percent of Providers who Prescribed at Least One Prescription Electronically	Percent of Prescriptions Prescribed Electronically
RBHA SMI Integrated		
CYE 2019	82.9%	76.6%
CYE 2018	69.8%	67.5%
CYE 2017	64.0%	62.1%

**Varied Baseline Year across lines of business/Managed Care Organizations (MCOs). PIP Closed in CYE 2017 for populations not included above. PIP closed for RBHA SMI Integrated population in CYE 2019.*

Note: The E-Prescribing PIP was considered closed in CYE 2018 for the RBHA General Mental Health/Substance Use (GMH/SU) population due to system integration.

Developmental Screening (DEV) PIP

Population(s): Acute, CMDP, and ALTCS DD

The purpose of this Performance Improvement Project is to increase the number of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the twelve months preceding their first, second, or third birthday. The goal is to demonstrate a statistically significant increase in the number and percent of children receiving a developmental screening followed by sustained improvement for one consecutive year.

Line of Business	Percentage of Members Screened in the Twelve Months Preceding their First Birthday	Percentage of Members Screened in the Twelve Months Preceding their Second Birthday	Percentage of Members Screened in the Twelve Months Preceding their Third Birthday	Percentage of Members Screened in the Twelve Months Preceding their First, Second, and Third Birthday
ACC (Acute)*				
CYE 2019 (Remeasurement 2)	Rate Pending	Rate Pending	Rate Pending	Rate Pending
CYE 2018 (Remeasurement 1)	27.1%	34.1%	29.3%	29.9%
CYE 2016 (Baseline)	21.1%	27.5%	23.1%	23.6%[1]
CMDP				
CYE 2019 (Remeasurement 2)	Rate Pending	Rate Pending	Rate Pending	Rate Pending
CYE 2018 (Remeasurement 1)	31.1%	48.6%	33.5%	37.7%
CYE 2016 (Baseline)	23.8%	36.2%	29.0%	30.0%
ATLCS DD				
CYE 2019 (Remeasurement 2)	n/a[2]	Rate Pending	Rate Pending	Rate Pending
CYE 2018 (Remeasurement 1)	n/a[2]	31.3%	22.3%	25.1%
ATLCS DD				
CYE 2016 (Baseline)	n/a[2]	24.4%	25.1%	24.9%

**ACC/Acute Aggregate rate inclusive of the CMDP population*

[1] Rate updated since previous reporting due to noted rounding issue

[2] Rates are not available for the ALTCS DD population as this population does not generally meet the continuous enrollment requirements specific to this age group

In addition, AHCCCS has implemented two additional PIPs starting CYE 2019 :

Back to Basics PIP

Population: AHCCCS Complete Care (ACC), CMDP, KidsCare, and ALTCS DD

The purpose of this Performance Improvement Project is to increase the number of well-child visits (15-month rate), child and adolescent well-care visits, and annual dental visits. The goal is to demonstrate a statistically significant increase in the number and percentage of child and adolescent well-child/well-care visits, as well as a statistically significant increase in the number and percentage of children and adolescents receiving an annual dental visit, followed by sustained improvement for one consecutive year.

Baseline Rates will be reported once they become available for ACC, CMDP, Kids Care and ALTCS/DDD for CYE 2019 (Baseline Year).

Breast Cancer Screening PIP

Population: ALTCS E/PD

The purpose of this Performance Improvement Project is to increase the number and percent of breast cancer screenings. The goal is to demonstrate a statistically significant increase, followed by sustained improvement for one consecutive year, for breast cancer screenings. Baseline Rates will be reported once they become available for CYE 2019 (baseline year).

Preventive Screening PIP

Population: RBHA SMI

The purpose of this Performance Improvement Project is to increase the number and percent of breast cancer and cervical cancer screenings. The goal is to demonstrate a statistically significant increase, followed by sustained improvement for one consecutive year, for breast cancer and cervical cancer screenings. Baseline Rates will be reported once they become available for CYE 2019 (baseline year).

X. Demonstration Implementation Update

AHCCCS Acute Care Program Demonstration

AHCCCS has operated under an 1115 Research and Demonstration waiver since 1982, when it became the first statewide Medicaid managed care system in the nation. The AHCCCS Acute Care program is a statewide, managed care system that delivers acute care services through prepaid, capitated health plans, known as MCOs.

The Acute Care program includes services for children, pregnant women, and families who qualify for the federal Medicaid program (Title XIX), as well as childless adults. Although most AHCCCS members are required to enroll in MCOs, American Indians and Alaska Natives in the Acute Care program may choose to receive services through either the contracted health plans or American Indian Health Program (AIHP). The Acute Care program also includes behavioral health benefits. All AHCCCS Acute Care MCOs must also be Dual Eligible Special Needs Plans (D-SNPs) to serve members who are eligible for both Medicaid and Medicare.

In March 2018, AHCCCS awarded contracts for ACC, which integrated physical and behavioral health care services under MCOs for the majority of members in the Acute Care program. The ACC contractors replaced the Acute and Children Rehabilitative Services (CRS) contractors serving the following Title XIX/XXI populations:

- Adults, who are not determined to have a Serious Mental Illness, are covered for integrated physical and behavioral health services, and
- All children, except for foster children enrolled with the Comprehensive Medical Dental Program (CMDP), are covered for integrated physical and behavioral health services.

The ACC contracts were awarded by geographical service area (GSAs), as outlined in the table below. ACC contracts were effective October 1, 2018 for a period of up to seven years.

ACC Managed Care Organization (MCO)	Geographical Service Area (GSA)			
	Central GSA *Maricopa, Gila, Pinal*	**North GSA** *Mohave, Coconino, Apache, Navajo, Yavapai*	**South GSA** *Cochise, Graham, Greenlee, La Paz, Santa Cruz, Yuma*	**South GSA** *Pima County*
Arizona Complete Health-Complete Care Plan	X		X	X
Banner University Family Care	X		X	X
Care1st Health Plan	X	X		
Magellan Complete Care	X			
Mercy Care	X			
Health Choice Arizona	X	X		
UnitedHealthcare Community Plan	X			X

Three RBHAs retain contracts with AHCCCS for the provision of services for the following populations:

- Adults who have been determined to have a Serious Mental Illness are covered for integrated physical and behavioral health services, and
- Children in foster care enrolled with CMDP are covered for behavioral health services.

Effective April 1, 2021, children in foster care and enrolled with CMDP will begin receiving integrated physical and behavioral health services from CMDP, rebranded with the new name Comprehensive Health Plan.

Arizona Long Term Care Program (ALTCS) Demonstration

In 1988, six years after the original waiver was implemented, the demonstration waiver was substantially amended to allow Arizona to implement ALTCS, a capitated, long term care program for individuals who are elderly and physically disabled and individuals who are developmentally disabled. Effective October 1, 1989, the ALTCS program, a distinct program from the AHCCCS Acute Care program, provides acute, long term care, behavioral health, and home and community-based services (HCBS) to Medicaid members who are at risk of institutionalization. Program services are provided through

contracted prepaid, capitated arrangements with MCOs. ALTCS members who are elderly or physically disabled (E/PD) are served through MCOs selected through a competitive bid process, and those members who have a developmental disability are served statewide through the Department of Economic Security, Division of Developmental Disabilities (DES/DDD).

ALTCS strives to ensure that members are living in the most integrated setting, are actively engaged, and are participating in community life. Over the past 31 years, ALTCS has achieved remarkable success increasing member placement in HCBS, resulting in significant program savings while also appropriately meeting the needs of members.

The current ALTCS E/PD contracts were awarded by Geographic Service Areas as outlined in the table below. ALTCS E/PD contracts were effective October 1, 2017 for a period of up to seven years.

ALTCS Managed Care Organization (MCO)	Geographical Service Area (GSA)			
	Central GSA *Maricopa, Gila, Pinal*	**North GSA** *Mohave, Coconino, Apache, Navajo, Yavapai*	**South GSA** *Cochise, Graham, Greenlee, La Paz, Santa Cruz, Yuma*	**South GSA** *Pima County*
Banner University Family Care	**X**		**X**	**X**
Mercy Care	**X**			**X**
UnitedHealthcare Community Plan	**X**	**X**		

Effective October 1, 2019, members served through DES/DDD began receiving integrated physical and behavioral health services, including services for CRS eligible conditions, when responsibility for the provision of behavioral health services was added to the DES/DDD contract for the first time.

Targeted Investments (TI) Program Demonstration

On January 18, 2017, CMS approved an amendment to Arizona's 1115 Research and Demonstration Waiver authorizing the Targeted Investments (TI) program. The TI program funds time-limited, outcomes-based projects aimed at building the necessary infrastructure to create and sustain integrated, high-performing health care delivery systems that improve care coordination and drive better health and financial outcomes for some of the most complex and costly AHCCCS populations. The TI Program provides funding for providers who serve the following populations:

- Adults with behavioral health needs,
- Children with behavioral health needs, including children with or at risk for Autism Spectrum Disorder, and children engaged in the child welfare system, and
- Individuals transitioning from incarceration.

Over five years, the program will make up to $300 million in directed incentive payments to AHCCCS providers who promote the integration of physical and behavioral health care, increase efficiencies in care delivery, and improve health outcomes. The TI program incentivizes providers to collaborate on the development of shared clinical and administrative protocols to enable patient care management across provider systems and networks. Incentive payments are distributed to participating providers through AHCCCS MCOs pursuant to 42 CFR 438.6(c). Providers are expected to meet performance improvement targets in order to receive payments. The table below displays the TI funding by FFY.

Estimated Annual Funding Distribution for the Targeted Investments Program

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Targeted Investments	*$19 M*	*$66.5 M*	*$85.5 M*	*$66.4 M*	*$47.5 M*	*$285 M*
Administrative Expenses	*$1 M*	*$3.5 M*	*$4.5 M*	*$3.5 M*	*$2.5 M*	*$15 M*
Totals	*$20 M*	*$70 M*	*$90 M*	*$70 M*	*$50 M*	*$300 M*

In Demonstration Years 3 through 5, the state must meet performance measure targets to secure full TI program funding. If the state does not meet certain performance requirements in a given demonstration year, the TI program will lose the amount of Designated State Health Program (DSHP) funds specified as "at risk" for that year.

Total Computable DSHP at Risk for Each Demonstration Year

	Year 1	Year 2	Year 3	Year 4	Year 5
Total Computable DSHP	*$6,274,400*	*$21,137,600*	*$27,177,000*	*$21,137,600*	*$15,098,300*
Percentage at Risk	*0%*	*0%*	*10%*	*15%*	*20%*
Total Amount at Risk	*$0*	*$0*	*$2,717,700*	*$3,170,640*	*$3,019,660*

TI Program Updates

Below is a summary of the TI program implementation activities conducted by AHCCCS in FY 2020:

- Established Year 4 performance measure milestones for determining incentives for program participants, including attribution methodologies and targets.
- Collaborated with the Center for Health Information Research(CHiR) at Arizona State University (ASU) to assist with the administration of the performance measure milestones, including

calculation of results, provision of technical assistance to program participants, and developing an interactive dashboard that illustrates timely and actionable performance measure results,

- Partnered with ASU College of Health Solutions to facilitate monthly virtual Quality Improvement Collaboratives (QIC) for program participants to discuss measure calculation & attribution methodologies, performance management & process improvement strategies, performance measure trends, regional challenges & resources, and peers' best practices to enhance program participants' milestone achievement,
- Held an in-person QIC kickoff meeting attended by approximately 300 attendees to orient participants to the Year 4 milestones and gathered participant input to ensure their priorities would be met by the QIC,
- Enhanced the reporting system for TI program participants to submit attestations of milestone completion and to upload documents for validation,
- Collaborated with Health Current, the statewide health information exchange (HIE), to assist program participants with establishing data exchange capabilities and guidance on how to utilize clinical data available most effectively through the HIE,
- Developed and implemented multiple communication avenues for participants and stakeholders including a detailed and regularly updated Targeted Investments webpage, direct email, a dedicated Targeted Investments email address and social media posts,
- Calculated and administered Year 3 interim incentive payments to providers to assist participants during the COVID-19 pandemic,
- Maintained ongoing dialogue between AHCCCS and its MCOs to facilitate alignment between the TI program guidance on enhanced provider level integration and the MCOs' provider network integration initiatives, established their representation in the QIC sessions, and solicited input regarding initiatives to support program sustainability,
- TI participants were engaged by AHCCCS through electronic and in-person forums, surveys, and webinars including (1) monthly newsletters sent to all the participants which includes pertinent information, tips and reminders, program updates and upcoming due dates; (2) the robust and up-to-date TI webpage with resources and communications; (3) extensive individualized provider assistance by TI staff.

