AHCCCS
Arizona Health Care Cost Containment System

Arizona's Section 1115 Waiver Demonstration
Annual Report

Federal Fiscal Year 2022
October 1, 2021 – September 30, 2022

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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 40 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 October 14, 2022, the Centers for Medicare and Medicaid Services (CMS) approved an extension of Arizona's 1115 Waiver for a five-year period from October 14, 2022 to September 30, 2027. 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 (HCBS) 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 85, 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

Waiver Renewal:

The Centers for Medicare and Medicaid Services (CMS) approved Arizona's request for a five-year extension of its 1115 Waiver. This 1115 Waiver approval continues the long-standing authorities and programs that have made Arizona's Medicaid program innovative, effective, and efficient, including integrated managed care for AHCCCS populations through AHCCCS Complete Care (ACC); the Arizona Long Term Care System (ALTCS); the Comprehensive Health Plan (CHP) for children in foster care; and Regional Behavioral Health Agreements (RBHAs) which provide integrated care for individuals with a Serious Mental Illness (SMI) designation and the Waiver of Retroactive eligibility, which authorizes us 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.

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 Arizona Long Term Care System (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, and
- Waiver of Prior Quarter Coverage for specific populations.

In addition to renewing these historic programs, this 1115 Waiver includes approval for transformative projects intended to advance member health outcomes including Targeted Investments (TI) 2.0 and Housing and Health opportunities (H2O) demonstrations.

Housing and Health Opportunities (H2O) Approved

CMS approved the new Housing and Health Opportunities project to further address health-related social needs for vulnerable populations and ensure their access to health care.

For many years, Arizona has prioritized housing and used State General Fund dollars to support rental subsidies for nearly 3,000 individuals experiencing homelessness each year. AHCCCS and its contracted health plans have successfully leveraged this experience to expand the reach of housing opportunities, improve member health outcomes, and reduce overall health care costs.

Recognizing that stable housing is an important component of overall health, CMS approved the H2O program to strengthen outreach to vulnerable Medicaid members, including those experiencing homelessness, those living with an SMI, and young adults transitioning out of the foster care system. AHCCCS will be able to reimburse for up to six months of medically necessary transitional housing specifically for individuals transitioning out of institutional care or congregate settings such as nursing facilities, large group homes, congregate residential settings, Institutions for Mental Diseases (IMDs), correctional facilities, and hospitals; individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined by 24 CFR 91.5; and enhance those services that support a member's success in housing (i.e., tenant rights education, eviction prevention, housing transition navigation services, and medically necessary home modifications).

Tribal Dental Benefit Added

In 2020, the Arizona State Legislature approved a dental benefit for American Indian/Alaska Native (AI/AN) members that removed a prior $1,000 limit on services. This waiver approval will allow AHCCCS to reimburse Indian Health Services and Tribal 638 facilities for dental services provided to AI/AN adults beyond the existing $1,000 limit.

Negotiations Continue on Traditional Healing and In-Reach Services

In its approval notice, CMS recognized the State's interest in reimbursing for traditional healing services offered by tribal nations and will continue to work with Arizona on this request. Additionally, CMS noted its willingness to further explore reimbursement for pre-release services for individuals in federal, state, local, and tribal correctional facilities.

The Waiver approval is effective October 14, 2022 through Sept. 30, 2027. All documents, including the original and amended waiver applications and the approval letter from CMS, are posted on the AHCCCS 1115 Waiver web page.

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

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 public health emergency) is available on the AHCCCS COVID-19 Federal Emergency Authorities Request 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 2022. Additionally, waiver updates were added to agendas for AZ Advisory Council on Indian Health Care (AACIHC), IHS area directors, and Chief Medical Officer (CMO) meetings on a quarterly basis.

Stakeholder Meetings on 1115 Waiver Renewal/Amendment:

AHCCCS presented the details about Arizona's demonstration renewal proposal to the public and solicited feedback at several agency meetings: two 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), Tribal consultations, Office of Individual and Family Affairs (OIFA) Advisory Council, and AHCCCS Managed Care Organization (MCO) Update meetings.

IV. Outreach and Innovation Activities

The Division of Community Advocacy and Intergovernmental Relations (DCAIR)

The Division of Community Advocacy and Intergovernmental Relations (DCAIR) has three distinct teams that interface with Medicaid beneficiaries and their family members, community members, tribal leaders, and federal and state stakeholders. These three teams oversee federal and tribal policy relations and advocate on behalf of members to ensure that all perspectives and voices are considered in the health care policy and service delivery decision-making process.

The Office of Individual and Family Affairs (OIFA)

The Office of Individual and Family Affairs (OIFA) promotes recovery, resiliency, and wellness for individuals with mental health and substance use challenges. OIFA builds partnerships with individuals, families of choice, communities, and organizations. 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 their experiences. OIFA does this through a variety of channels and venues, such as:

- Participating on the AHCCCS Leadership team,
- Hosting a monthly System Navigation meeting highlighting OIFA empowerment tools and demonstrating how to use them when members encounter barriers to care,
- Connecting one-on-one with members and family members to promote healthcare literacy. Additionally, to better interface with the community, OIFA has developed an online survey form to capture direct communication with AHCCCS OIFA,
- Providing regular Jacob's Law training sessions for families and stakeholders, and
- Facilitating a monthly Community Policy meeting to educate community members on providing feedback through the Tribal Notification and Public Comment process.

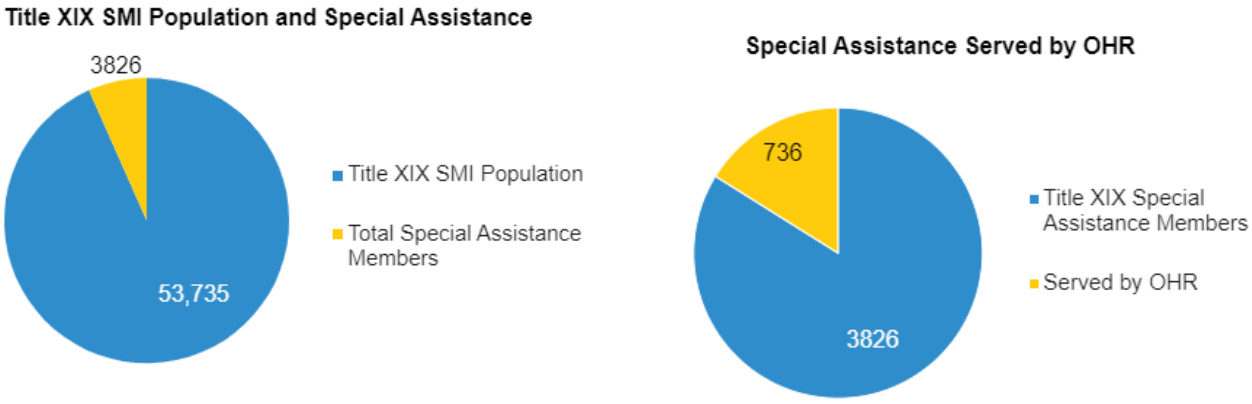
Beginning in May 2022, OIFA embarked on an innovative relationship with its contracted health plans and each of their OIFA Administrators by jointly creating the OIFA Alliance. This collaboration has proven to be a critical mechanism for making systemic changes and effective transformative improvements. Results since the inception of the OIFA Alliance include:

- Creation of the Peer Support Credentialing Enhancement Initiative,
- Revitalization of foundational document: 12 Guiding Principles in the Children's System of Care, and
- Educational training on the importance of member *Voice and Choice.*

The Office of Human Rights (OHR)

The Office of Human Rights (OHR), established under Arizona Administrative Code (A.A.C.) R9-21-104, is responsible for assisting AHCCCS members living with a Serious Mental Illness (SMI), promoting their rights, and ensuring access to entitled Medicaid services. OHR promptly identifies and assigns designated representatives to assist these members in participating in treatment planning, discharge planning, and the SMI appeal, grievance, and investigation processes. OHR provides technical assistance to all members with an SMI designation who request it. As of September 30, 2022, 7.1% of AHCCCS members living with a Serious Mental Illness (SMI) met the criteria for Special Assistance. Of those qualifying for Special Assistance, OHR serves as the designated representative to 19%, while the remainder are supported by court-appointed guardians and/or natural supports who also receive ongoing support from OHR as needed. The OHR advocates work with the members and natural support to promote self-advocacy and behavioral health education. Each advocate strives to empower members and their natural supports to navigate the behavioral health system independently when possible.

Statewide SMI Population/Members Designated to Need Special Assistance as of September 30, 2022



OHR tracks all field encounters which can include: an individual's home, community, jail, or hospital visit to a Special Assistance member; clinical staffing for Special Assistance member; meetings and coordination with behavioral health and other providers (such as DES/DDD); grievance and appeal investigations, interviews, informal conferences, and hearings; discharge planning and Individual Service Plan meetings, Adult Recovery Team meetings, intakes and/or transfer meetings with Special Assistance members, meeting for temporary short-term technical assistance (for SMI members who do not require Special Assistance), and training conducted or received directly related to behavioral health.

During the COVID-19 Public Health Emergency, although all field encounters were conducted virtually to meet social distancing and public health guidelines, the average number of monthly encounters remained consistent year-over-year from 2020 through 2022.

OHR offers training opportunities to members, families, natural supports, guardians, and professional stakeholders, which has increased community engagement and increased the number of members who meet special assistance criteria.

OHR hosted five trainings from October 1, 2021 through September 30, 2022, providing engagement and education to a total of 1472 attendees for the following topics:

- The Individual Service Plan (ISP) and Why it Matters,
- SMI Rights for Individuals with a Serious Mental Illness,
- Court-ordered Evaluation/Treatment (COE/COT)for Individuals Living with a Serious Mental Illness,
- Inpatient Treatment and Discharge Planning (ITDP) for Individuals with a Serious Mental Illness, and
- The Grievance and Appeals Process for Individuals Living with a Serious Mental Illness.

Federal Relations and Communications (FRAC)

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

- Federal Relations and Health Policy Advisor,
- Federal Waiver and Evaluation Administrator,
- 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 and ad hoc Tribal Consultation meetings with Arizona tribal communities, Indian Health Services, including Urban Indian Organizations, and tribally-owned, and/or operated 638 programs and facilities; and 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.

With the onset of the COVID-19 pandemic and the declaration of the Public Health Emergency (PHE), the AHCCCS FRAC team guided AHCCCS leadership through the federal process of requesting waivers of Medicaid and Children's Health Insurance Program (CHIP) requirements in order to combat the continued spread of COVID-19. The agency identified more than 50 different programmatic changes that strengthened the provider workforce, removed barriers to care for AHCCCS members, enhanced Medicaid services and support for vulnerable members, and removed cost sharing and other administrative requirements for the duration of the emergency period.

On March 11, 2021, the American Rescue Plan Act of 2021 (ARPA) was enacted into law. Section 9817 of the ARPA provides an opportunity for states to infuse additional dollars into Home and Community Based Services (HCBS) programs through reinvestment funds generated by an enhanced Federal Medical Assistance Percentage (FMAP) on qualifying services. Throughout 2021, the FRAC team solicited stakeholder feedback, aggregated this feedback and system needs, and compiled a comprehensive spending plan for the utilization of these funds to sustainably improve the HCBS system in Arizona. On January 19, 2022, AHCCCS received conditional approval from CMS to implement activities described in

the State's spending plan. Since that date, AHCCCS has initiated planning and implementation of these initiatives, including making over $500 million in direct provider payments to attract and retain the HCBS workforce.