Waiver Evaluation Update

In accordance with 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 Health Services Advisory Group (HSAG) to serve as the independent evaluator for Arizona's 1115 Waiver demonstration. In SFY 2019, AHCCCS worked with HSAG to develop evaluation design plans for the following programs:

- ACC,
- ALTCS,
- CMDP,
- RBHA,
- Targeted Investments,
- AHCCCS Works, and
- Retroactive Coverage Waiver.

On November 13, 2019, AHCCCS submitted an evaluation design plan to CMS for Arizona's demonstration components noted above, with the exception of AHCCCS Works. Additionally, AHCCCS 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 the implementation of the community engagement requirements. 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 with the Waiver renewal application on December 22, 2020.

Due to data limitations 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, an updated interim evaluation report will be completed by HSAG in the summer 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, in order to control for confounding factors and identify the impact of Arizona's demonstration initiatives on access to care, quality of care, and member experience with care. AHCCCS intends to post the updated interim evaluation report to its website for public comment in the summer/early fall 2021.

XI. Notable Achievements

Achievements during CYE 2020 noted below:

INNOVATIONS IN SERVICE DELIVERY & TECHNOLOGY

- Successfully transitioned more than 60 percent of AHCCCS employees to a virtual work environment, allowing the agency 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.
- Launched the AHCCCS Provider Enrollment Portal (APEP), allowing providers to enroll with AHCCCS electronically any time of day.
- Implemented an Electronic Visit Verification 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 reimbursement 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.
- 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 COVID-19 PUBLIC HEALTH EMERGENCY

- Obtained permission to pursue more than 46 programmatic flexibilities from the Centers for Medicare and Medicaid Services. 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 the agency's Targeted Investments Program and hospitals participating in the graduate medical education program.

APPENDIX A:

1115 WAIVER PUBLIC FORUM AGENDA, SLIDES AND FLYERS

AHCCCS
Arizona Health Care Cost Containment System

Welcome to the Public Forum

While you are waiting TEST YOUR AUDIO.

LISTEN FOR MUSIC.

You were automatically muted upon entry.

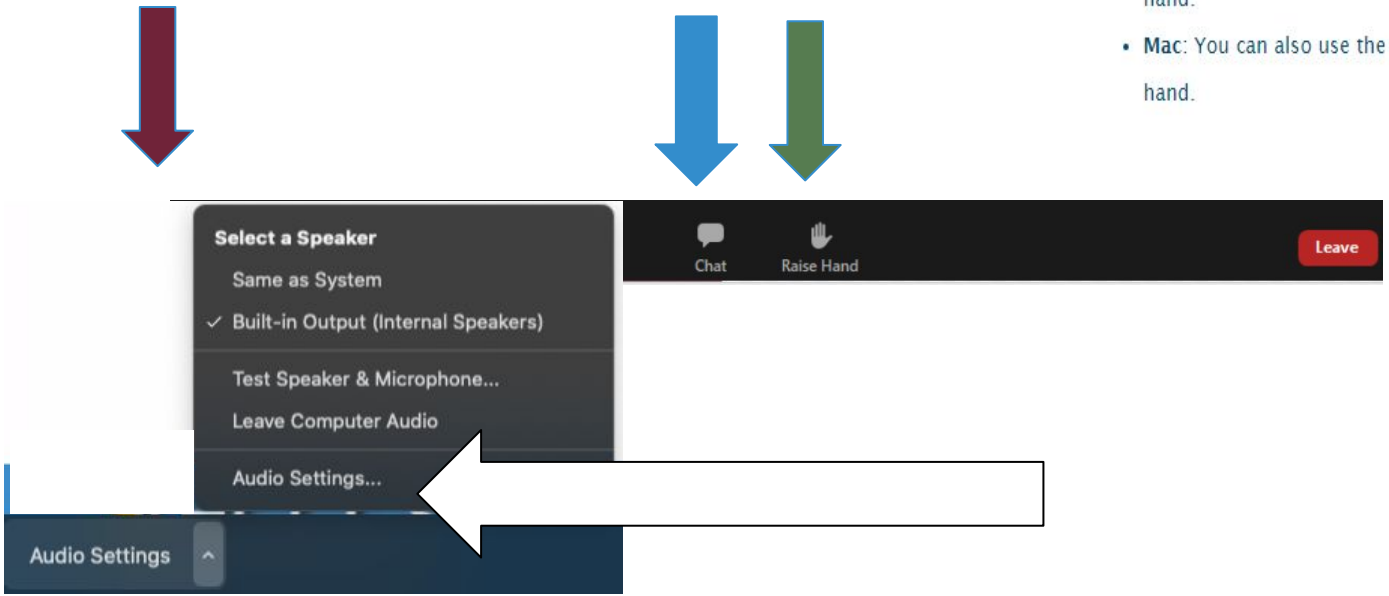
Please only join by phone or computer.

Please use the chat feature for questions or raise your hand.

Thank you.

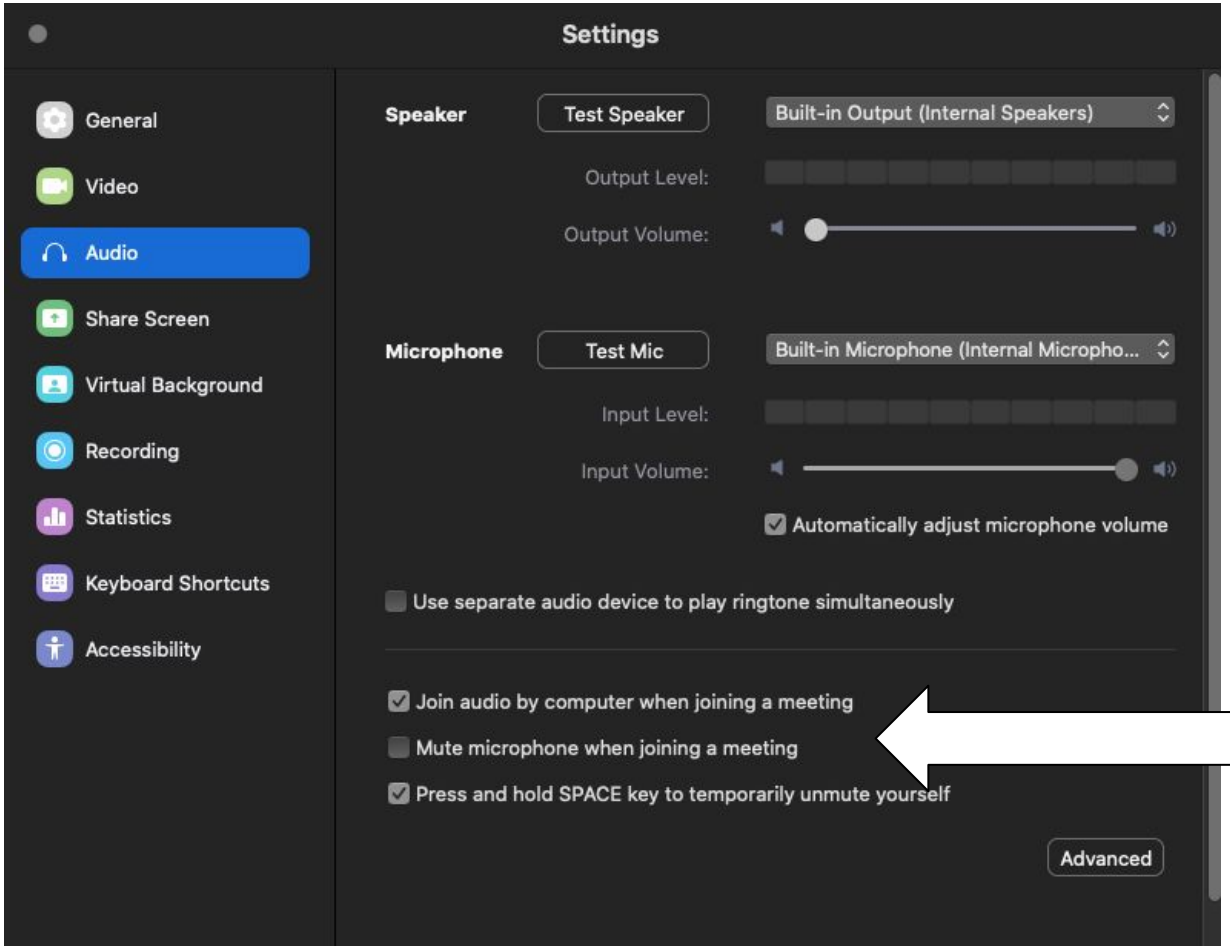
Zoom Webinar Controls

Navigating your bar on the bottom...



- **Windows**: You can also use the **Alt+Y** keyboard shortcut to raise or lower your hand.
- **Mac**: You can also use the **Option+Y** keyboard shortcut to raise or lower your hand.

Audio Settings



Tips for successful ZOOM PARTICIPATION

1. MUTE your mic when you're not speaking
2. BACKGROUND NOISE watch when turning on mic
3. Limit the DISTRACTIONS around you
4. Look at the CAMERA not your screen
5. PREPARE & queue docs or links that you plan to share
6. Stay FOCUSed by not texting or side conversations
7. Use GALLERY VIEW to see all participants
8. Use CHAT to ask questions or share resources







AHCCCS Demonstration Public Forum
1115 Waiver Renewal

AHCCCS
Arizona Health Care Cost Containment System

Today's Presentation

- Review content of the upcoming 1115 waiver proposal
- Take public comment and questions via chat feature, raise hand feature, and at conclusion by telephone
  - All comments in the chat and by phone will be captured as public record; or
  - Submit comments in writing by email to: waiverpublicinput@azahcccs.gov; or
  - Submit comments via mail to: AHCCCS, c/o Division of Community Advocacy and Intergovernmental Relations, 801 E. Jefferson Street, MD 4200, Phoenix, AZ 85034

AHCCCS At A Glance

Largest insurer in AZ, covering over 2 million individuals and families

more than 50% of all births in AZ

two-thirds of nursing facility days

AHCCCS uses federal, state and county funds to provide health care coverage to the State's Medicaid population

98,321 registered healthcare providers

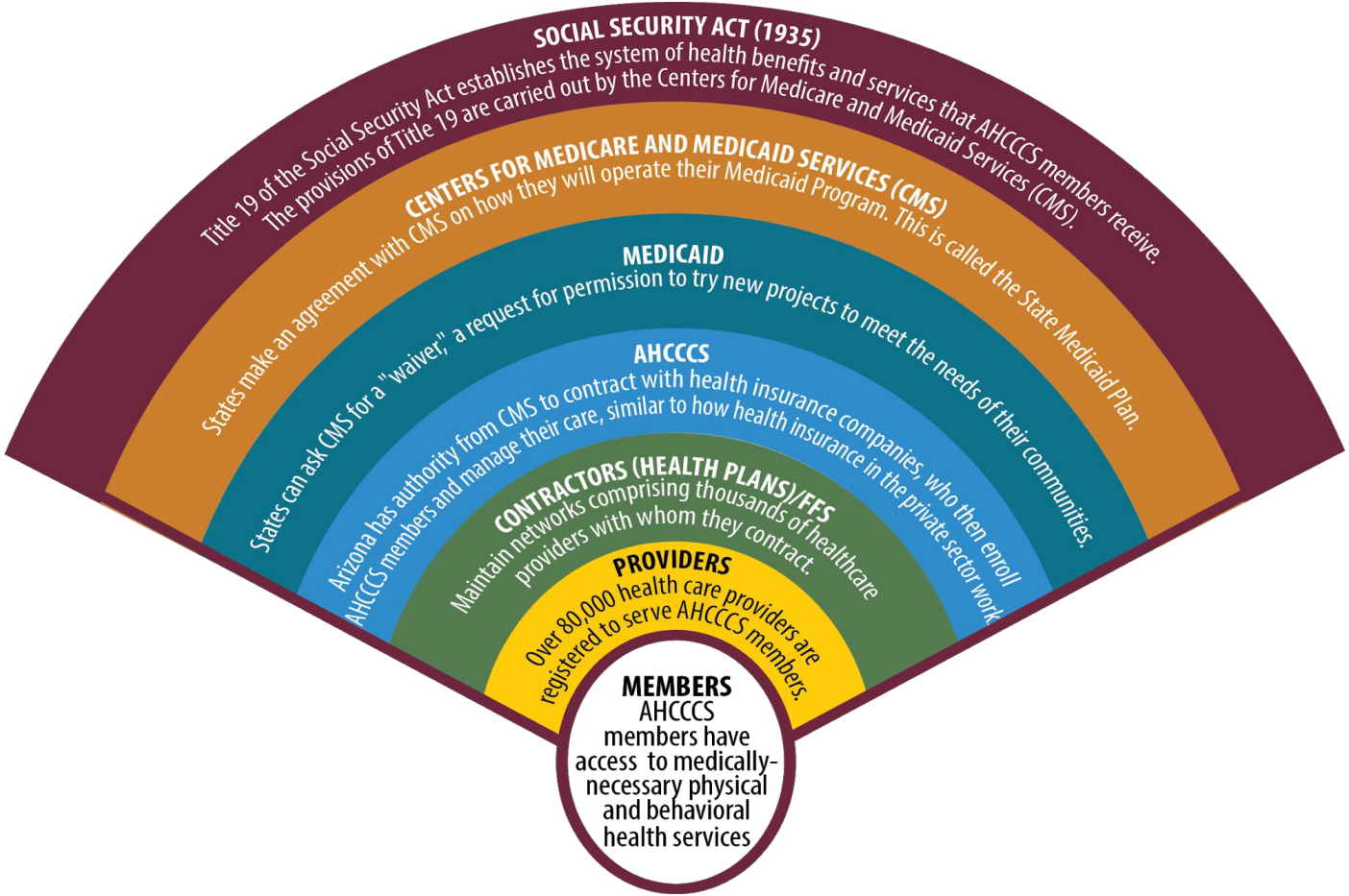
Payments are made to 15 contracted health plans, who are responsible for the delivery of care to members


Welcome to the 2020
AHCCCS Waiver
Public Forum

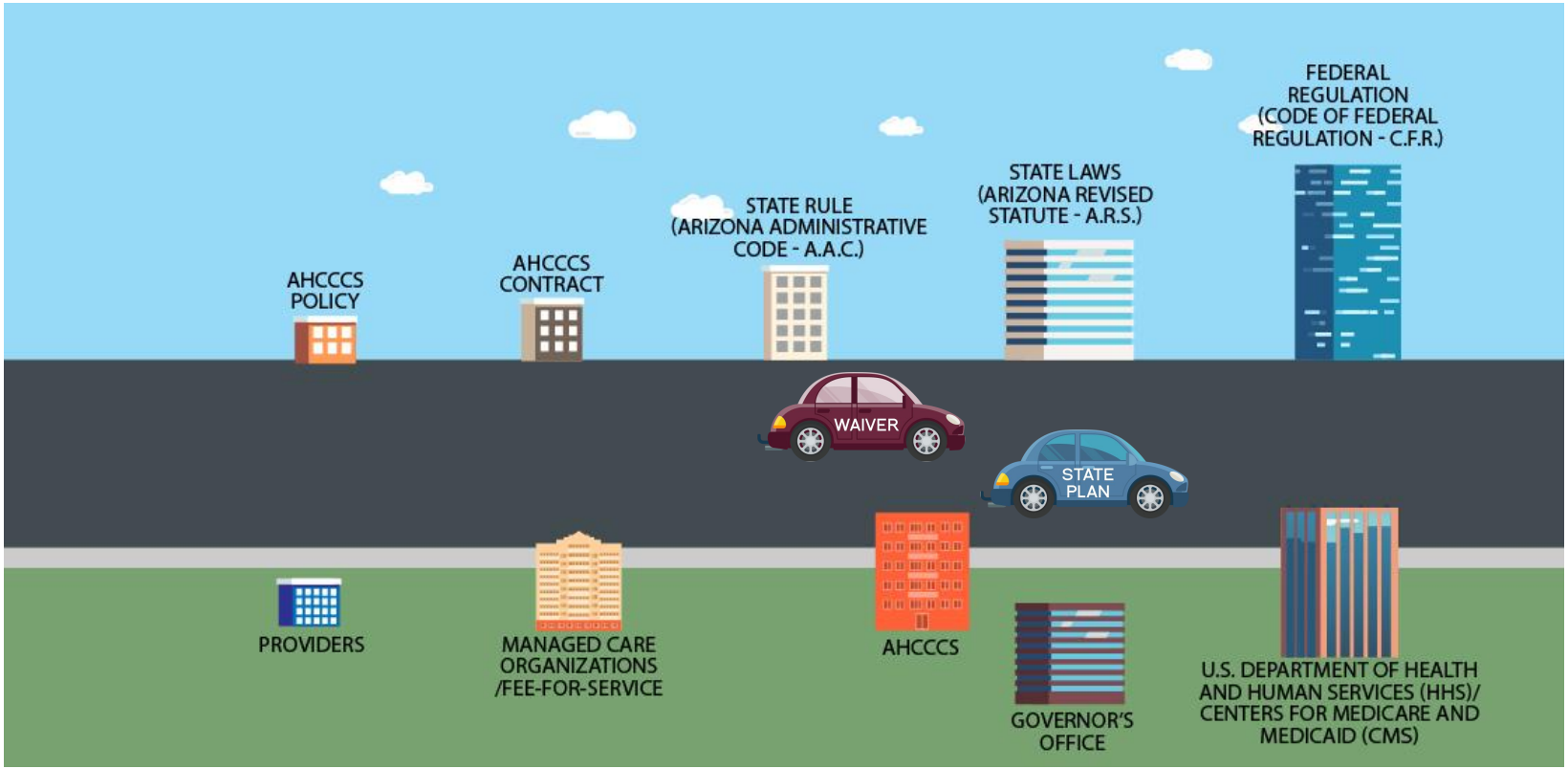

1115 Waiver Overview

AHCCCS
Arizona Health Care Cost Containment System

AHCCCS Oversight



Making Programmatic Changes



Section 1115 of the Social Security Act

- Allows states flexibility to design Demonstration projects that promote the objectives of the Medicaid program
- Demonstration projects are typically approved for a five year period and can be renewed every five years
- Must be budget neutral meaning that federal spending under the waiver cannot exceed what it would have been in absence of the waiver

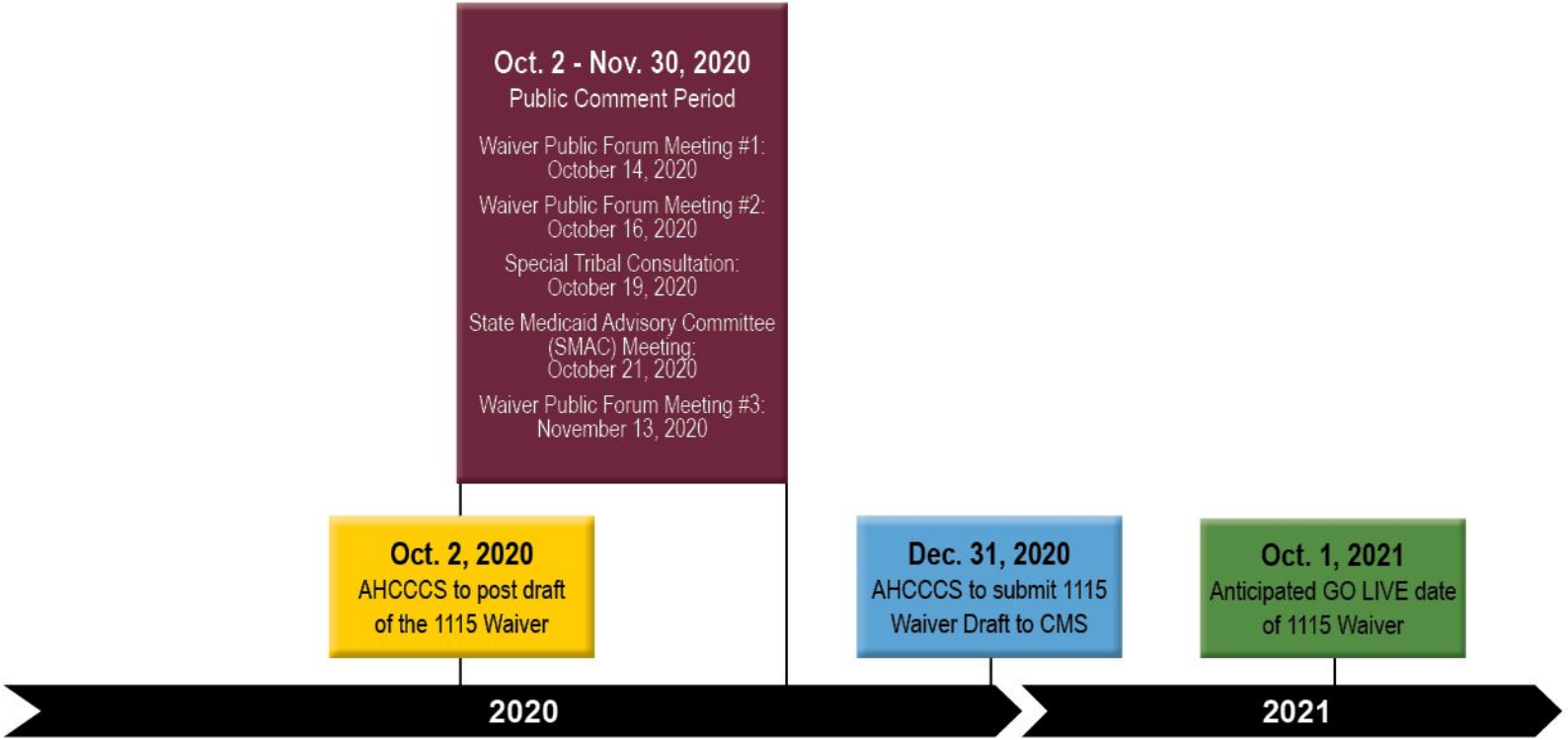
Arizona's Demonstration Renewal

- Arizona's current waiver is scheduled to expire September 30, 2021
- Waiver renewal request must be submitted to the Centers for Medicare and Medicaid Services (CMS) one year in advance
- Due to the pandemic, CMS granted AHCCCS a three-month extension to submit the waiver renewal application by December 31, 2020

Public Notice & Comment Period

- Arizona must provide at least a 30-day public notice and comment period prior to submitting renewal application to CMS
- Arizona's draft application will be available for public review and comment: **October 2, 2020** - **November 30, 2020**
- Submit written comments no later than **November 30, 2020**
- Arizona's renewal application can be found on the AHCCCS website: www.azahcccs.gov/WaiverRenewal

Arizona's 1115 Waiver Renewal Timeline



Arizona's Demonstration Historical Background

AHCCCS Demonstration Goals

Providing quality healthcare to members

Ensuring access to care for members

Maintaining or improving member satisfaction with care

Continuing to operate as a cost-effective managed care delivery model

Arizona's First Demonstration Approval Letter

"I look forward to personally following the progress and achievements of the AHCCCS program. The models that AHCCCS will be implementing will be of great importance in developing cost containment features for the [Medicaid] program."

Carolyne K. Davis - Federal Administrator, 1982

Key Milestones

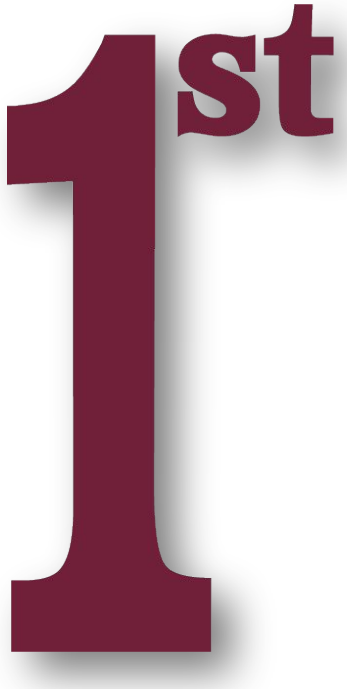
- **1965** - Congress enacts Medicaid
- **1982** - 1115 Waiver approved, establishing mandatory managed care and providing vehicle for Arizona to join Medicaid
- **1989** - Waiver expanded to add long term care & home and community based services (HCBS)
- **1990-1995** - Waiver expanded to include behavioral health services
- **1998** - KidsCare added
- **2001** - Waiver expanded to include childless adults up to 100% of the Federal Poverty Level (Proposition 204)
- **2008 - 2012 -** Great Recession
    - *Enrollment frozen for Kidscare- effective January 1, 2010*
    - *Enrollment frozen for Proposition 204 population - effective July 1, 2011*

Key Milestones

- **2014 -** Restoration and Expansion
  - *Enrollment restored for Proposition 204 population and eligibility expanded to individuals up to 133% of the Federal Poverty Level*
- **2014 - 2015** - Implementation of integrated RBHA health plans
- **2016** - DBHS merged with AHCCCS
- **2016**- Enrollment restored for KidsCare
- **2017** - Implementation of Targeted Investments Program
- **2019** - AHCCCS Works* & Waiver of Prior Quarter Coverage approved
- **2020** - COVID-19 pandemic