On December 22, 2020, AHCCCS submitted an 1115 waiver renewal application to CMS, and on May 26, 2021, a subsequent amendment to this request titled Health and Housing Opportunities (H2O). On September 30, 2021, CMS issued a one-year extension, and on October 14, 2022, AHCCCS' innovative waiver renewal was approved. This approval included the continuation of AHCCCS' legacy programs including retroactive eligibility, HCBS, and managed care. It also included innovative programming such as an expanded tribal dental benefit, Targeted Investments 2.0, and the H2O demonstration proposal. AHCCCS continues to negotiate terms for Traditional Healing services and pre-release services for individuals in correctional facilities.

In FFY 2022, AHCCCS submitted several State Plan Amendments (SPAs) to implement program changes intended to improve access to and quality of care received by Medicaid and CHIP members. These changes include the addition of services provided by chiropractors as well as diabetes self-management training. In addition, Arizona submitted a SPA to implement 12-month continuous eligibility for all CHIP members and 12-month postpartum continuous eligibility for both Medicaid and CHIP members.

Communication and Engagement

In March 2022, AHCCCS added Instagram to its list of official social media accounts and is now reaching more than 5,000 additional screens each month on that platform. Engagements across other platforms (Twitter, LinkedIn, and YouTube) continue to increase month over month. Year over year, AHCCCS has increased posts by 900, garnered over 10,000 more engagements with a 8.1% combined engagement rate, and now has a total of almost 10,000 followers. In addition, the agency has launched a new video series called "AHCCCS Explains" which is the most watched series of videos across its social media channels.

To standardize language in all public-facing publications, FRAC created and published an Agency Editorial Guide and proofreading process that has increased consistency and accuracy in all materials. Since its implementation, more than 17,000 pages of documents have been through the proofreading process. The communication team presents regular webinars to train employees on this process.

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

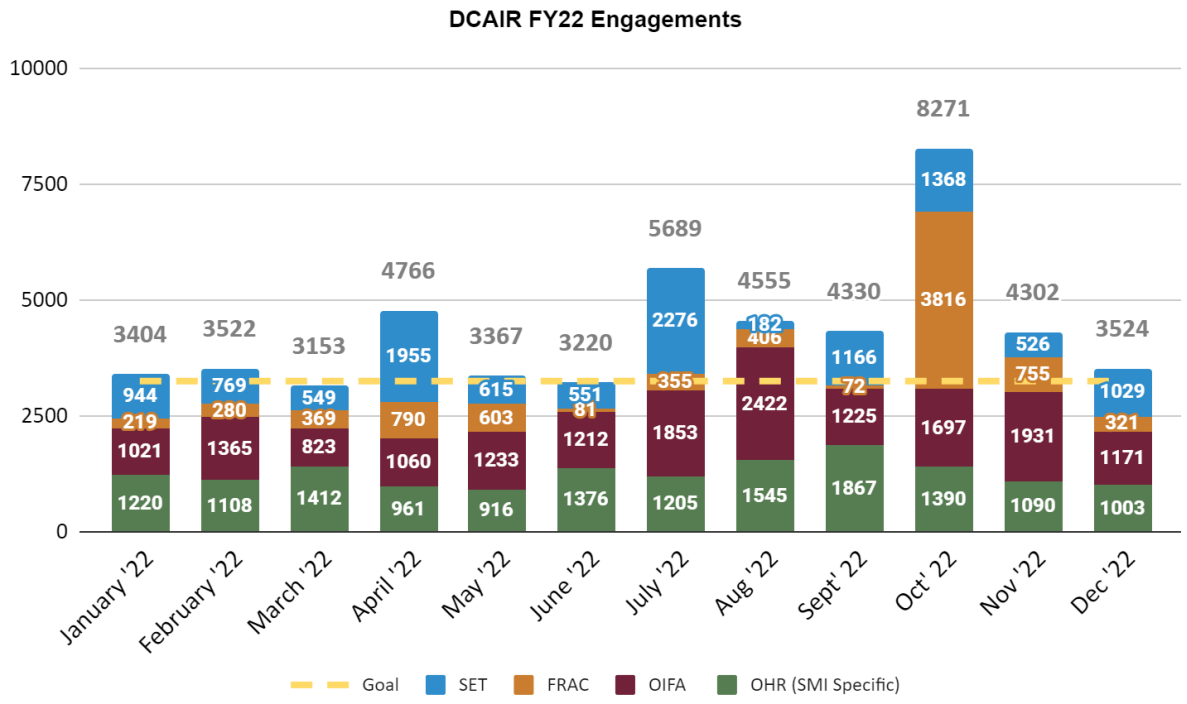
- ALTCS Advisory Council meets quarterly to assist the ALTCS program to develop and monitor a work plan that addresses opportunities for new service innovations or systemic issues impacting ALTCS members. The Advisory Council consists of ALTCS members and their family/representatives, Managed Care Organizations (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. 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. SMAC is composed of 10 professional members, 10 members of the public, and three ex-officio members. The AHCCCS Director attends these meetings.
- The 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, Autism Spectrum Disorder (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.
- The 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 (Department of Economic Security, Department of Health Services, Administrative Office of the Courts, 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 leaders 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 (AI/AN) members.
- The OIFA Advisory Council is a monthly meeting consisting of peers, family members, and other community stakeholders. The purpose of this council is to bring together leadership of peer and family behavioral health service providers and peer and family advocacy groups to influence system structures and policies and to benefit from regular contact with each other and with AHCCCS Leadership.

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,
- Unwinding from the COVID-19 Public Health Emergency (PHE),
- Grants,
- Behavioral health initiatives,
- Arizona's crisis system,
- The American Rescue Plan (ARP),
- 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, and/or methods to simplify system navigation). Thus, in 2022, DCAIR engaged with 52,103 community members, stakeholders, and external partners between January 1, 2022 and December 28, 2022, fully illustrating outstanding engagement metrics performance for this division.



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:

- Ask an Expert meetings: On a monthly basis, AHCCCS holds a one and a half hour-long meeting, Ask an Expert, 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 Health E- Arizona Plus (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 can ask questions directly to a panel of agency subject matter experts. This meeting is two hours long with an average participation of more than 300 assistors.
- Annual Security Training 2022: In 2022, AHCCCS provided a Community Partner- New Assistor Training to refresh understanding of roles and responsibilities and educate assistors about Health E-Arizona plus (HEAPlus) features and navigation and how to obtain technical assistance.
- Joint Eligibility Appeals meetings. This joint meeting of staff involved in the eligibility appeal process from AHCCCS and DES was held to discuss the appeals process once the PHE ends.
- Provided twelve presentations on general eligibility requirements, renewal policies and processes, enrollment choice and changes, and PHE related topics in FFY 2022. The presentations were provided to Indian Health Service, Tribal, and Urban Indian health programs (CMS ITU) Regional Training event attendees, the Veterans Administration, the Behavioral Health Council, Verde Valley, and a monthly community forum hosted by the Department of Economic Security for legal assistance advocates. AHCCCS Eligibility Overview presentations were provided to an average audience size of 50 attendees.

V. Enrollment Information

Table 1 contains a summary of the number of unduplicated enrollees for FFY 2022 (October 1, 2021—September 30, 2022), 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	1,363,290	16, 814	22,096
Acute SSI	232,439	1,169	12,108
Prop 204 Restoration	547,627	7,576	13,969
Adult Expansion	195,800	2,661	3,025

LTC DD	37,772	221	610
LTC EPD	34,358	172	6,781
Non-Waiver	157,304	1,519	7,360
Total	**2,568,590**	**30,132**	**65,949**

Table 2 is a snapshot of the number of current enrollees (as of October 1, 2022) 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]	**1,582,125**
Title XXI funded State Plan [2]	**68,783**
Title XIX funded Expansion[3]	**674,904**
• **Prop 204 Restoration (0-100% FPL)**	**530,773**
• **Adult Expansion (100% - 133% FPL)**	**144,131**
Enrollment Current as of	10/1/2022

VI. Consumer Issues

Table 3 is a summary of advocacy issues received by the Office of Client Advocacy (OCA) in FFY 2022.

[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

Table 3

Advocacy Issues[4]	Quarter 1 10/1/21-12/31/21	Quarter 2 1/1/22-3/31/22	Quarter 3 4/1/22-6/30/22	Quarter 4 7/1/22-9/30/22	Total
Billing Issues ● Member reimbursements ● Unpaid bills	18	19	11	4	**52**
Cost Sharing ● Co-pays ● Share of Cost (ALTCS) ● Premiums (KidsCare, Medicare)	3	2	2	5	**12**
Covered Services	27	40	17	9	**93**
ALTCS ● Resources ● Income ● Medical	18	8	3	13	**42**
DES ● Income ● Incorrect determination ● Improper referrals	36	47	38	62	**183**
KidsCare ● Income ● Incorrect determination	0	0	0	0	**0**
SSI/Medical Assistance Only ● Income ● Not categorically linked	12	3	14	13	**42**
Information ● Status of application ● Eligibility criteria ● Community resources ● Notification (Did not receive or didn't understand)	144	155	137	148	**584**
Medicare ● Medicare coverage ● Medicare Savings Program ● Medicare Part D	6	5	5	11	**27**
Prescriptions ● Prescription coverage ● Prescription denial	2	2	3	6	**13**
Fraud-Referred to Office of Inspector General (OIG)	2	3	4	5	**14**
Quality of Care-Referred to Division of Health Care Management (DHCM)	38	63	38	21	**160**
Total	**306**	**347**	**272**	**297**	**1,222**

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

Table 4

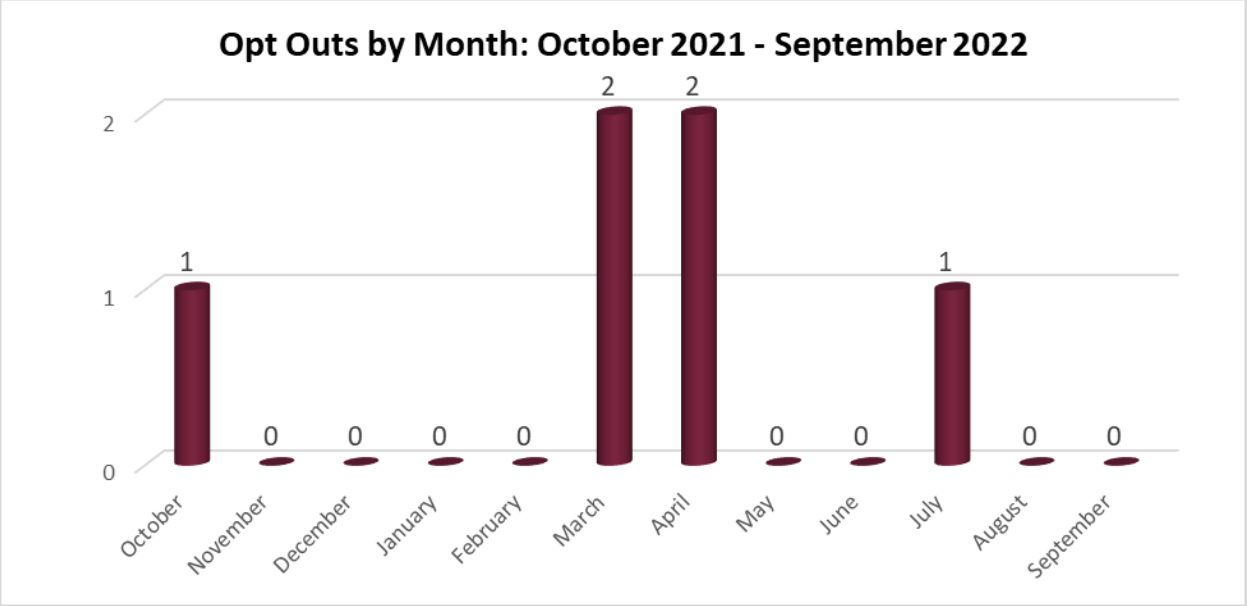
Issue Originator[5]	Quarter 1 10/1/21-12/31/21	Quarter 2 1/1/22-3/31/22	Quarter 3 4/1/22-6/30/22	Quarter 4 7/1/22-9/30/22	Total
Applicant, Member or Representative	165	229	161	123	**678**
CMS	4	5	5	9	**23**
Governor's Office	43	25	28	27	**123**
Ombudsmen/Advocates/Other Agencies	91	81	68	135	**375**
Senate & House	3	7	10	3	**23**
Total	**306**	**347**	**272**	**297**	**1,222**

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

Tables 5 through 9 below illustrate the number of opt-out requests filed by individuals with an SMI designation 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.