*AHCCCS Works program has not been implemented

AHCCCS Has Long Been A Leader In Health Care Innovation

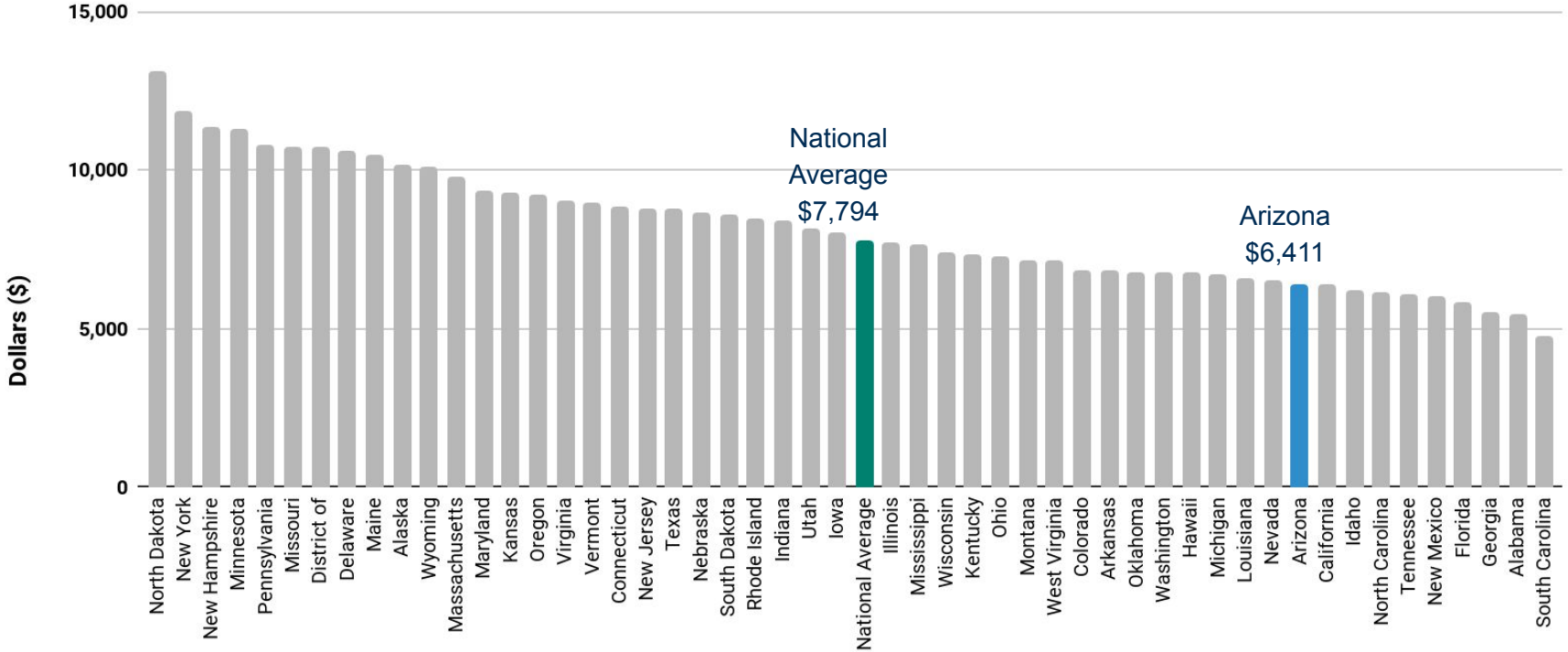


- To operate a statewide Medicaid managed care program
- To implement MLTSS & HCBS for long term care members
- To establish the integrated health plan to bring physical health, behavioral health, and social support services together in one plan for members with a SMI designation
- To establish integrated clinics where behavioral and physical health providers and county probation offices deliver services to improve health outcomes and reduce recidivism for members who were formerly incarcerated

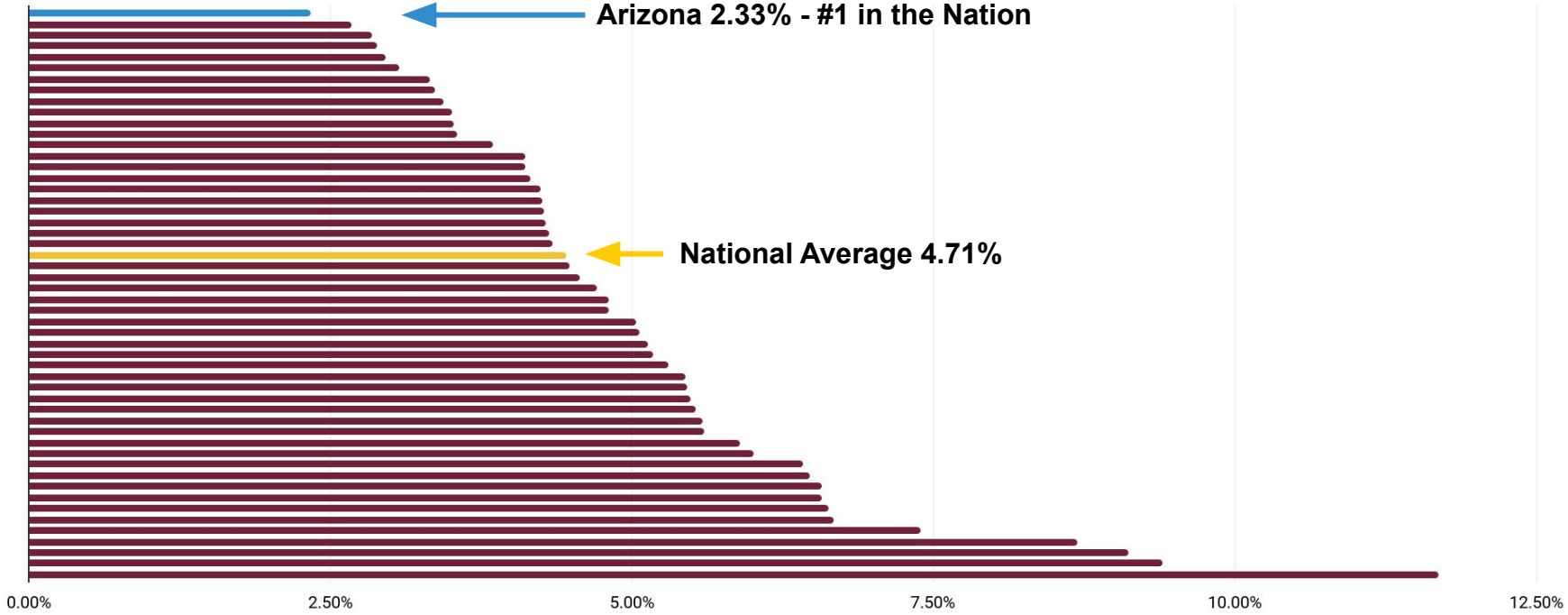
AHCCCS Evaluation Findings

- Laguna Research Associates completed multiple evaluations with final report in 1996; GAO report also had similar findings in 1995
  - Arizona beneficiaries had fewer hospital days, fewer procedures, and more evaluation and management services
  - The acute program averaged savings of 7% per year over the first 11 years of the program
  - The long term care savings are estimated to be 16% per year over the first five years of the program
  - Evaluators supported innovative development in other states modeled on Arizona's success

Medicaid Spending Per Member Per Year by State - FY 2018

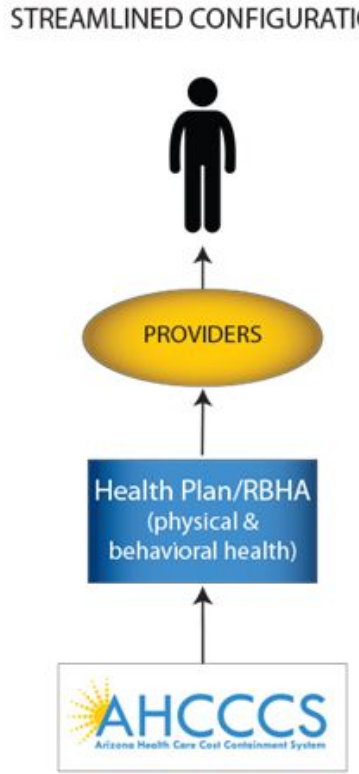


Medicaid Administrative Expense Ratio by State FY 2019

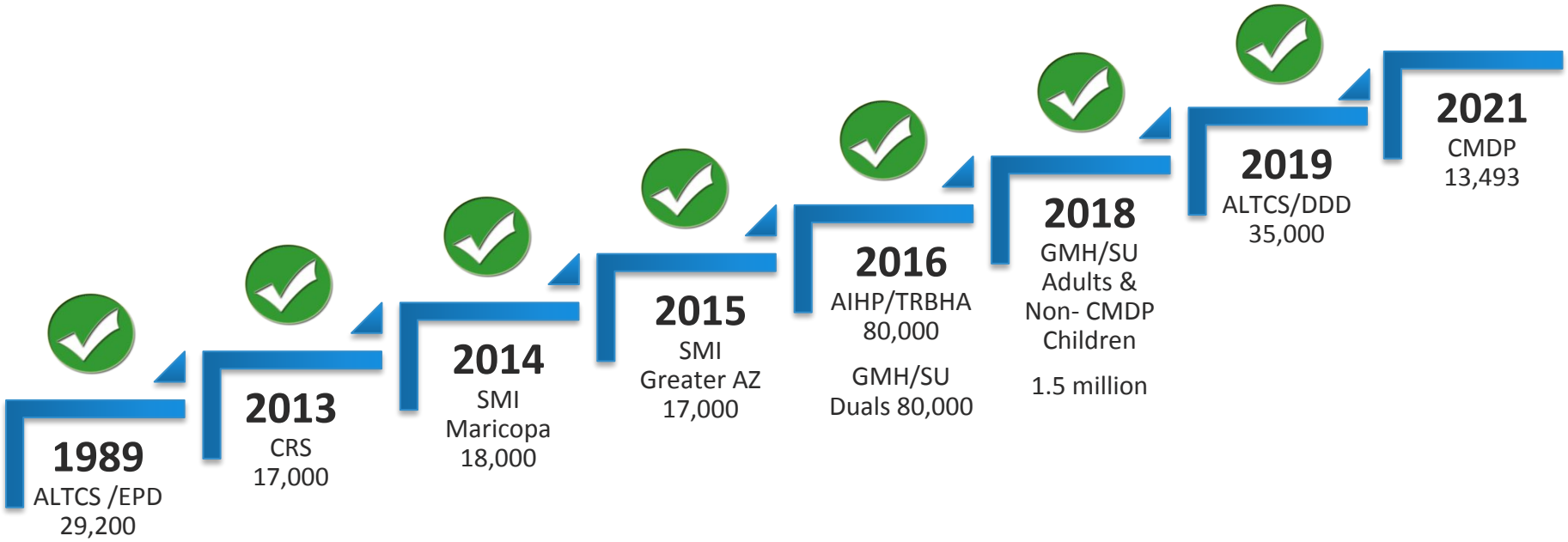


SMI Integration Findings

- An independent study conducted by Mercer determined that over 75% of the program indicators demonstrated improvement during the post-integration period for members in Maricopa County
- A study by Mercy Care also showed integrated care for members with SMI resulted in:
  - Increased primary care utilization with no decrease in mental health services
  - Fewer ED visits
  - Greater accountability at the primary health home



Integration Progress To Date

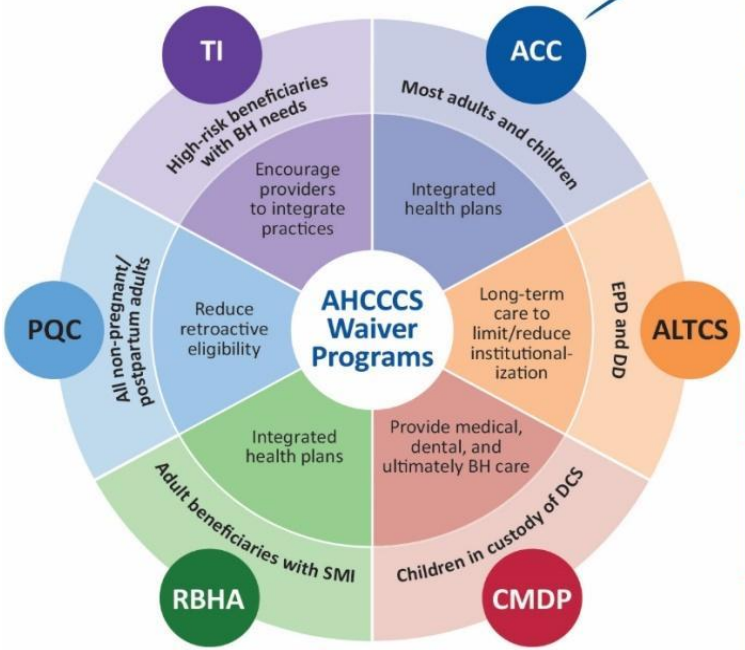





Current Demonstration Evaluation Activities

Independent Evaluation

- AHCCCS contracted with Health Services Advisory Group (HSAG) to conduct an independent evaluation of Arizona's current Demonstration
- Evaluation consist of three main phases of work:
  - **Phase I:** Develop the Evaluation Design Plans
  - **Phase II**: Conduct Interim Evaluations & Develop Interim Evaluation Reports
  - **Phase III:** Conduct Summative Evaluations & Develop Summative Evaluation Report