Opt Out Charts for FY22
October 2021 – September 2022

Table 5



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

Table 6

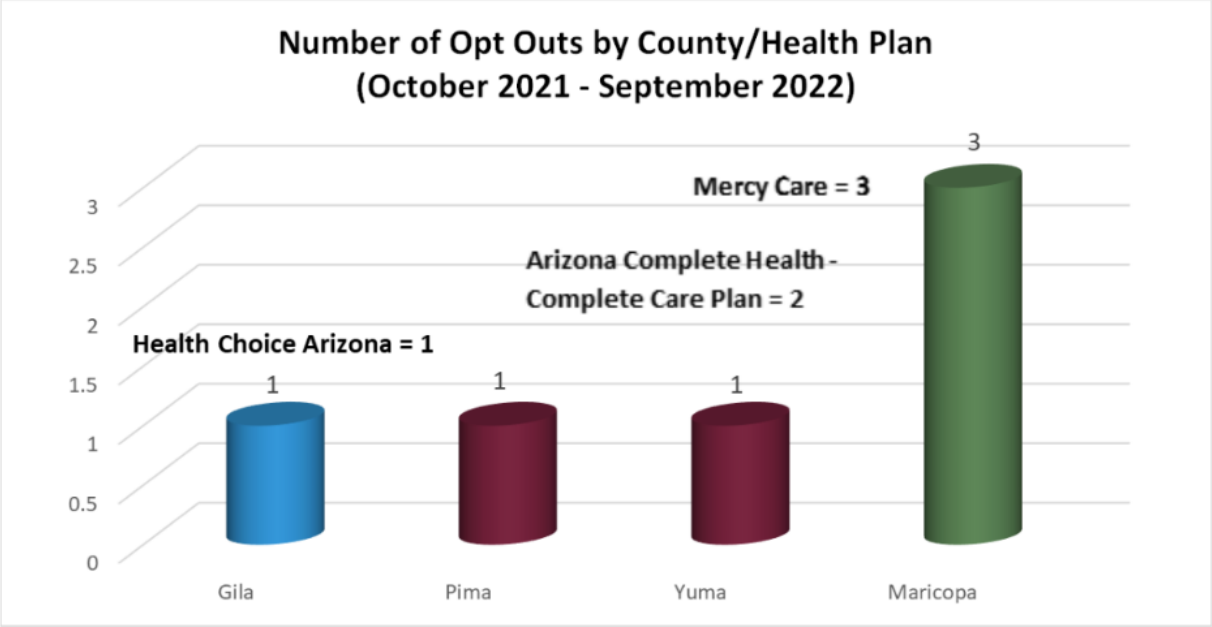


Table 7

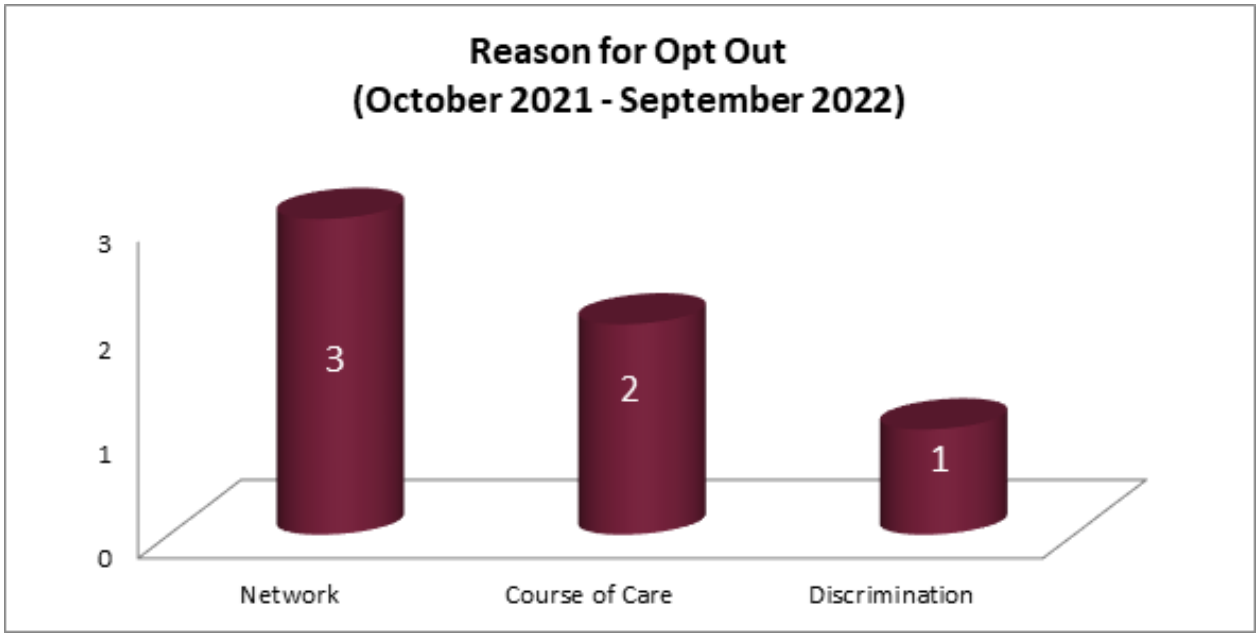


Table 8

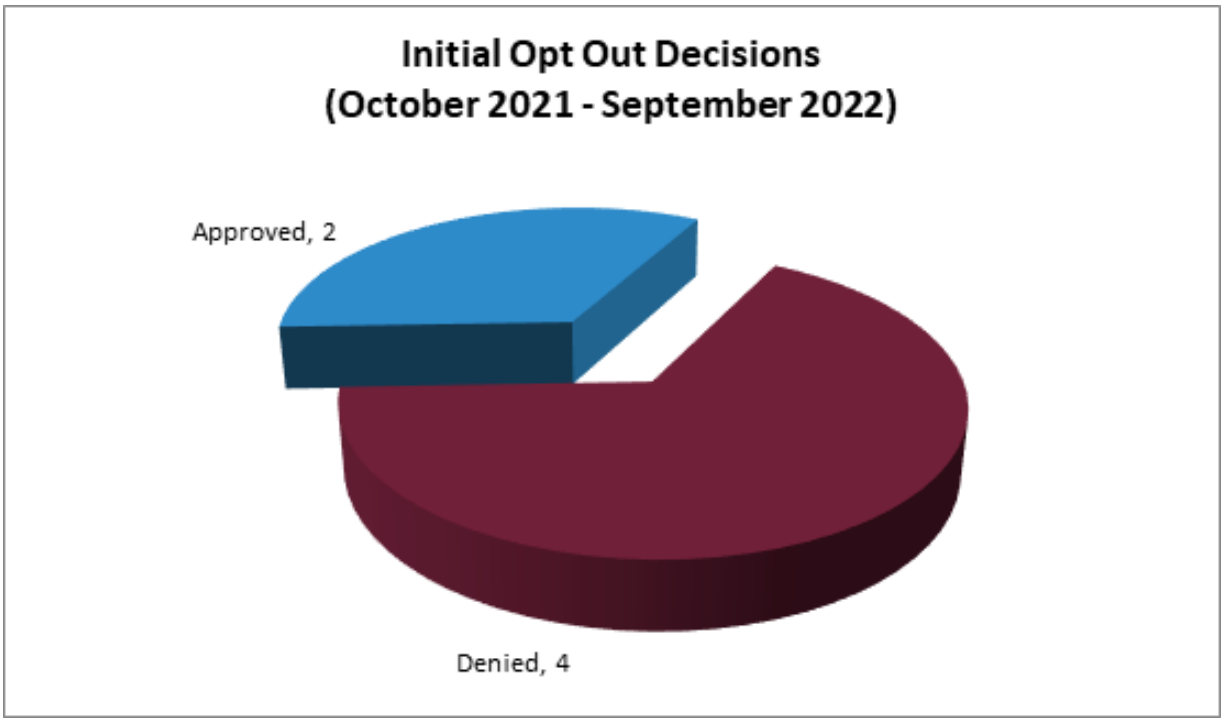


Table 9

Appeal Outcomes (October 2021 - September 2022)			
Approved	**Withdrawn**	**Denied**	**Pending**
0	**0**	**0**	**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. Solari Crisis Response Network, AHCCCS' contracted vendor, 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.

VIII. Demonstration Operations and Policies

Legal Update

The Office of the General Counsel (OGC) provides legal counsel to the AHCCCS Administration, is responsible for the Agency rulemaking process, ensures compliance with privacy and public records requirements, and oversees the TXIX and SMI Grievance Systems for the AHCCCS Program. 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. Oversight of privacy and confidentiality matters, including HIPAA and Part II compliance issues, is another key responsibility of OGC and is performed by the AHCCCS Privacy Officer.

From October 1, 2021 through September 30, 2022, OGC received 17,074 matters, including member appeals, provider claim disputes, ALTCS trust reviews, and eligibility appeals. Of the 17,074 total cases received during this time period, 332 were member appeals, 15,521 were provider claim disputes, 168 were ALTCS trust reviews, and 1,053 were eligibility appeals. OGC issued 581 Director's Decisions after State Fair hearings were held. In addition, OGC issued 15,664 informal dispositions of disputes filed with the AHCCCS Administration. In excess of 97 percent of these disputes were resolved at the informal level, thus obviating the need for State Fair Hearings in these cases.

Litigation Activity

The following is a summary of major litigation involving legal challenges to the AHCCCS program during this federal fiscal year (FFY). Major litigation activity during FFY 2022 concerned the following four cases. Historical details for the matters were outlined, and are available, in previous annual reports at https://azahcccs.gov/Resources/Reports/federal.html.

- Arizona Alliance of Community Health Centers et al. v AHCCCS,
- John Doe v. Snyder (Formerly D.H. and John Doe v. Snyder),
- CMS Disallowance of Medicaid School-Based Direct Services Claims, and
- The Center to Promote Healthcare Access (d/b/a Alluma) v AHCCCS.

For these four matters, major litigation developments during this FFY are summarized below.

1. Arizona Alliance of Community Health Centers et al. v AHCCCS(Refer to previous annual reports for earlier legal activity)

Oral argument before the Ninth Circuit Court of Appeals was heard on March 10, 2022. On September 2, 2022, the Ninth Circuit reversed in part and vacated in part the district court order dismissing the case. The court ruled AHCCCS must cover adult chiropractic services in FQHCs and sent the case back to

determine CMS's rationale for approving AHCCCS's state plan's limitations on the other "physicians' services" in FQHCs. On September 13, 2022, AHCCCS filed a Petition for Panel Rehearing asking the court to consider the effect of new legislation covering chiropractic in Arizona and asking that part of the decision to be reconsidered. AHCCCS is waiting for a ruling on its Petition.

2. John Doe v. Snyder (Formerly D.H. and John Doe v. Snyder) (Refer to previous annual reports for earlier legal activity)

The Plaintiffs appealed the denial of their requested preliminary injunction and the Ninth Circuit heard oral argument on the denial of the motion for preliminary injunction on November 19, 2021. On March 10, 2022, the Ninth Circuit affirmed the denial of Plaintiffs' motion for a preliminary injunction. On July 19, 2022, the remaining plaintiff stipulated to dismiss the case and on July 29, 2022, the court entered its order dismissing the case.

3. CMS Disallowance of Medicaid School-Based Direct Services Claims (Refer to previous annual reports for earlier legal activity)

On January 28, 2022, the district court ruled in AHCCCS' favor on CMS' motion to dismiss. On February 2, 2022, AHCCCS filed a Second Amended Complaint and on February 22, CMS filed its Answer. A schedule for discovery and briefing was set on April 5, 2022. Discovery closed September 2, 2022, and AHCCCS filed its Opening Brief on September 16, 2022. CMS filed its Motion for Summary Judgment on the equitable tolling issue and Answering Brief on October 19, 2022.

4. The Center to Promote Healthcare Access (d/b/a Alluma) v AHCCCS (Refer to previous annual reports for earlier legal activity)

The Maricopa County Superior Court heard oral argument on the briefs of the parties on October 19, 2021. On December 14, 2021, the court issued a ruling that upheld the rejection of Alluma's bid but held the ALJ should have allowed Alluma to contest peripheral issues. Alluma did not appeal and the Office of Administrative Hearings set a hearing for April 8, 2022. Alluma decided to drop its further appeal and the case was dismissed with prejudice at OAH on March 22, 2022.

Legislative Update

The legislature passed a number of bills in the 2022 legislative session that will impact the agency, including:

- **HB 2157** ("supplemental appropriations; community-based services") provided expenditure authority to AHCCCS for implementation of its ARPA HCBS spending plan for SFY22, with certain reporting requirements and other provisions. HB 2157 was signed into law and went into effect on 3/1/2022.
- **HB 2551** ("CHIP; redetermination") requires AHCCCS to allow a member who is determined eligible for CHIP to maintain coverage for a period of 12 months, unless the member exceeds the age of

eligibility during that 12-month period, with additional specific exceptions. Contingent upon CMS approval.

- **HB 2622** ("eligibility; AHCCCS") requires AHCCCS to annually renew eligibility of individuals within the foster care system until age 26, with certain specific exceptions, contingent upon CMS approval.
- **HB 2691** ("health care workforce; grant programs") creates a variety of programs to promote healthcare workforce development, including certain grant programs to be administered through AHCCCS, including the Student Nurse Clinical Rotation and Licensed or Certified Nurse Training Pilot Program, and the Behavioral Health Pilot Program.
- **HB 2862/HB 2863** (budget bills) contain appropriations for state agencies and programs. Specific to the AHCCCS Administration, the budget included the following items:
    - Additional funding for providers of services for Elderly and Physical Disabled individuals,
    - Additional funding for increased reimbursement rates for Behavioral Health Outpatient services and the Global Obstetric Package,
    - Expansion of covered services, to include chiropractic services and outpatient diabetes self-management training education, contingent upon CMS approval,
    - Funding to extend postpartum eligibility to 12 months, contingent upon CMS approval, and
    - Funding for critical IT projects, such as a system integrator for AHCCCS' Medicaid Enterprise System (MES) Modernization, and funding to come into compliance with federal interoperability regulations.

The Arizona Legislature adjourned Sine Die on June 24, 2022; the general effective date for legislation was September 24, 2022. The next legislative session will begin in mid-January of 2023.

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. 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). In FFY 2022, OIG achieved a total of $47,110,320.70 in recoveries and savings for all programs.

The OIG includes five sections 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, performs three Program Integrity data audits, and conducts periodic utilization reviews of target providers to identify trends, determine potential fraudulent billing practices, and to use the data to drive case development.

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: a Compliance and Audit unit, a Post Pay Audit unit, Collections unit, and a Referral Administrative team. PIAS conducts performance improvement projects and independent provider audits.

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).

Forensic Accountant Unit (FAU)

FAU provides financial fraud assistance in cases related to Complex Health Care Frauds, Health Care Corporate Compliance Fraud, and Health Care Financial Frauds. FAU makes independent referrals to the State Medicaid Fraud Control Unit (MFCU) and other city, state, and federal law enforcement authorities.

OIG works to continually increase its partnerships among federal, state, and local law enforcement. To support this effort, the OIG has developed relationships with several county prosecutors who successfully prosecuted cases involving health care theft, fraudulent schemes, and/or elder abuse prosecutions. OIG's primary goal is to increase associations with county prosecutors to create joint casework and initiatives between agencies. The secondary goal is to identify the subjects who accept plea deals, are convicted, and are sentenced, and to report those individuals to the U.S. Department of Health and Human Services' (HHS) OIG, for potential exclusions. OIG has submitted county prosecutions to HHS OIG for review of potential exclusions.

This year, OIG has developed successful partnerships, and renewed established partnerships, with law enforcement to bolster its ongoing program integrity efforts, including, but not limited to, the following:

- Division of Fee for Service Management's (DFSM) Audit Unit has established a renewed partnership with OIG to provide FWA referrals to OIG. Referrals are provided to OIG on a weekly basis, in which OIG either accepts or rejects the referral. Additionally, Audit requests come through once a month for proposed audits that DFSM would like to perform. OIG reviews these audit requests for any case overlap prior to any approvals. All audit findings are then reported to OIG, during a joint divisional audit finding review and as important items are identified, for further fraud, waste and abuse referral processes. There were 205 referrals from DFSM Audit Unit that were reviewed and accepted by OIG for investigation. 78 audit requests were approved for DFSM to proceed with audits. 22 audit requests were denied due to existing OIG cases.

- Adult Protective Services (APS) and Law Enforcement Collaboration Meetings. OIG has successfully partnered in the joint monthly law enforcement meetings where APS presents cases to determine if there is overlap, criminal liability and other items worthy of sharing. This collaboration meeting is also staffed with several county prosecutors, AGO, City of Phoenix Police Department, and the APS investigators. New leads and other items unrelated to FWA were identified through this collaboration. All quality of concern issues were given to OIG and sent to the appropriate AHCCCS sections.
- The Internal Revenue Service (IRS) established a Joint Criminal Task Force to pursue Financial Crimes in Arizona. For the first time ever, the IRS has connected with OIG to jointly investigate providers of interest. Due to the other Law Enforcement agencies also involved with the IRS's task force, several new leads have resulted from this collaboration. OIG currently has several joint cases open with the IRS.
- OIG and the Attorney General's Medicaid Fraud Control Unit (MFCU) developed an additional partnership under their Memorandum of Understanding with the creation of a joint liaison position. This partnership involves an Investigator who works out of the MFCU Office one day a week to facilitate the communication and progression of joint cases between the two agencies. Duties include data mining and research, inquiries on providers, reviewing of records and data with MFCU personnel, and other items as they arise.
- Arizona Department of Health Services (ADHS) and OIG have collaborated to work jointly to remove providers from the AHCCCS system who are no longer licensed and have closed their facilities. ADHS has begun proactively sending OIG Closure notices so that OIG can, in turn, terminate the Provider Participation Agreements (PPA) for these providers. The discussion of a potential Memorandum of Understanding (MOU) is in the works between the two agencies. The goal of the MOU would be to enable information sharing without jeopardizing existing cases.
- OIG continues to be an active member in a new, undergraduate Health Care Compliance and Regulations degree program as a member of the Advisory Board Committee, and as a faculty member, for Arizona State University (ASU), Edson College of Nursing and Health Innovation. 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. This year OIG has brought on four interns to collaborate and work with various projects in the OIG. Two of the interns applied for full time positions and were offered full time positions within MCS and PIAS.

The OIG Self Disclosure Program incorporates both Title XIX and Non-TXIX program violations. Once an inappropriate payment is discovered by a provider that warrants Self-Disclosure, providers are encouraged to contact OIG as early in the process as possible to maximize the potential benefits of Self-Disclosure. In FFY 2022, OIG realized a total of $1,796,452.16 of combined recoveries and program savings for both Title XIX and Non-Title XIX Self Disclosures.

- Accepted 31 Self-Disclosure cases

  - 30 Title XIX cases
  - 1 Non-TXIX cases
- Achieved $1,493,847.05 in total recoveries
  - $1,468,330.86 Title XIX recoveries
  - $24,668.96 Non-TXIX recoveries
- Accomplished $302,605.11 in program savings
  - $302,605.11 Title XIX program savings
  - $0 Non-TXIX program savings

OIG is not interested in fundamentally altering the day-to-day business processes of provider organizations for minor or insignificant matters. OIG recognizes that many improper payments are discovered during a provider's internal review or audit process. While providers who identify that they have received improper payments from the AHCCCS program are required to return the overpayments, OIG desires to develop and maintain a fair, rational process that will be mutually beneficial for both the State of Arizona and the concerned provider. The OIG Self-Disclosure process is a proven success and will continue to be so.

Provider Compliance Section

In FFY 2022, AHCCCS' OIG:

- Accepted 1,185 cases for investigation,
- Achieved a total of 20 convictions, and
- A total of $29,904,200.94 was recovered and saved with the Provider Compliance Program.

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. Billing under the wrong provider ID is a violation of the Provider Participation Agreement, AHCCCS policies, and is viewed as filing a false claim. Case examples include, but are not limited to, the following:

- PCS recovered $311,874.69 from a physician who was billing under the wrong ID and had multiple providers who were not credentialed with the Health Plans at the time services were provided.
- PCS recovered $220,347.22 from another physician who was billing under the wrong ID.
- PCS recovered $167,504.41 from yet another physician who was billing under the wrong ID.

PCS initiated a joint project with the Bureau of Residential Facilities Licensing Team at ADHS to work to terminate providers that were unlicensed and/or closed, and had failed to report the closures to AHCCCS as required in their Provider Participation Agreements (PPA). As a result of this project, 94 Behavioral Health Residential Facilities (BHRF) were terminated and $12,070,747.63 in savings were recognized. Additionally, $273,234.19 was identified as overpayments for providers that billed AHCCCS while they were no longer licensed. Approximately 25 Investigators from OIG and approximately 5 ADHS employees worked to facilitate this project to completion.

PCS identified a need to reduce the number of aged provider cases. Therefore, PCS implemented a plan for a Case Closure Project. PCS Investigators were required to spend four hours per week dedicated to reviewing aged provider cases to determine if there was credible evidence to substantiate Medicaid Fraud, Waste, and Abuse. Those cases that did not warrant an investigation were closed and no further action was taken. By allowing PCS Investigators to focus four hours on aged case work per week, they were able prioritize their work to address the problem. Additionally, it allowed for consistency among all PCS Investigators to be working on the problem together. As a result of this successful project, 653 cases were able to be closed during this FFY.