Program Objectives and Outcomes

Program	Objectives	Anticipated Outcomes
ACC	• Reduce fragmentation of care • Reduce fragmentation of care • Improve care coordination	• Easier to navigate AHCCCS • Streamlined care coordination • Improved health outcomes for all beneficiaries
ALTCS	• Provide best residency setting • Reduce fragmentation of care • Improve care coordination	• Improved quality of care and access to care • Improved quality of life • Improved overall satisfaction for ALTCS program beneficiaries
CMDP	• Provide care addressing needs of children in foster care • Reduce fragmentation of care • Improve care coordination	• Easier to navigate AHCCCS • Streamlined care coordination • High-quality, clinically appropriate, medically necessary health care
RBHA	• Reduce fragmentation of care • Effectively transition beneficiaries across levels of care • Identify and manage high-risk beneficiaries with an SMI	• Easier to navigate AHCCCS • Streamlined care coordination • Reduced use of crisis services • Support beneficiaries to promote health and wellness
PQC	• Encourage beneficiaries to obtain and maintain coverage, even when healthy	• Reduced costs to AHCCCS ensuring long-term fiscal sustainability • Increase continuity of care
TI	• PCPs and BH providers work together to provide whole-person care • Provide ACC plans with feedback and lessons learned	• Facilitate provider collaboration sustained by ACC plans long-term • Comprehensive and cost-effective care for beneficiaries with BH and physical needs

Overarching Goals of AHCCCS' Section 1115 Waiver Demonstration

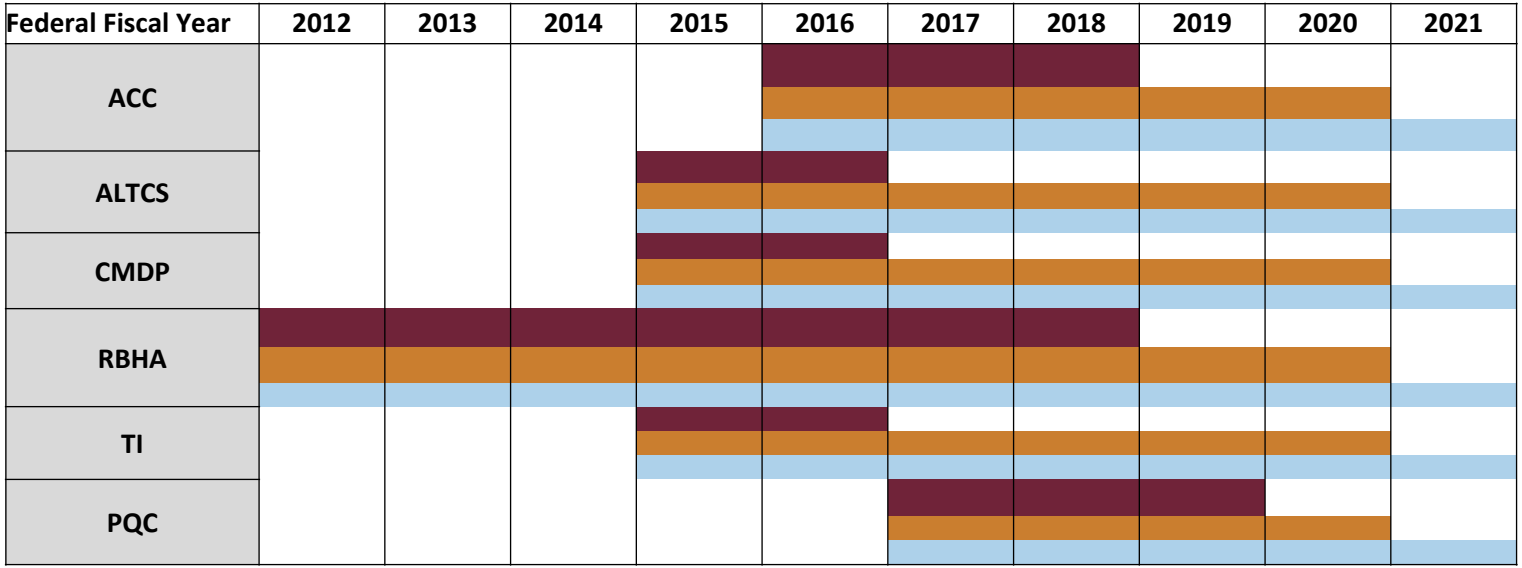
1	2	3	4
Provide quality health care to members	Ensure access to care for members	Maintain or improve member satisfaction with care	Continue to operate as a cost-effective managed care delivery model

Note: EPD: Elderly/Physically Disabled; DD: Intellectually/Developmentally Disabled; DCS: Department of Child Safety; SMI: Serious Mental Illness; PCP: Primary Care Physicians; BH: Behavioral Health

Interim Evaluation Report

- An interim evaluation report is being submitted in conjunction with AHCCCS' Demonstration renewal application
- Due to the operational constraints imposed by the COVID-19 pandemic, the interim evaluation report only includes baseline performance rates for all Demonstration programs (except RBHA)
- An updated interim evaluation report will be completed by HSAG on June 30, 2021, and will be posted on the AHCCCS website for public comment

Time Periods Covered By Interim & Summative Evaluation Reports



Interim Report for Renewal | Interim Evaluation Report | Summative Evaluation

Current Demonstration Features to Continue Under Waiver Renewal

Arizona Will Continue Waiver Authorities That Allow AHCCCS To:

- Operate its successful managed care model
- Serve ALTCS members in HCBS settings
- Provide integrated health plans for AHCCCS members
- Implement administrative simplifications that reduce the inefficiencies in eligibility determination

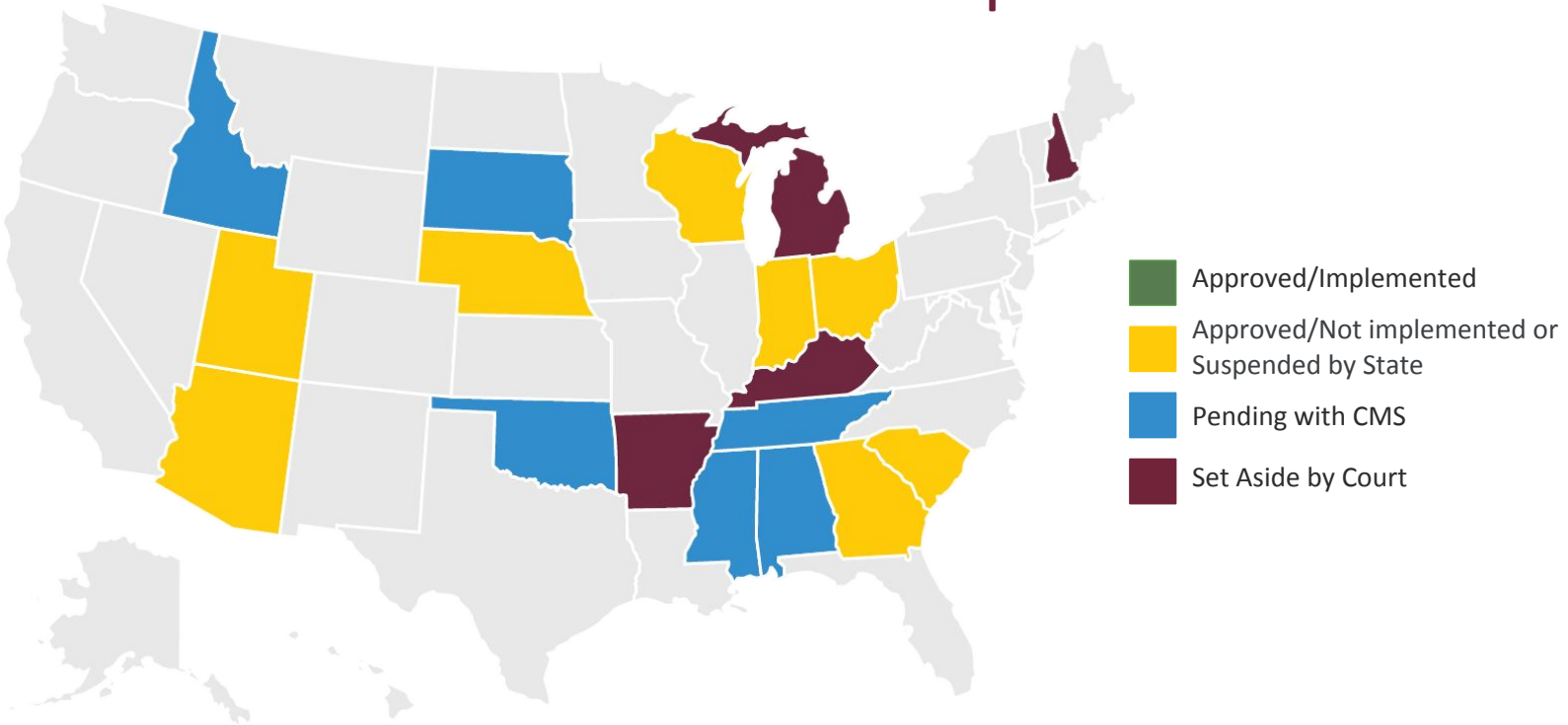
Payments to IHS and 638 Providers

- Arizona's Demonstration includes expenditure authority to make supplemental payments to IHS and 638 facilities to address the fiscal burden of uncompensated care for services provided by such facilities to Medicaid-eligible adults to overcome healthcare disparities
- AHCCCS is seeking to maintain this authority under this renewal proposal

AHCCCS Works

- Under this waiver renewal, AHCCCS is seeking to maintain its current authority to implement AHCCCS Works
- 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

Community Engagement Waivers National Landscape



AHCCCS Works Requirements

- Able-bodied adults* 19-49 who do not qualify for an exemption must, for at least 80 hours per month:
  - Be employed (including self-employment)
  - Actively seek employment
  - Attend school (less than full time)
  - Participate in other employment readiness activities, i.e., job skills training, life skills training & health education
  - Engage in Community Service

* Adults = SSA Group VIII expansion population, a.k.a, Adult group

Who is Exempt

- Members of federally recognized tribes and their children and grandchildren
- Former Arizona foster youth up to age 26
- Members determined to have a serious mental illness (SMI)
- Members with a disability recognized under federal law and individuals receiving long term disability benefits
- Individuals who are homeless
- Individuals who receive assistance through SNAP, Cash Assistance or Unemployment Insurance or who participate in another AHCCCS-approved work program
- Pregnant women up to the 60th day post-pregnancy
- Members who are medically frail
- Caregivers who are responsible for the care of an individual with a disability
- Members who are in active treatment for a substance use disorder
- Members who have an acute medical condition
- Survivors of domestic violence
- Full-time high school, college, or trade school students
- Designated caretakers of a child under age 18