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

- Thirteen payment suspensions of behavioral health providers for providing services to AHCCCS members through unlicensed/unqualified personnel, billing for services not provided, failing to adhere to the requirements of AHCCCS provider agreements, creating false documentation, failing to adhere to medical documentation requirements, etc.
- Two 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.
- One payment suspension for a provider misrepresenting themselves as an Attendant Care (ATC) company. acting as a NEMT company. An ATC company is required to be billing at least 70% of ATC services, with a maximum of 30% being NEMT.

OIG also reviewed and performed eight terminations either in conjunction with or in lieu of the Credible Allegation of Fraud Payment Suspensions.

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

- Billing for services for a member by one provider while the member is in an inpatient facility.
- Utilizing Lexis Nexis data to identify prescribers who account for a high percentage of prescriptions or dollar amounts at pharmacies or other dispensers.
- Reviewing data outputs to better define potential overlap flags. Redefined identification includes ensuring providers flagged within potential data analytics are also identified as having an open OIG case.

Fee for Service Investigations Unit (FIU)

In FFY 2022, FIU, as part of PCS, continues to drive casework. FIU investigates matters related to AHCCCS Fee for Service business line as it relates to fraud, waste, and abuse. However, it should be noted that referrals are received from multiple avenues and not just limited to AHCCCS Division of Fee for Service Management (DFSM) as a referral source. FIU consists of seven investigators, four of whom have extensive, in-depth Fee-for-Service knowledge. FIU works closely with local police departments, MFCU, and federal agencies in working joint investigations.

FFY 2022 activity for FIU includes:

- 67 referrals received and cases opened from AHCCCS Division of Fee for Service Management (DFSM) Audit Team. This does not include 204 additional cases and referrals received from other sources,
- 11 joint cases with a Law Enforcement Agency,
- 2 Credible Allegations of Fraud payment suspensions issued,
- 21 Cases referred to internal AHCCCS Divisions for Quality of Care concerns,
- $751,091.23 in savings, and
- $8,503,610.37 identified as preliminary losses on active cases.

In FFY 2022, the Pharmacy Fraud Investigative Team (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 fraud experience. The PFIT has two pharmacists and two pharmacy technicians on the team. The PFIT continues to work closely with local police departments, MFCU, and federal agencies in working joint investigations.

FFY 2022 activity for the PFIT includes:

- 14 referrals received,
- 4 cases opened,
- 1 lock-down request,
- 1 case management request,
- 1 indictment,
- 8 convictions, and
- $2,820,226.80 in funds recovered and saved.

Member Compliance Section (MCS)

- The MCS includes two units: the Criminal Investigative Unit (CIU) and the Fraud Prevention Unit (FPU). Combined, these units handled 6,843 cases in FFY 2022 with total recovery and savings of $15,409,667.96.
- With units in Tucson and Phoenix, FPU closed a total of 5,868 cases with a total savings of $12,985,744.47 in FFY 2022.
- With units in Tucson and Phoenix, CIU closed a total of 975 cases, with total savings and recoveries of $2,423,923.49 in FFY 2022.
- The MCS investigated a member who assumed the identity of an adult male in order to obtain Supplemental Security Income (SSI) and AHCCCS medical benefits. This member received benefits he was not entitled to receive between 10/01/2010 – 08/31/2019, causing a loss of $303,304.33 to the AHCCCS program . This member pled guilty to Theft-Control Property a class 4 felony, Taking Identity of Another a class 4 felony, and Forgery-W/Written Instrument a class 4

felony. He was sentenced to three years of Supervised Probation, and ordered to pay $382,084.33 in restitution, $78,780 to Social Security Administration, and $303,304.33 to AHCCCS.

- The MCS investigated a member who failed to report her husband and his income to AHCCCS when applying for AHCCCS medical benefits. The member and her three children received benefits they were not entitled to. The member pleaded guilty to 3 class 6 felony counts in violation of the following sections: A.R.S. 13-701, 13-702, and 13-801. The member was sentenced to supervised probation for a period of 3 years, incarcerated in the Yavapai County Jail for 120 days. and ordered to pay a total of $54,634.57 in restitution.
- The MCS conducted a joint investigation with the Federal Bureau of Investigations (FBI). It was alleged that a member had been receiving large amounts of deposits from his business located in his home country, and was the owner of an agricultural business in Arizona that he failed to report to AHCCCS. The member pled guilty to Count 003, a Misdemeanor, Attempt to commit Welfare Fraud/Program Disqualification. The member was sentenced to 3 years of Supervised Probation and ordered to pay $75,612.61 in restitution to AHCCCS.

P**rogram Integrity Team (PIT)**

- The PIT handles high-volume data requests from internal and external customers. In FFY 2022, the 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 $6,530,820.81 in global settlements from four cases in FFY 2022. PIT currently has 98 pending global settlement cases.
- In addition to fulfilling data requests, PIT analysts conducted investigations resulting in $1,700,966.17 in recoveries and reported $1,040,983.68 in program savings from disenrolled members.
- Program Integrity Audits and Provider Self-Audits produced $4,034,068.87 in recoveries.
- The PIT created a comprehensive set of reports that identify fraudulent behavioral health billing. The reports are created for specific providers listed in a request. A set of ranking reports were also created to highlight the scope of the fraud and the most egregious providers involved.
- The PIT tracks provider board terminations, which totaled three providers and $17,410.52 in program savings in the reporting period. We anticipate board terminations to return to pre-COVID levels when the PHE waiver expires.
- During FY2022 the PIT tested a new random sample process, created procedures and trained users. Four training sessions were performed and 70 random sample requests processed using the new method by September 30, 2022.
- Throughout the year, the PIT supported a data analytics RFP process which included requirements, reviewing proposals, evaluating presentations, and grading vendors. The new contract was awarded to LexisNexis with a start date of July 1, 2022. The PIT continues to work

closely with LexisNexis to augment data analytic activities and identify quality investigation leads. Recent developments include Deployment Reports and Provider of Interest enhancements (these Deployment Reports identify payment spikes across adjacent quarterly deployments, and Provider of Interest is based on unusual billing characteristics).

Performance Improvement and Audit Section (PIAS)

In FFY 2022, the Collections team focused on the 1,360 cases that were 60 days or more past due, a decrease of 16 percent from FFY 2021.

Additional Collections Team statistical accomplishments include:

- $8,981,810.02 total collections (on-time & past-due),
- 1,478 payments received (on-time & past-due),
- 1,360 60 days+ past-due cases identified,
- 216 60 days+ past-due cases collected, and
- $938,582.76 collected on 60+ past-due cases.

In FFY 2022, the OIG Audit Team completed the following audits:

- 4 Operational Reviews,
- 10 Deficit Reduction Act (DRA) audits,
- 97 MCO deliverable reviews,
- 2 FQHC audits pending,
- 3 Date of Death audits complete with 62 pending, and
- 331 Credit Balance audits reviewed.

The Post Pay Audit Team completed the following audits in FFY 2022:

- 48 Eligible Hospitals (EH) meaningful use (MU) audits,
- 61 Eligible Providers (EP) Meaningful Use (MU) audits,
- 31 Targeted Investments (TI) audits,
- 3 American Rescue Plan Act (ARPA) audits,
- 1 Federally Qualified Health Center (FQHC) audit initiated, and
- 142 Housing Audits.

Forensic Accountant Unit

The Forensic Accounting Unit (FAU) staffing consisted of three investigators in FY 2022. All three are Certified Fraud Examiners (CFE); and two out of three are Certified Public Accountants (CPA). During the current reporting period, FAU recorded recoveries totaling $795,791.56 and generated program savings of $3,663,818.63.

FAU provided ancillary support to all OIG investigative sections and units through the utilization of a computer application called BankScan. Using BankScan in conjunction with Optical Character Recognition (OCR) software, FAU processed approximately 76,000 individual bank transactions received by the OIG in paper or image-only format. This is a 52% increase from FY 2021. These transactions were converted into Microsoft Excel, provided to the investigators for further analysis, and resulted in multiple recoveries, savings, and convictions. By using BankScan, FAU saved the OIG 1,267 investigative hours, approximately 53 days, that would have been required to manually enter the bank transactions into Excel.

State Plan Update

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

Table 10

SPA #	Description	Filed	Approved	Eff. Date
19-0007-A DSH Pool 5	Updates the State Plan to reflect DSH Pool 5 funding and participating hospitals for FY 2020.	9/30/19	3/15/22	10/1/19
19-0010 GF GME	Updates the General Fund GME Program in the State Plan.	9/30/19	12/3/21	12/3/21
20-0017 DSH Pool 4 Reallocation	Describes the reallocation of Disproportionate Share Hospital (DSH) Pool 4 Funds.	9/30/20	4/12/22	9/30/20
20-0018 GME 2021	Updates the State Plan to continue the GME program for FY 2021.	9/30/20	2/8/22	9/30/20
20-0019 GF GME	Updates the State Plan with the amounts and methodology related to the GME program General Fund dollars.	9/30/20	5/10/22	9/30/20
21-0003 MAT Services	Updates the State Plan to attest to the state's coverage of Medication Assisted Treatment and related counseling and behavioral health therapies.	2/12/21	1/24/22	10/1/20
21-0006 School Based Claiming Reimbursement	Describes the methods and standards for reimbursing for school based health and related services.	4/26/21	10/25/21	10/1/21
21-0008 ET3	Adds Emergency Triage, Treat and Transport (ET3) services to the State Plan.	9/7/21	11/4/21	10/1/21
21-009 GF GME	Updates the State Plan to detail amounts and methodology related to the GME program General Fund dollars for FY 2022.	9/27/21	8/16/22	9/30/22

21-012 DSH Budget	Updates the DSH budget in the state plan.	9/27/21	5/17/22	10/1/21
21-0013 Clinical Nurse Specialist	Adds Clinical Nurse Specialist as a new provider type in alignment with ARS 32-1651.	9/28/21	12/21/21	10/1/21
21-0016 EMT Rates	Updates the State Plan EMT rates	11/10/21	1/18/22	10/1/21
21-0017 LTC and Rehab Rates	Updates the State Plan rates for long-term care and rehabilitation.	11/10/21	11/24/21	10/1/21
21-0018 NF Rates	Updates the State Plan Nursing Facility Rates.	11/10/21	12/3/21	10/1/21
21-0019 Outpatient Hospital Rates	Updates the State Plan outpatient hospital rates.	11/10/21	2/4/22	10/1/21
21-0020 Other Provider Rates	Updates the State Plan other provider rates.	11/10/21	1/20/22	10/1/21
21-021 - Pediatric Immunization Program Rates	Updates the State Plan Rates for Vaccines Under the Pediatric Immunization Program, effective October 1, 2021.	11/10/21	12/17/21	10/1/21
SPA 21-022 - DRG Rates	Updates the DRG rates, effective October 1, 2021.	11/10/21	12/8/21	10/1/21
SPA 21-023 Inpatient Hospital DAP	This amendment updates the Inpatient Hospital Differential Adjusted Payment (DAP) Program.	11/15/21	12/22/21	10/1/21
21-0024 Outpatient DAP	Updates the Outpatient Differential Adjusted Payment (DAP) program.	11/15/21	2/4/22	10/1/21
21-0025 NF DAP	Updates the Nursing Facility DAP Program in the State Plan.	11/15/21	12/22/21	10/1/21
21-0026 Third Party Liability	Attests to the State's compliance with Third Party Liability requirements as outlined in 1902(a)(25)(E) and 1902(a)(25)(F)(i).	12/20/21	12/27/21	12/31/21
22-0001 January NF Rates	Updates the State Plan nursing facility rates.	1/24/22	2/8/22	1/1/22
22-0002 Clinical Trial Routine Patient Costs	Attests to the State providing mandatory Medicaid coverage of routine patient costs furnished in connection with participation in qualifying clinical trials.	3/14/22	3/29/22	1/1/22
22-0003 COVID-19 Testing	Attests to the State's coverage of COVID-19 testing.	4/7/22	NA	3/11/21