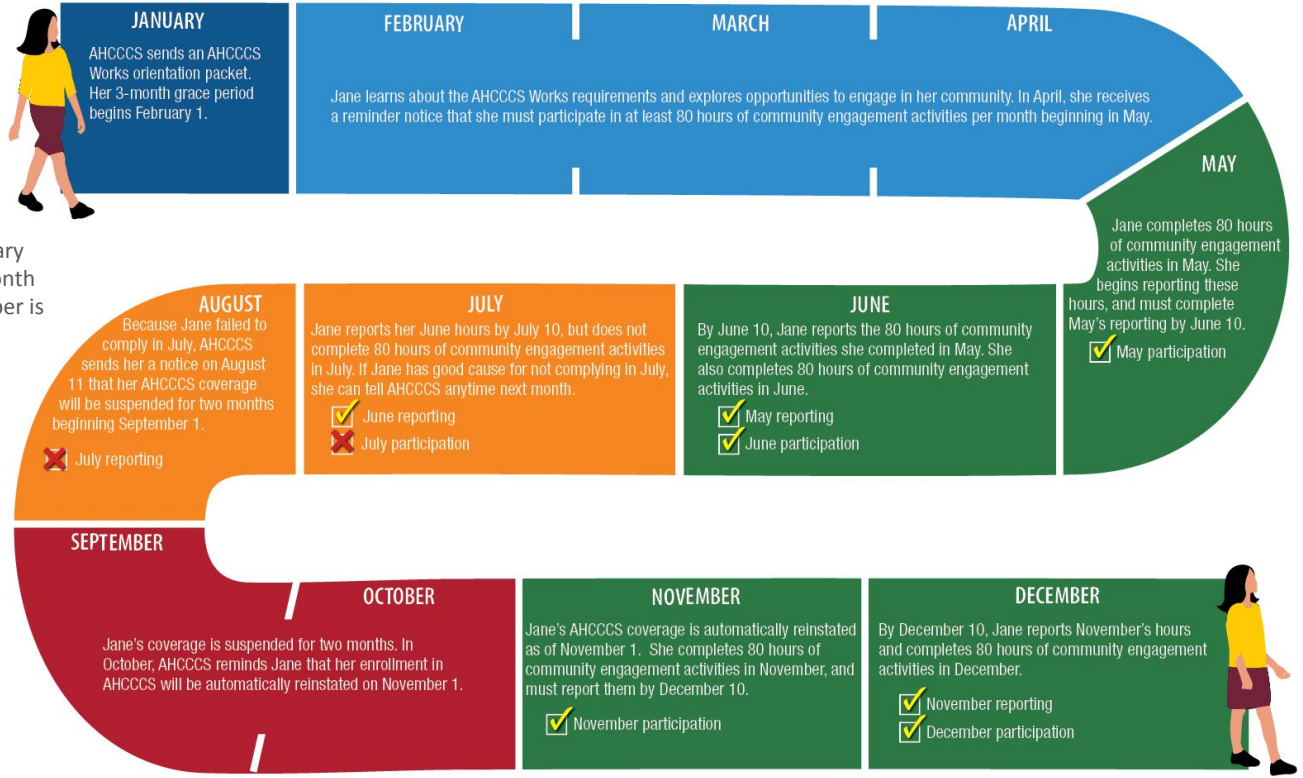
AHCCCS Works Exemptions

AHCCCS Works Exemptions	Members (Ages 19-49) Who Are Subject To AHCCCS Works Requirement Who Qualify For This Exemption
American Indians/Alaska Natives	26,338
Individuals designated as having a Serious Mental Illness	9,279
Individuals receiving disability benefits	1,324
Individuals who are homeless	3,164
Full time student	17,572
Designated caretakers of a child under 18 years of age	40,738
Members receiving SNAP, Cash Assistance, or Unemployment Insurance	50,185

Data as of 7/1/2020

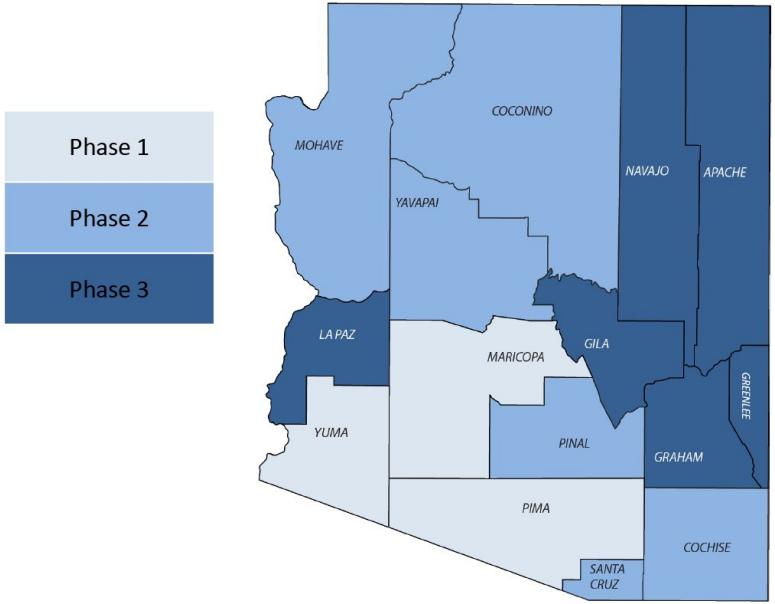
AHCCCS Works Member Compliance

In this example, January represents the first month any new AHCCCS member is required to comply



AHCCCS Works Geographic Phase-in

- Gradually phase-in AHCCCS Works program by geographic areas.
- AW program will be implemented in three phases:
  - **Phase 1:** Most Urbanized Counties: Maricopa, Pima, & Yuma
  - **Phase 2:** Semi-Urbanized Counties: Cochise, Coconino, Mohave, Pinal, Santa Cruz, & Yavapai
  - **Phase 3:** Least Urbanized Counties: Apache, Gila, Graham, Greenlee, La Paz, & Navajo

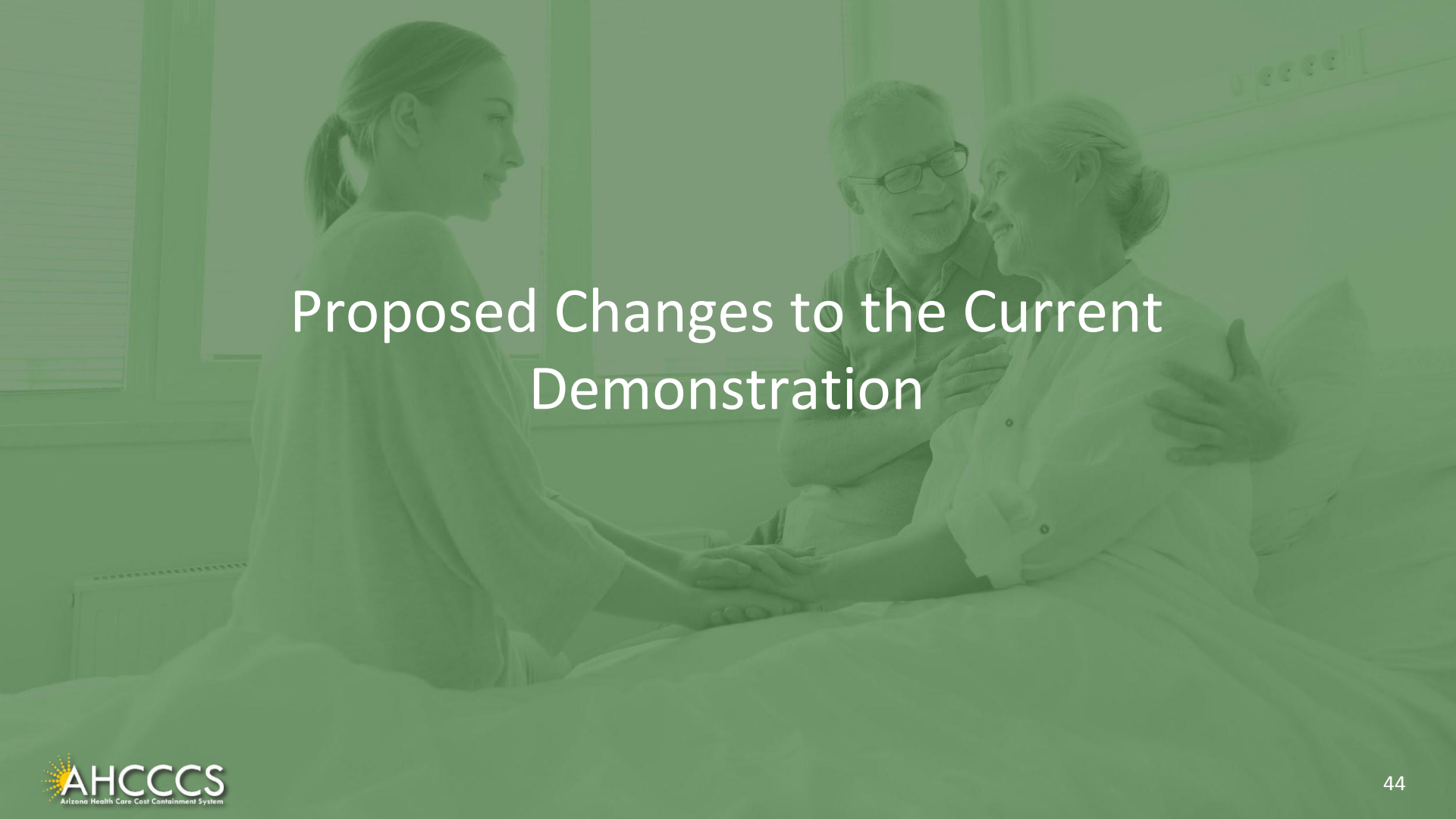


AHCCCS Works Geographic Phase-in

- Need time to establish community engagement supports for members in regions with limited employment, educational and training opportunities, accessible transportation, and child care services
- Phase-in approach will give the State time to assess the availability of community engagement resources in rural areas and address gaps
- Counties with a higher percentage of urban populations are likely to have sufficient community engagement supports compared to counties with a higher percentage of rural populations

Waiver of Prior Quarter Coverage

- Authorizes AHCCCS to limit retroactive coverage to the first day of the month of application for all Medicaid members, except for pregnant women, women who are 60 days or less postpartum, and children under 19 years of age
- AHCCCS is seeking to continue the Waiver of Prior Quarter Coverage



Proposed Changes to the Current Demonstration

AHCCCS CARE

- The AHCCCS CARE (Choice, Accountability, Responsibility, Engagement) program was approved by CMS in 2016
- Members would be required to pay monthly premiums & strategic copays applied retrospectively for services already received
- Members who fail to make timely payments would be disenrolled from AHCCCS
- AHCCCS did not implement the AHCCCS CARE program during the current waiver period and intends to discontinue this program from Arizona's Demonstration

Verbal Consent In Lieu Of Written Signature For ALTCS Members

- Arizona received COVID-19 emergency authority to use verbal consent in lieu of written signature for person-centered service plans for ALTCS members
- Temporary authority allowed AHCCCS to establish a timely process for ALTCS members to obtain authorization of critically needed health services while reducing risk of COVID-19 transmission
- AHCCCS is seeking the continuation of this flexibility beyond the termination of the COVID-19 public health emergency

Verbal Consent In Lieu Of Written Signature For ALTCS Members

- Verbal consent will be obtained telephonically where the identity of the ALTCS member can be reliably established
- The member's consent will be documented in the member's record
- After verbal consent is received, members will have 30 days to submit their signature to the case manager electronically or by mail
- Services for the member will commence during this 30-day time period

Targeted Investments Program

- $300 million authorized by CMS in January 2017 as a part of 1115 waiver renewal
- Five year project providing resources to providers to support integration of behavioral and physical health care at the point of service
- Incentive payments based on meeting milestones that support integration and whole person care

Provider Participation

- Providers eligible to participate include:
  - Adult and pediatric primary care practices
  - Adult and pediatric behavioral health organizations
  - Acute and psychiatric hospitals
  - Justice co-located clinics
- Nearly 500 sites participating across state

TI Program Payments

- **Year 1:** $19 million paid to TI providers for meeting participation requirements
- **Year 2:** $67 million paid to TI providers for achieved milestones
- **Year 3:** $86 million will be paid to TI providers for achieved milestones
- **Years 4 & 5:** providers will be paid ($66.5 and $47.5 million respectively) for improved performance on select quality metrics
- Milestone requirements support/complement AHCCCS Complete Care implementation, e.g. bi-directional data exchange through HIE

Participant Support-Quality Improvement Collaborative (QIC)

- Partnership with ASU College of Health Solutions and Center for Health Information Research (CHiR)
- QIC participation is a provider milestone
- The QIC provides:
  - Dashboards for providers on Quality Measures performance
  - Assistance with quality improvement actions
  - Technical assistance
  - Peer learning

SAMHSA Integrated Practice Assessment Tool (IPAT)

SAMHSA Six Levels of Collaboration/Integration					
Coordinated Care Key Element: Communication		Co-Located Care Key Element: Physical Proximity		Integrated Care Key Element: Practice Change	
LEVEL 1 Minimal Collaboration	**LEVEL 2** Basic Collaboration at a Distance	**LEVEL 3** Basic Collaboration On site	**LEVEL 4** Close Collaboration On site with Some Systems Integration	**LEVEL 5** Close Collaboration Approaching an Integrated Practice	**LEVEL 6** Full Collaboration in Transformed/Merged Integrated Practice

Positive Change in Level Of Integration

- Participating providers reported having a higher level of integration after the implementation of TI Program protocols from Year 2 (CYE 2018) to Year 3 (CYE 2019)

IPAT Levels	All Sites
Increased 5 Levels:	12 (3%)
Increased 4 Levels:	46 (13%)
Increased 3 Levels:	56 (15%)
Increased 2 Levels:	27 (7%)
Increased 1 Level:	80 (22%)
Any Increase	221 (60%)
No Increase:	147 (40%)
Total Sites:	**368**