22-0004 COVID-19 Treatment	Attests to the State's coverage of COVID-19 treatment.	4/7/22	NA	3/11/21
22-0005 COVID-19 Vaccination	Attests to the State's coverage of COVID-19 vaccination.	4/7/22	NA	3/11/21
22-0006 COVID Directed Payment	Provides for a COVID-19 related directed payment for select providers.	5/10/22	7/29/22	4/1/22
22-0007 CHIP COVID Attestation	Attests to the State providing mandatory CHIP coverage of COVID-19 testing, vaccination and treatment services.	5/31/22	7/13/22	3/11/21
22-0008 Crisis Services	Adds clarifying language on crisis intervention services to the State Plan.	6/27/22	9/23/22	4/1/22
22-009 Medicaid Postpartum Continuous Eligibility	Establishes 12-months of postpartum continuous eligibility for pregnant women in Medicaid.	9/12/22	NA	TBD
22-0010 CHIP Postpartum Continuous Eligibility	Establishes 12-months of postpartum continuous eligibility for pregnant women in CHIP.	9/12/22	NA	TBD
22-0011 GF GME	Updates the State Plan to detail the amounts and methodology related to the General Fund (GF) Graduate Medical Education (GME) program for FY 2023.	9/27/22	NA	9/30/22
22-0012 IGA GME	Updates the State Plan to detail the amounts and methodology of the Intergovernmental Agreement (IGA) Graduate Medical Education (GME) program for FY 2023.	9/27/22	NA	9/30/22
22-0013 FQHC GME	Describes the Federally Qualified Health Center (FQHC) GME Program.	9/27/22	NA	9/30/22
22-0014 DSH Budget	Updates the Disproportionate Share Hospital (DSH) budget in the State Plan for FY 2023.	9/27/22	NA	10/1/22
22-0015 DSH Pool 5	Updates the State Plan to reflect DSH Pool 5 funding and participating hospitals for FY 2023.	9/27/22	NA	10/1/22

IX. Quality Assurance/Monitoring Activities

This section of the report describes AHCCCS' quality assurance and monitoring activities that occurred during the quarter, as required in Special Terms and Conditions of the State's Section 1115 Waiver. This report highlights activities related to delivery system initiatives, innovations, and improvements as well as Managed Care Organization (MCO) monitoring and compliance for Quarter 4 (July 1, 2022 – September 30, 2022). The sections under the sub-headers contain quarterly-specific updates. AHCCCS' Division of Health Care Management (DHCM), including Operations, Compliance, Quality Management (QM), Performance Improvement (PI), Medical Management (MM), Maternal, Child Health/Early and Periodic Screening, Diagnostic and Treatment (MCH/EPSDT), Integrated System of Care, and Payment Modernization oversee the reported activities.

Managed Care Programs

AHCCCS' maintains its overall objectives for its Managed Care Demonstration programs, AHCCCS Complete Care (ACC), Arizona Long Term Care System (ALTCS) for the Elderly and/or Physically Disabled (EPD) and Developmentally Disabled (DD), Comprehensive Health Plan for children in the foster care system (CHP), and Regional Behavioral Health Authorities (RBHAs). These objectives include maintaining and improving care coordination among primary care and behavioral health providers; maintaining and enhancing access to care and quality of care; improving health outcomes and member satisfaction as well as quality of life for members; and continuing to operate as a cost-effective managed care delivery model. AHCCCS has engaged in a multi-year effort to reduce delivery system fragmentation at all levels through the transformational initiative of integrating physical and behavioral health services under the same MCO in order to enhance care management and quality of care across the entire continuum of care. AHCCCS' objectives are further supported by evidence of integration's benefits (including whole-person care, increased care coordination, simplifying a complex health care system for members and providers, and resulting in improved health outcomes). AHCCCS is continually reviewing opportunities to improve the effectiveness and efficiency of Arizona's health care delivery system, as well as the methods utilized to promote optimal health for members.

Delivery System Initiatives, Innovations, and Improvements

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. Throughout AHCCCS, various teams undertake extensive efforts to promote delivery system innovation and improvement for internal and external processes.

Initiatives

American Rescue Plan Act (ARPA)

In January 2022, CMS granted approval of Arizona's American Rescue Plan (ARP) Act of 2021 (Pub. L. 117-2) Home and Community Based Services (HCBS) Spending Plan. This allowed the agency to begin implementing activities outlined in the Spending Plan and to qualify for a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain HCBS Medicaid expenditures, provided such funds are expended during the approved timeframe. While CMS has approved an expenditure authority through March 2025 (SMD #22-002), AHCCCS has opted to adhere to a shorter extension through September 30, 2024, or until funds are expended, whichever comes first.

Arizona has identified two critical priorities in its Spending Plan: (1) Strengthening and Enhancing Arizona's HCBS System of Care; and (2) Advancing Technology to Support Greater Independence and Community Connection). Each activity identified in the State's Spending Plan supports these priorities, resulting in member-centric strategies that will serve as a roadmap for the State's use of these dollars. Further, the State's Spending Plan activities are designed to support transformational change of the delivery system, leading to enhancements in care delivery to individuals who are accessing General Mental Health and Substance Use Disorder (GMH/SUD) services. Arizona has identified four key populations at the center of the efforts outlined in this spending plan, specifically seniors, individuals with disabilities, individuals with an SMI designation, and children with behavioral health needs.

AHCCCS has worked to implement and operationalize activities since the approval of the ARP HCBS Spending Plan. These include the following:

1. AHCCCS obtained expenditure authority from the State Legislature; upon approval, the agency immediately released one-time directed payments to providers for the purposes of strengthening their workforce and enhancing HCBS. Based on stakeholder feedback, these funds provided immediate support for HCBS direct care workers to ensure effective and efficient service delivery. AHCCCS anticipates that all funds for year one ARP funds will be dispersed by February 2023.
2. AHCCCS is working with the community colleges to develop partnerships to assist with the implementation of workforce development activities, including tuition assistance and curriculum development for Direct Care Workers(DCW) and Behavioral Health Technician (BHT)/Behavioral Health Practitioner (BHP) providers. These conversations are ongoing and the State is in the process of defining formal relationships with these stakeholders to operationalize activities.
3. AHCCCS is partnering with the Department of Economic Security (DES) for several ARP HCBS Spending Plan initiatives. These activities include enhancements to the Disability Benefits website, creation of a central employment repository, and support for the abuse and neglect awareness campaign. AHCCCS will continue to work with DES to ensure that activities are implemented in line with the goals and objectives of the ARP Spending Plan.

4. AHCCCS has also begun conversations with other national organizations to assist with timely implementation of Spending Plan initiatives. AHCCCS will continue these conversations to support diligent and thoughtful implementation of its Spending Plan in a manner that aligns with existing program goals and that supports long-term innovative growth for HCBS populations.

Child Adolescent Level of Care Service Intensity Utilization System (CALOCUS) and Early Childhood Service Intensity Instrument (ECSII) Tools

AHCCCS implemented use of the CALOCUS on October 1, 2021. Providers have been utilizing a portal developed to complete training for tool usage and to input CALOCUS level of care scores. AHCCCS continues to monitor general completion of training and use of the tool. During the fourth quarter, AHCCCS provided trended results with MCOs and technical assistance in order to ensure use among MCO-contracted child-serving providers. Based on the monitoring of the use of CALOCUS, AHCCCS has planned several portal system improvements that include implementation of member consent acknowledgements, National Provider Identifiers, Tax Identification Numbers, logic to ensure accuracy of member identifications, and birthdate exclusion for individuals under six years of age. During the fourth quarter, AHCCCS collaborated with American Academy of Child and Adolescent Psychiatry to provide training to providers for administration of the Early Childhood Service Intensity Instrument (ECSII) tool. This tool offers a standardized method of assessing children birth through five years of age, who are at the highest need for intervention. AHCCCS will have a full continuum of standardized tools to utilize with children from birth to age 18.

Children Family Team Facilitators (CFT) Training

Since the adoption of CFT, numerous changes occurred to the children's system of care that prompted AHCCCS to evaluate the CFT program, its curriculum, and approach to develop CFT facilitators. In partnership with its MCOs, the AHCCCS System of Care and Workforce Development (WFD) Administrator completed a training timeline for a single, statewide, in-person, experiential training approach focused on competencies required to perform nine essential activities of CFT practice. In May 2022, provider agencies with staff that facilitate CFT meetings were to identify a qualified CFT Champion for their agency. In June 2022, CFT Champions were trained on how to provide the new CFT training curriculum to those staff at their agencies that facilitate CFTs. Additionally in September 2022, the CFT Champions were trained in the curriculum designed to teach supervisors how to coach and monitor CFT facilitators in the nine essential activities of CFT practice. This training will also teach supervisors how to evaluate a facilitator's skills using the CFT Supervisory Fidelity Review Tool. Once a CFT Champion has completed both CFT Facilitator training and Supervisor training, they will receive certification as a trainer and will participate in tri-annual meetings to ensure support in their role**.** Beginning in January 2023, WFD will develop CFT training for caregivers, stakeholders, or anyone who may be invited to participate as a member of a child and family team, to help them understand CFT practice, what to expect, and to outline the nine activities of CFT facilitators.

Clinical and Operational Significant Policy Changes

In quarter four, the following significant Policy revisions were completed:

1. *AHCCCS Medical Policy Manual (AMPM) Policy 320-B, Member Participation in Experimental Services and Clinical Trials* was revised to include new CMS requirements that members may participate in, and AHCCCS will cover services related to, qualifying clinical trials, with health care provider attestation of appropriateness. [Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30)]

2. *AMPM Policy 420, Family Planning Services and Supplies* was revised to clarify that, prior to insertion of intrauterine and subdermal implantable contraceptives, the maternity care provider has provided proper counseling to increase the member's success with the Long-Acting Reversible Contraception (LARC) device according to the member's reproductive goals.

3. *AMPM Policy 430, EPSDT* was revised to add a requirement for maternal postpartum depression screening to be completed at the 1, 2, 4, and 6-month EPSDT visit; to add a requirement for suicide screening to be performed at each of the EPSDT visits for children ages 10-20; to add coverage of cochlear implants for unilateral severe hearing loss; and to include requirements for developmental surveillance to be performed at each EPSDT visit.

4. *AMPM Policy 1230-A, Assisted Living Facilities (ALFs)* was revised to comply with Home and Community Based Services (HCBS) Rules and explained that ALFs should be located in the community and if co-located with a Skilled Nursing Facility, shall be licensed, and operate separately. The Policy was also revised to include expectations that ALFs facilitate access to the community, facilitate alternate schedules for members, update the service plan upon a member's request, and refer to the Case Manager if the member expresses a desire to work.

5. *AMPM Policy 1240-B, Adult Day Health Facilities* was revised to comply with HCBS Rules and explained that Adult Day Health Facilities should be located in the community and if co-located with a Skilled Nursing Facility, shall be licensed, and operate separately. The Policy was also revised to include expectations that Adult Day Health Facilities facilitate access to the community, exercise strategies for skill building, update the service plan upon a member's request, and refer to the Case Manager if the member expresses a desire to work.