Performance Outcomes TI vs. Non-TI

	Non-TI beneficiaries			TI beneficiaries			TI vs. Non-TI beneficiaries
Measure Description	**2017**	**2019**	**% Change**	**2017**	**2019**	**% Change**	**Difference- in- Difference**
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)	55.72%	57.51%	1.78%	58.73%	62.03%	3.30%	1.52%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	39.82%	36.67%	-3.15%	41.26%	41.30%	0.03%	3.18%
Follow-Up after Hospitalization for Mental Illness: 6-17 Years (7-day)	57.22%	55.92%	-1.30%	72.13%	70.79%	-1.34%	-0.04%
Follow-Up after Hospitalization for Mental Illness: 6-17 Years (30-day)	70.00%	70.14%	0.14%	87.82%	88.43%	0.61%	0.47%
Follow-Up after Hospitalization for Mental Illness: 18 and Older (7-day)	30.97%	24.76%	-6.21%	43.72%	45.12%	1.40%	7.61%
Follow-Up after Hospitalization for Mental Illness: 18 and Older (30-day)	45.35%	36.96%	-8.39%	66.82%	67.00%	0.17%	8.57%
Follow-Up after Emergency Department Visit for Mental Illness: 6-17 Years (7-day)	29.05%	30.66%	1.60%	76.48%	75.76%	-0.71%	-2.32%
Follow-Up after Emergency Department Visit for Mental Illness: 6-17 Years (30-day)	41.22%	41.61%	0.39%	84.43%	87.17%	2.74%	2.35%
Follow-Up after Emergency Department Visit for Mental Illness: 18 and Older (7-day)	17.84%	15.45%	-2.39%	46.30%	45.09%	-1.21%	1.17%
Follow-Up after Emergency Department Visit for Mental Illness: 18 and Older (30-day)	24.50%	24.28%	-0.22%	56.18%	54.29%	-1.88%	-1.66%
Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: 18 and Older (7-day)	7.44%	5.43%	-2.01%	27.44%	24.84%	-2.60%	-0.58%
Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: 18 and Older (30-day)	9.37%	8.08%	-1.30%	35.44%	33.61%	-1.83%	-0.53%
Well-Child Visits (Ages 3-6 Years): 1 or More Well-Child	57.40%	57.71%	0.31%	75.57%	77.64%	2.06%	1.76%
Adolescent Well-Care Visits: At Least 1 Comprehensive	36.36%	36.95%	0.59%	52.68%	56.47%	3.79%	3.21%

Targeted Investments Program 2.0

- AHCCCS seeks waiver authority to extend the TI Program from 2021 through 2026, known as the TI Program 2.0
- TI Program 2.0 will include two distinct cohorts:
  - **Extension cohort** will include current TI Program providers
  - **Expansion cohort** will include primary care practices and behavioral health providers with no prior TI participation
- AHCCCS will develop a concept paper in 2021 that outlines the details for the TI Program 2.0

Extension Cohort

- Projects will be designed to foster collaboration between medical providers and CBOs, particularly those crucial to addressing housing, food, employment, social isolation, and transportation
- Incentive payments will be based on:
  - Achievement of outcome measures
  - Continuation of high priority promising practices
  - Establishment of additional systems and infrastructure that supports advancing whole person care

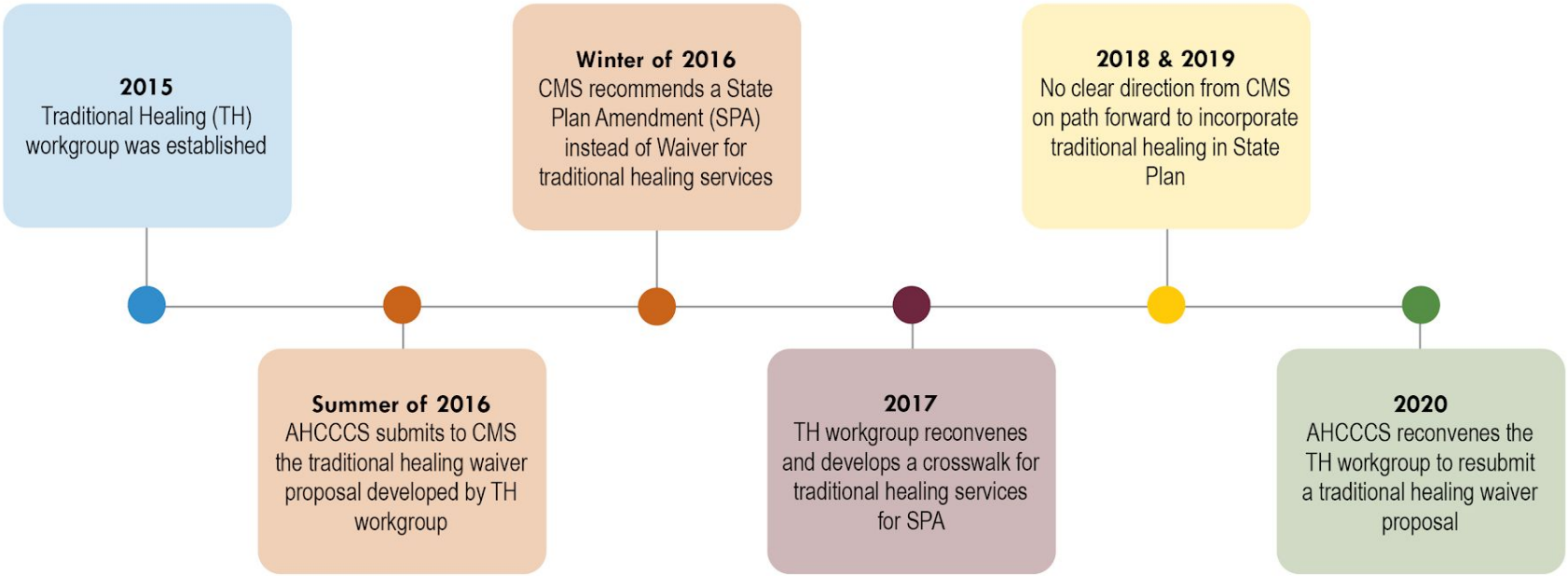
Expansion Cohort

- Eligibility requirements for this cohort will include:
  - Certified EHR that is capable of bi-directional data exchange
  - Minimum volume thresholds
  - Commitment to participate in the Learning Collaborative
- The program structure for this cohort will be modeled on the current TI Program with updates and revisions to the original core components, milestones, and incentives

Traditional Healing Services

- Tribes that reside in the state of Arizona utilize traditional healing practices
- Supported primarily through tribal funds, various pilot programs, grants, and individual personal resources
- Tribes have advised AHCCCS that traditional healing services will aid care coordination and help AHCCCS members achieve improved health outcomes

Traditional Healing Timeline



Traditional Healing Services

- AHCCCS is seeking waiver authority to reimburse traditional healing services and claim FFP for these services when provided by I/T/U facilities at the 100% FMAP

- The goal is to improve the health outcomes of AHCCCS members by making traditional healing services available in a complementary fashion with allopathic medicine

Traditional Healing Waiver Proposal

- Upon approval by CMS, the covered traditional healing services, limitations, and exclusions shall be described by each facility (working with each tribe they primarily serve)

- The array of practices provided by traditional healers shall be in accordance with an individual tribe's established and accepted traditional healing practices as identified by the Qualifying Entity

Qualifying Entity

- Responsible to define and endorse traditional healers and the services they perform
- An I/T/U facility or clinic governing body may serve as the Qualifying Entity
- The tribe(s) served by the facility may choose to designate another governing body as its Qualifying Entity

Tribal Dental Benefit (HB 2244)

- In 2016, AHCCCS implemented a dental benefit of $1,000 per member per contract year for individuals enrolled in ALTCS
- In 2017, AHCCCS implemented an emergency dental benefit of $1,000 per member per contract year for adult AHCCCS members
- In 2020, HB 2244, authorized AHCCCS to seek approval from CMS to reimburse IHS and 638 facilities to cover the cost of adult dental services that are eligible for 100% FMAP, that are in excess of the $1,000 limit

Tribal Dental Benefit (HB 2244)

- The purpose of this Demonstration is to improve oral health outcomes for American Indian/Alaska Native (AI/AN) members
- AI/AN adults suffer from untreated dental caries at twice the prevalence of untreated caries in the general U.S. population
- The geographic isolation of tribal populations & inability to attract dentists to practice in IHS or tribal health facilities in rural and frontier areas are contributors to these oral health disparities

Resources & Public Comment

- AHCCCS Waiver Renewal Request (2021-2026)

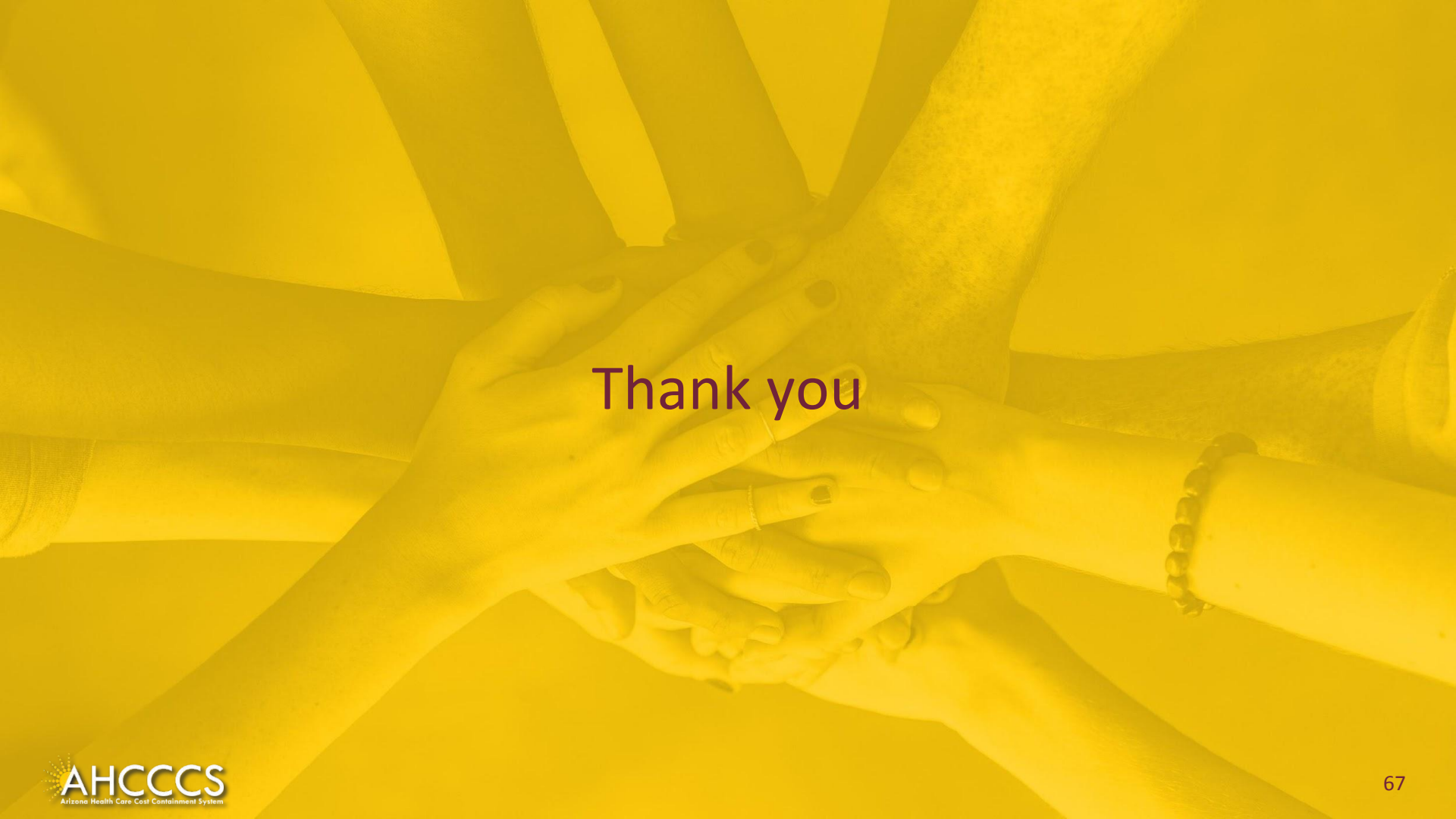
How do I submit public comment? Public comment can be

Discussed at public forums

Emailed to waiverpublicinput@azahcccs.gov

Mailed to 801 E Jefferson, Phoenix, AZ 85034 Attn: Federal Relations

Questions?



AHCCCS
Arizona Health Care Cost Containment System

AHCCCS
Arizona Health Care Cost Containment System

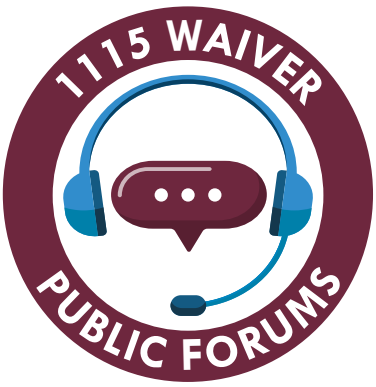
1115 WAIVER PUBLIC FORUMS

1115 Waiver Timeline

PUBLIC FORUMS	
Date/Time	Zoom Links
10/14/2020 **1:30 p.m. - 3:30 p.m.**	**Join from a PC, Mac, iPad, iPhone or Android device** **Link:** ahcccs.zoom.us/s/95104437350?pwd=VEoyczlBcFJzeDd1dnY1Q1BQbW1sZz09 **Passcode:** AHCCCS1# **Or join by phone** **Dial:** 1-408-638-0968 or 1-312-626-6799 or 1-646-876-9923 or 1-888-475-4499 (Toll Free) **Webinar ID:** 951 0443 7350 *International numbers available: ahcccs.zoom.us/u/acqEPtIyFX*
10/16/2020 **1:30 p.m. - 3:30 p.m.**	**Join from a PC, Mac, iPad, iPhone or Android device** **Link:** ahcccs.zoom.us/j/93089289712?pwd=Wnc3dVVWRmlpOVY5d3Y2UThZVVVEQT09 **Passcode:** AHCCCS2# **Or join by phone** **Dial:** 1-253-215-8782 or 1-669-900-6833 or 1-301-8592 or 1-312 626 6799 or 1-888-475-4499 (Toll Free) **Webinar ID:** 930 8928 9712 *International numbers available: ahcccs.zoom.us/u/ad7ZgYJXgJ*
11/13/2020 **1:30 p.m. - 3:30 p.m.**	**Join from a PC, Mac, iPad, iPhone or Android device** **Link:** ahcccs.zoom.us/s/93579026861?pwd=QThoVkVqN1NXbXNsbmo1SnhZVkVuUT09 **Passcode:** AHCCCS3# **Or join by phone** **Dial:** 1-669-900-6833 or 1-346-248-7799 or 1-408 638 0968 or 1-646-876-9923 or 1-877-853-5257 (Toll Free) **Webinar ID:** 935 7902 6861 *International numbers available: https://ahcccs.zoom.us/u/anRW3sYc*

During the public comment period of Oct. 1 through Nov. 30, comments can be emailed to waiverpublicinput@azahcccs.gov

AHCCCS
Arizona Health Care Cost Containment System



1115 Waiver Timeline

TRIBAL FORUMS		
Date/Time	Type of Forum	Zoom Link (* public meeting)
10/19/2020 1:00 p.m. - 4:00 p.m.	Special Tribal Consultation	**Registration Link:** ahcccs.zoom.us/webinar/register/WN_7PPYlgJ9QxqkdO5BL1U5cw **To connect via phone only:** 1-877-853-5257 OR 1-888-475-4499 (US Toll-free) **Webinar ID:** 923 6300 7953
11/5/2020 1:00 p.m. - 4:00 p.m.	Quarterly Tribal Consultation	**Registration Link:** ahcccs.zoom.us/webinar/register/WN_liV3Ku-dT8C5hioPKAjlig **To connect via phone only:** 1-877-853-5257 OR 1-888-475-4499 (US Toll-free) **Webinar ID:** 964 3342 7796

During the public comment period of Oct. 1 through Nov. 30, comments can be emailed to waiverpublicinput@azahcccs.gov

State Medicaid Advisory Committee (SMAC)

Quarterly Meeting
Wednesday, October 21, 2020
AHCCCS
(To Join by Web)
https://ahcccs.zoom.us/s/96486245677?pwd=YmQ2cFFmMUdsWmIvVmVvZEVKOVZ6Zz09
Meeting ID: 964 8624 5677
(To Join by Phone) 1-888-475-4499 Meeting ID: 964 8624 5677 (VIRTUAL MEETING)
1:00 PM - 3:00 PM

Agenda		
I.	**Welcome**	**Director Jami Snyder**
II.	**Attendance and Quorum Confirmation**	**ALL**
State Medicaid Advisory Committee Member Nominations		
III.	**Nomination Recommendations and Formal Vote**	**Tara McCollum Plese**
IV.	**Welcome New SMAC Members**	**Director Jami Snyder**
V.	**Appreciation and Farewell to the Expiring Committee Members**	**Director Jami Snyder**
Agency Updates		
VI.	**1115 Waiver Renewal**	**Director Jami Snyder**
VII.	**Call to the Public**	**Director Jami Snyder**
VIII.	**Adjourn at 3:00 PM**	**ALL**

2021 SMAC Meetings
Per SMAC Bylaws, meetings are to be held the 2nd Wednesday of January, April, July and October.
All meetings will be held from 1:00 PM - 3:00 PM unless otherwise deemed necessary by the Director.

January 13 , 2021
April 14, 2021
July 14, 2021
October 13, 2021

For information or assistance, please contact Brenda Morris at (602) 417-4029 or Brenda.Morris@azahcccs.gov.

AHCCCS SPECIAL TRIBAL CONSULTATION MEETING AGENDA

With Tribal Leaders, Tribal Members, Indian Health Services, Tribal Health Programs Operated under P.L. 93-638 and Urban Indian Health Programs

Topic: AHCCCS 1115 Waiver Renewal
Date and Time: October 19, 2020 from 1:00 p.m. to 4:00 p.m. (MST)
Location: VIRTUAL ONLY
Webinar Registration Link:
https://ahcccs.zoom.us/webinar/register/WN_7PPYlgJ9QxqkdO5BL1U5cw
Phone: **+1 877-853-5257 OR +1 888-475-4499 (US Toll-free)** / **MEETING ID**: 923 6300 7953

TIME	TOPIC	Presenter
1:00 PM – 1:05 PM	**Welcome and Introductions**	**Amanda Bahe** *AHCCCS Tribal Liaison*
1:05 PM – 2:00 PM	**AHCCCS 1115 Waiver Overview** • Waiver Renewal Timeline • AZ's Demonstration Historical Background • Demonstration Goals • Key Milestones • Current Demonstration Evaluation Activities • Current Demonstration Features to Continue Under Waiver Renewal • Proposed Changes to the Current Demonstration • Resources and Public Comment	**Jami Snyder** *AHCCCS Director*
2:00 PM – 4:00 PM	***Open Discussion and Tribal Consultation*** • AHCCCS Works • Tribal Dental Benefit • Traditional Healing Services • Prior Quarter Coverage • Targeted Investments Program • Verbal Consent In Lieu of Written Signature for ALTCS Members • General 1115 Waiver	
4:00 PM	**Announcements & Adjourn**	**Amanda Bahe**

Next AHCCCS Tribal Consultation Meeting: November 05, 2020

Time: 1 p.m. to 4 p.m. | Location: Virtual Only

Please see AHCCCS Tribal Consultation Webpage for Information

AHCCCS TRIBAL CONSULTATION MEETING AGENDA

With Tribal Leaders, Tribal Members, Indian Health Services, Tribal Health Programs Operated under P.L. 93-638 and Urban Indian Health Programs

Date and Time: November 5, 2020 from 1:00 p.m. to 4:00 p.m. (MST)
Location: VIRTUAL ONLY
Webinar Registration Link: https://ahcccs.zoom.us/webinar/register/WN_liV3Ku-dT8C5hioPKAjlig
Phone: **+1 877-853-5257 OR +1 888-475-4499 (US Toll-free)** / **MEETING ID**: 964 3342 7796

TIME	TOPIC	Presenter
1:00 PM – 1:05 PM	**Welcome and Introductions**	**Amanda Bahe** *AHCCCS Tribal Liaison*
1:05 PM – 1:45 PM	**AHCCCS Updates, including Waiver Renewal**	**Jami Snyder** *AHCCCS Director*
1:45 PM – 2:00 PM	***Open Discussion/Consultation on AHCCCS Updates***	
2:00 PM – 2:15 PM	**Housing Overview**	**David Bridge** *Director of Housing Programs*
2:15 PM – 2:25 PM	***Open Discussion/Consultation on Housing***	
2:25 PM – 2:40 PM	**AHCCCS Provider Enrollment Portal**	**Patricia Santa Cruz** *Division of Member and Provider Services*
2:40 PM – 2:50 PM	***Open Discussion/Consultation on AHCCCS Provider Enrollment Portal***	
2:50 PM – 3:05 PM	**SB 1523** **(previously listed as "Children's Behavioral Health Services Fund (CBHSF)")**	**Megan Woods** *Integrated Care Administrator*
	Open Discussion/Consultation on SB 1523	
3:05 PM – 3:30 PM	**DIVISION OF FEE FOR SERVICE MANAGEMENT UPDATES**	
	DDD-AIHP Update	**Karen Grady** *Deputy Assistant Director*
	American Indian Medical Home Update	**Leslie Short** *Integrated Services Administrator*
	Pharmacy Updates	**Ewaryst Jedrasik** *Clinical Administrator*
3:30 PM – 3:40 PM	***Open Discussion/Consultation on DFSM Updates***	
3:40 PM – 3:50 PM	**FEDERAL RELATIONS UPDATES**	
	State Plan Amendments	**Alex Demyan** *AHCCCS State Plan Manager*
	Open Discussion/Consultation on Federal Relations Updates	
3:50 PM – 4:00 PM	**AHCCCS POLICY UPDATES**	
	AHCCCS Tribal Consultation Policy Updates	**Amanda Bahe**
	Open Discussion/Consultation on AHCCCS Policy Updates	
4:00 PM	**Announcements & Adjourn**	**Amanda Bahe**

Next AHCCCS Tribal Consultation Meeting: December 10, 2020

Time: 3 p.m. to 5 p.m. | Location: Virtual Only

Please see AHCCCS Tribal Consultation Webpage for Information

AHCCCS
Arizona Health Care Cost Containment System

AGENDA

Medical Directors Meeting

October 16, 2020 9:00am – 12:00pm

Virtual Only

Join Zoom Meeting ID: 6313342545 Passcode: AHCCCS1!

Time	Topic	Presenter
9:00AM	**Welcome and Introductions** Lou, Matthew Isiogu, Julie Ambur, Will Buckley, Brittany Dettler, Chanchal Yadav, Cynthia Layne, Dana Flannery, Dr. Tim, Eric Tack, Jessica Kane, Jill Rowland, Kristin Nelson, Mark Carroll, Megan Woods, Marcia Smith, Ricardo Reyes, Sam O'Nel, Sara Salek, Seth Dubry, Steven Chakmakian, Vicki Copeland, Y Sebesan, Jakenna Lebsock, Cindy Hostetler, Scott Van Valkenburg, Ed Fess, Ed Gentile, Dr. Wilcox **Matthew Isiogu – CYE20 VBP Update**	Sara Salek, MD Chief Medical Officer - AHCCCS
9:05AM	**Waiver Updates**	Dana Flannery Assistant Director Division of Community Advocacy and Intergovernmental Relations (DCAIR)
9:15AM	**CMO Updates** • Telehealth • BH Taskforce • BK Lawsuit • Arizona Substance Abuse Partnership (ASAP) • ASD Advisory Committee • Community Quality Forum • AzAAH Steering Committee • Flu Strategy	Sara Salek, MD
9:40AM	**OOD Clinical Updates** • Crisis Counseling Program • ArMA Physician Peer Support Program • ASAM CONTINUUM PA-CR Revised Memo (Postponed to COVID Medical Directors Workgroup on 11/22)	Jill Rowland AHCCCS Chief Clinical Officer
10:10AM	**Telehealth Data Update**	Will Buckley AODA BI Manager
10:35AM	**DHCM Update** • MCO Performance Measure Workgroup - Jakenna • AMPM 320-P - Alex • AMPM 430 - Eric • ADHS Maternal Mortality Review Program - Eric • ADHS COVID/Flu Data - Eric • LOCUS and CALOCUS - Megan • TPL and COB - Christina	Jakenna Lebsock, Assistant Director - DHCM Eric Tack, MD Assistant Deputy Director - DHCM Alex Herrera Project Manager – DHCM Megan Woods Integrated Care Administrator - DHCM Christina Quast Operations Administrator - DHCM

11:30AM	**Birth To Five Helpline - Presentation**	Ana Arbel, MS Ed Senior Program Manager Southwest Human Development
11:55AM	**Agenda Items for Next Meeting**	All
12:00PM	**Meeting Adjourned** Next Meeting: Dec 4th	

AHCCCS
Arizona Health Care Cost Containment System
OFFICE OF INDIVIDUAL AND FAMILY AFFAIRS

OIFA Advisory Council Agenda

Tuesday, October 20th, 2020 10:30 AM - 12:00 PM

Introductions of first time attendees	10:30 - 10:33
Approve September Minutes	10:33 - 10:35
Foster Care, Steve Leibensperger	10:35 - 10:40
Family Support, Jamie Green	10:40 - 10:45
Member Focused Network Integration, Rick Ploski	10:45 - 11:00
1115 Waiver, AHCCCS FRAC	11:00 - 12:00

Join Zoom Meeting
https://ahcccs.zoom.us/j/92904855511?pwd=clVmWFo3UHJneEM4cGpYeG5KRDVRQT09

Meeting ID: 929 0485 5511
Passcode: AHCCCS1!

Next Meeting November 17th, 2020