6. *AMPM Exhibit 1620-15, Assisted Living Facility Residency Agreement* was revised to comply with HCBS Rules to include the expectations of having an option to choose a roommate; and having lockable doors, a key or key code to the front door; an option to have meals and snack at any time and visitors at any time. The Exhibit was revised to include expectations that any restrictions to these rights be documented in the Person-Centered Service Plan.

Collaboration with Arizona Department of Education (ADE) and Arizona Department of Health Services (ADHS) for Behavioral Health in Schools

AHCCCS collaborates with ADE and ADHS on innovative projects that bring together behavioral health and education. The Arizona Project AWARE team is a partnership between ADE, AHCCCS, and six local school districts. Project AWARE is a federal initiative funded by Substance Abuse and Mental Health Services Administration (SAMHSA) to expand the partnership between education and mental health systems at the state and local levels. Project AWARE is focused on ensuring access to behavioral health services for students by establishing referral pathways and communication between schools, parents, and behavioral health providers. Project AWARE also supports suicide prevention training.

During the fourth quarter, the AHCCCS Project AWARE team has been engaged in several activities that include an analysis of the different referral forms being used by the Children's Behavioral Health Services Fund (CBHSF) providers and the development of a universal referral form. This form is currently being presented to MCOs and providers for feedback with the goal of having a single, uniform referral form for schools to utilize. The AHCCCS AWARE team has been heavily involved in working to resolve network issues experienced by school district partners. This has resulted in bringing additional providers into areas that have a demonstrated need, as well as working to educate school district staff on how to navigate the crisis system. The results include reduced frustration by school mental health personnel and reduced wait times to access crisis services. Another activity to report is through active dialogue, the AHCCCS team has found a need to deliver more presentations/education to the community regarding AHCCCS benefits, available services, block grants, the Mitch Warnock Act, and clarification regarding the Children's Behavioral Health Services Fund (CBHSF) which will be starting in the next quarter. Final activity provided is the diligence for completion of the next application for the Project AWARE grant named Project AWARE III. With this AWARE III grant, the team will focus on adding the northern region of the state to complement the central and southern regions having participated in Project AWARE I & II.

National Committee for Quality Assurance (NCQA) MCO Accreditation

AHCCCS is continuing its efforts related to MCO accreditation and comparing the NCQA Health Plan Accreditation standards, NCQA Medicaid Managed Care Toolkit, as well as current contractual and policy requirements, to ensure maximum alignment of regulatory oversight, increase opportunities for non-duplication as permitted by 42 CFR 438.360, and to leverage data validation tools. AHCCCS' MCOs are simultaneously prioritizing initial NCQA MCO accreditation efforts and raising questions and considerations for the Agency as they work through their processes. Quarter four accreditation activities included working with AHCCCS MCOs to review MCO deliverables and compliance review standards required under 42 CFR 438.358(b)(1)(iii) against NCQA standards to identify recommendations for alignment and non-duplication. AHCCCS' preliminary review has resulted in identification of 14 CFRs as deemable per 42 CFR 438.360.

Innovative Approaches and Continuous Quality Improvement

Medicaid Innovation Collaborative (MIC)

In August, AHCCCS concluded its work on the 2022 MIC. This year's collaborative focused on identifying improvements in our adolescent behavioral health system. MIC worked with AHCCCS stakeholders to determine system gaps and propose technological solutions to help fill those gaps. The MIC team gathered currently available technological resources to prevent adolescents from a behavioral health crisis, navigate the system if they are in crisis, and provide post-crisis support. Each of our MCOs are engaging with the resources presented so they can determine one that fits the needs of their members. MCOs are encouraged but not required to utilize any of the resources to improve their system of care. Additionally, MIC provided AHCCCS with technical assistance by gathering current practices in other states to help inform future policies at AHCCCS.

Statewide Closed-Loop Referral System (CLRS)

The contract for the statewide CLRS is managed by Arizona's statewide Health Information Exchange (HIE), Contexture, with a supportive partnership with AHCCCS. User onboarding for the CLRS began in late 2021. However, the vendor selected to provide the system, NowPow, was acquired by another entity, Unite Us, and onboarding activities were paused until a contract was negotiated between Contexture and Unite Us. The Contexture team executed a contract with Unite Us at the end of July 2022. During August and September of this year, Contexture and Unite Us began building the system interface, while simultaneously engaging and enrolling system users. A marketing plan was developed to promote enrollment of both health care providers and Community Based Organizations (CBOs). An official name for Arizona's CLRS was selected; the system will be branded with the name CommunityCares. Contexture and Unite Us began hosting public presentations to provide an overview and demo of the system. The first batch of system users will begin using the system in early December when the platform is live. Additionally, in September, AHCCCS won the 2022 Medicaid Innovation Award from the Robert Wood Johnson Foundation (RWJF) and the National Academy for State Health Policy (NASHP) for its efforts to improve Social Determinants of Health for members, which includes the adoption of the statewide CLRS.

Managed Care Organization Monitoring and Compliance

AHCCCS monitors and evaluates availability of services and access to care, organizational structure and operations, clinical and non-clinical quality measurement, and performance improvement outcomes through several methods including:

1. Operational Reviews,
2. Review and Analysis of Periodic Monitoring Reports,
3. Performance Measures,
4. Performance Improvement Projects,
5. Data Analysis,
6. Provider Network Time and Distance Standards Monitoring,

7. Appointment Availability, Monitoring, and Reporting,
8. Case Management Ratios,
9. Assessment of Fidelity to Service Delivery for Individuals with a Serious Mental Illness Designation, and
10. Surveys.

A number of Contract deliverables are used to monitor and evaluate MCO compliance and performance. AHCCCS reviews, provides feedback, and approves these reports as appropriate.

Monitoring and Compliance

ACC-RBHA Competitive Contract Expansion (CCE) Readiness Activities

In November of 2021, AHCCCS awarded select ACC MCOs an expanded contract to provide coverage to individuals with a Serious Mental Illness (SMI) designation effective October 1, 2022. Prior to the effective date, services were provided by contracted MCOs known as Regional Behavioral Health Authorities (RBHAs). Effective October 1, 2022, RBHAs are called ACC-RBHAs (AHCCCS Complete Care Contractors with Regional Behavioral Health Agreements).

The awarded ACC-RBHAs are Mercy Care in the Central Geographic Service Area (GSA), Arizona Complete Health-Complete Care Plan in the South GSA, and Care1st Health Plan in the North GSA. This resulted in members who were enrolled with the Health Choice RBHA in the North GSA, transitioning to Care1st Health Plan ACC-RBHA on October 1, 2022. Approximately 6,100 members changed their health plan to Care1st as a result of this change. Additionally, the current GSAs are now aligned to match the ACC and ALTCS-EPD GSAs. Gila County moved from the North GSA to the Central GSA, and Pinal County moved from the South GSA to the Central GSA; thus, Central expanded from one county to three (Maricopa, Gila, and Pinal). Approximately 1,900 members transitioned to Mercy Care ACC-RBHA as a result of this change. An additional change that was implemented October 1, 2022, as part of the CCE solicitation, includes the ACC-RBHAs selecting a single crisis phone line vendor to serve statewide. Previously, each RBHA was responsible for operating a Crisis Phone Line in their assigned GSA. Existing statewide crisis telephone numbers will remain for at least one-year after the October 1, 2022, transition date.

Readiness activities for the ACC-RBHAs, as required under 42 CFR 438.66(d), continued utilizing Readiness Assessment Tools which focused on the following review areas:

- Operations/Administration,
- Delivery Systems,
- Medical Management,
- Behavioral Health,
- Quality Management and Quality Improvement,
- Financial Management,
- EPSDT and Maternal and Child Health, and
- Member Services.

In July, AHCCCS continued meeting with RBHAs and ACC-RBHA MCOs to discuss the transition of member data for members transitioning to a new MCO as of October 1, 2022.

In August, the first round of member data files was transferred between RBHAs and ACC-RBHA MCOs. AHCCCS held meetings with all MCOs involved to discuss any concerns with the data files. In September, two more rounds of member data files were transferred between RBHAs and ACC-RBHA MCOs. These member data files contain key elements related to care for members to help ensure the transition of member care without disruption.

In August and September, AHCCCS leadership continued to meet with each ACC-RBHA for updates on readiness progress. Items discussed in these meetings include network updates, staffing updates, communication plan, and discussion of any identified risks and/or barriers to implementation. No significant risks or barriers were identified during these meetings.

Fidelity to Service Delivery for Individuals with a Serious Mental Illness Designation

In accordance with exit stipulations of Arnold v. Sarn, AHCCCS continues to support the implementation of four evidence-based practices (EBPs) within Maricopa County for individuals living with a Serious Mental Illness (SMI). The four EBPs are monitored for fidelity through reviews conducted by the Western Interstate Commission for Higher Education (WICHE) through the utilization of SAMHSA Fidelity Reviews. In quarter four, the annual fidelity report was completed and made available on the AHCCCS website. This annual fidelity report is a culmination of the individual provider reviews completed for the year which identifies strengths, recommendations for improvement, and trends. The annual fidelity report synthesized information from 19 fidelity reviews, including 11 Assertive Community Treatment (ACT) teams, two Consumer Operated Services providers, three Permanent Supportive Housing, and three Supported Employment programs. The recommendations from the individual and annual reports will be utilized to improve services to more closely align with fidelity protocols. In quarter four, AHCCCS continued collaborating with various stakeholders to review trends, identify barriers, and support ongoing efforts to effectively capture services provided to members.

MCO Operational Reviews

AHCCCS conducts compliance reviews (i.e., Operational Reviews [ORs]) to evaluate MCO compliance related to access MCO compliance with availability and quality of services, including implementation of policies, procedures, and progress toward plans of correction to improve quality of care and service for members. A complete OR is conducted every three years. Historically, ORs have been conducted with a combination of onsite and desk reviews. However, due to the COVID-19 Public Health Emergency, these reviews have been completed via desk review and virtual meetings with the MCOs.

During quarter four, AHCCCS conducted the following ORs:

1. July 2022 – Health Choice Arizona, ACC.
2. September 2022 – UnitedHealthcare Community Plan, ACC.

Quality Improvement

AHCCCS implements interventions to monitor, evaluate, and report on performance through several activities which include, but are not limited to, the following:

Performance Measure Dashboard **-** In this quarter, AHCCCS updated its Performance Measure Data Dashboard, which includes a selected set of performance measures that are reported based on the lines of business. The dashboard compares the line of business and statewide aggregate rates with the associated CMS Medicaid or National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS)® Medicaid benchmark data. Within this update, AHCCCS expanded the list of selected performance measures to include four statewide hybrid performance measure rates.

Performance Improvement Projects - AHCCCS considers a Performance Improvement Project (PIP) as a planned process of data gathering, evaluation, and analysis to determine interventions or activities that are anticipated to have a positive outcome. PIPs are designed to improve the quality of care and service delivery and usually last at least four years. While contractors are required to select and implement internal PIPs to address self-identified opportunities, AHCCCS mandates other program-wide PIPs in which contractors must participate, and monitors performance until each contractor meets requirements for demonstrable and sustained improvement.

During the quarter, AHCCCS initiated a Prenatal and Postpartum Care PIP for the ACC/KidsCare and RBHA Contractors with a baseline measurement year of calendar year (CY) 2022. The purpose of this PIP is to increase the number and percent of members with live birth deliveries that: 1) received a prenatal care visit, and 2) received a postpartum visit.

Summary and Reference to Appendix A - For additional information related to CY 2021 performance measure and PIP indicator rates, as validated by AHCCCS' External Quality Review Organization, refer to Appendix A.

Request for Proposal (RFP) – ALTCS-EPD

AHCCCS has begun activities for the development of an RFP to solicit bids from qualified Contractors for the service delivery of the ALTCS-EPD Program. AHCCCS will include significant initiatives and other items that will need to be considered including detailed information regarding pricing and services in the Contractor's bid. Currently there are three Contractors working with the ALTCS-EPD populations. The current contracts are scheduled to expire on September 30, 2024, with the new contract beginning on October 1, 2024. The RFP is scheduled to post to the AHCCCS website on August 1, 2023. AHCCCS will be analyzing and comparing contractor skills, experience, and rates to find the right contractor partners and announce the award on November 17, 2023. Presentations to solicit input from stakeholders regarding the current ALTCS-EPD program began in June 2022. AHCCCS has since received 22 comments/suggestions from stakeholders.

Request for Proposal (RFP) - SMI Eligibility Determinations

AHCCCS is continuing its activities for development of an RFP to solicit for a vendor that will perform eligibility determinations for individuals who may be living with an SMI. AHCCCS is adding responsibilities for the contracted vendor to implement a standardized Serious Emotional Disturbance (SED) eligibility determination process for youth up to the age of 18, similar to the SMI eligibility determination process. The current contract with vendor Solari Crisis and Human Services expires on September 30, 2023, with the new contract beginning on October 1, 2023. Presentations to solicit input from stakeholders regarding the current SMI eligibility determination process began in April. In quarter four, AHCCCS evaluated stakeholder feedback and drafted the RFP contractual requirements and RFP submission requirements for vendor response and evaluation. The RFP is anticipated to post to the AHCCCS website by October 5, 2022.

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 Managed Care Organizations (MCOs).

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

In March 2018, AHCCCS awarded contracts for the AHCCCS Complete Care (ACC) program, which integrates physical and behavioral health care services under MCOs for the majority of members in the Acute Care program. The ACC Contractors serve 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 Arizona Department of Child Safety Comprehensive Health Plan (DCS CHP), are covered for integrated physical and behavioral health services.

The ACC contracts were awarded by GSA, as outlined in the table 11 below.

Table 11

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		
Molina Complete Care	X			
Mercy Care	X			
Health Choice Arizona	X	X		
UnitedHealthcare Community Plan	X			X

As part of the 2018 ACC Contract, AHCCCS indicated its intent to offer a future Competitive Contract Expansion (CCE) for the provision of integrated physical and behavioral health services to individuals 18 years and older who have been designated with a Serious Mental Illness (SMI) through one ACC Contractor in each GSA. In November 2021, AHCCCS awarded three existing ACC Contractors expanded ACC contracts with a Regional Behavioral Health Agreement (ACC-RBHA), which were effective October 1, 2022. The ACC-RBHA contracts replace the Regional Behavioral Health Authority (RBHA) Contracts, which expired September 30, 2022.

The ACC-RHBA contracts were awarded by GSA, as outlined in the table 12 below.

Table 12

ACC-RBHA 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, Pima, Santa Cruz, Yuma
Arizona Complete Health-Complete Care Plan			**X**
Mercy Care	**X**		
Care1st Health Plan		**X**	

Services for children in foster care are provided through a statewide MCO contract with the Arizona Department of Child Safety. These children are enrolled in the Arizona Department of Child Safety Comprehensive Health Plan (DCS CHP), receiving integrated physical and behavioral health services.

Arizona Long Term Care System (ALTCS) Program Demonstration

In 1988, six years after the initial 1115 Waiver program implementation, the original demonstration waiver was substantially amended to allow Arizona to implement a capitated long term care program for individuals who are elderly and/or have physical disabilities, and individuals with intellectual and/or developmental disabilities – the Arizona Long Term Care System (ALTCS) program. The ALTCS program, administered as a distinct program from the AHCCCS ACC program, provides acute, long term care, behavioral health, and Home and Community Based Settings (HCBS) services to Medicaid members who are at risk of institutionalization. ALTCS Program services are provided through contracted prepaid, capitated arrangements with MCOs. ALTCS members who are elderly, blind or physically disabled (EPD) are served through one of three ALTCS-EPD-contracted MCOs and those members who are developmentally disabled are served through an MCO contract with the Department of Economic Security, Division of Developmental Disabilities (DES/DDD).

The priority of the ALTCS program is to ensure that members are living in the most integrated setting and actively engaged and participating in community life. Over the past 33 years, the ALTCS program has achieved remarkable success increasing member placement in HCBS, resulting in significant program savings while also appropriately meeting the needs of members.

The ALTCS-EPD Contracts were awarded by GSA, as outlined in the table 13 below. ALTCS-EPD Contracts were effective October 1, 2017 for a period of up to seven years.

Table 13

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 statewide through DES/DDD began receiving integrated physical and behavioral health services, including services for CRS eligible conditions.

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 (ASD), 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

The newly added Year 6 due to the extension of the Waiver adds one more year of funding which matches the Year 5 total of $50 million, thus increasing the 6 year program to $350 million in total. 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. Due to the impacts of the COVID-19 PHE impacting Year 3, the requirement for performance measure targets was limited to Years 4 and 5.

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%*	*0%*	*15%*	*20%*
Total Amount at Risk	*$0*	*$0*	*$2,717,700*	*$3,170,640*	*$3,019,660*

The newly added Year 6 due to the extension of the Waiver includes a DHSP computable which matches the Year 5 DSHP computable

TI Program Updates

Below is a summary of the TI program implementation activities conducted by AHCCCS in FFY 2022:

- Solicited diverse and extensive stakeholder input to redesign the Targeted Investments Program Renewal request submitted as part of the AHCCCS 1115 Waiver submittal that informed two subsequent TI 2.0 Renewal approaches submitted to CMS,
- Allocated and disbursed incentive funding to participants that met Year 4 performance measure targets to encourage performance improvement thru the end of the program,
- Established Year 6 performance measure milestone targets for determining incentives for program participants that accounted for challenges resulting from the PHE,

- Collaborated with the Center for Health Information Research (CHiR) at ASU to assist with the administration of the performance measure milestones, including calculation of results and provision of technical assistance to program participants,
- Collaborated with CHiR to develop interactive dashboards that illustrate timely and actionable performance measure results and provided tutorials for program participants on the effective use of the data for improving performance,
- Partnered with ASU College of Health Solutions to facilitate quarterly virtual Quality Improvement Collaboratives (QIC) and Quality Improvement Workgroups for program participants to present measure calculation and attribution methodologies; performance management and process improvement strategies; performance measure trends, regional challenges and resources, and peers' best practices to enhance program participants' milestone achievement; and overcome challenges associated with the PHE impact to the healthcare delivery system,
- Enhanced the reporting system for TI program participants to submit attestations of milestone completion and to upload documents for validation,
- Collaborated with Health Current (now called Contexture), 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, including a learning-lab to improve understanding and functionality of ADT alerts,
- Developed several "Best Practice Audit Guides" including best practice information and resources from QIC presentations and discussions to support and assist program participants performance improvement initiatives,
- 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, and
- 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; and 3) extensive individualized provider assistance by TI staff.

Waiver Evaluation Update

In accordance with STC section XIV, AHCCCS must submit a draft Waiver Evaluation Design for its 1115 Waiver demonstration. In addition, AHCCCS is also required by CMS to submit an Interim Evaluation Report and a Summative Evaluation Report of the 1115 Waiver Demonstration by December 31, 2020, and March 30, 2023, respectively.

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

- AHCCCS Complete Care (ACC) Program,
- Arizona Long Term Care System (ALTCS) Program,

- Comprehensive Health Plan (Formerly CMDP),
- Regional Behavioral Health Agreements (Formerly Authorities)
- Targeted Investments (TI) Program,
- Retroactive Coverage Waiver, and
- AHCCCS Works program.

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

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

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

For this reason, an updated interim evaluation report was developed and completed by August 30, 2021. HSAG's updated report contains results for additional years and includes findings-to-date from focus groups and qualitative interviews. In addition, the report used statistical techniques, where possible, to control for confounding factors and identify the impact of Arizona's demonstration initiatives on access to care, quality of care, and member experience with care. CMS approved AHCCCS' Interim Evaluation Report on Oct 6, 2022 and the report is now available on AHCCCS Reports for Centers for Medicare and Medicaid Services (CMS) web page.

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

Going forward, AHCCCS will work with HSAG on the demonstration's Summative Evaluation Report, in alignment with the approved Evaluation Design. The Summative Evaluation Report will include a longer implementation period with more robust analysis and promises to provide additional evidence to support a fuller understanding of the effects of each of the programs included on the demonstration.

XI. Notable Achievements

AHCCCS Receives 1115 Waiver Approval

CMS approved Arizona's 1115 Waiver renewal request to continue the long-standing authorities that have made its Medicaid program innovative, effective, and efficient, and to initiate two transformative projects designed to advance member health outcomes, Housing and Health Opportunities and Targeted Investments 2.0.

NASHP and RWJF Recognize AHCCCS with 2022 Medicaid Innovation Award

In September 2022, AHCCCS received a 2022 Medicaid Innovation Award from the Robert Wood Johnson Foundation (RWJF) and the National Academy for State Health Policy (NASHP) for developing the Whole Person Care Initiative which offers a range of support services to enrollees including transitional housing; referrals for and transportation to community-based services such as employment and food assistance; and long-term care services to reduce social isolation. Selected by a panel of expert advisers, Medicaid Innovation Award recipients are Medicaid agency leaders who implemented or enhanced initiatives that demonstrate innovative and unique approaches to improving the health and lives of Medicaid enrollees.

MACPAC Includes Arizona's Efforts to Address HCBS Workforce Barriers

A March 2022 MACPAC report included Arizona's efforts to identify and address barriers to Home and Community Based worker recruitment and retention in this study.

AHCCCS Recognized as Healthy Arizona Worksite for Fourth Consecutive Year

AHCCCS received Platinum-level recognition for the fourth consecutive year from the statewide Healthy Arizona Worksites Program for demonstrating data-driven programming and leveraging cross-sector collaborations to improve the health, well-being and equity of employees and the community. The Platinum level award recognizes organizations for addressing health challenges impacting communities across the state.

Artificial Intelligence Technology Increases Call Center Capability

AHCCCS converted to a new telephone technology platform in January 2022 and implemented artificial intelligence capability including virtual assistance for phone calls and chat. AHCCCS identified 25 common inquiries that a virtual assistant could answer in English and Spanish. Now common questions are answered automatically and the system more efficiently routes calls that require human interaction.

XII. Appendix A: Performance Measure Data

XII. Appendix A: Performance Measure Data

AHCCCS is committed to the development of a thoughtful, data-informed delivery system that incorporates CMS priorities and AHCCCS' business needs, as well as promotes optimal health outcomes for all members. 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 agency's External Quality Review Organization (EQRO). 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 various quality improvement activities throughout the year. These activities included further advancing the Agency's Quality Steering Committee and continuing an Agency and MCO Quality Improvement Workgroup intended to facilitate collaboration and promote improvement in MCO quality performance.

Performance Measures

AHCCCS worked to strategically align its statewide performance measures with the CMS Child and Adult Core Sets prior to implementation of mandatory child and adult behavioral health measure reporting. AHCCCS included a requirement for its MCOs to achieve NCQA First Accreditation [inclusive of the NCQA Medicaid Module and specific to its Medicaid Line(s) of Business] by October 1, 2023. In addition, 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 Medicaid Mean) in evaluating performance. AHCCCS also intends to utilize historical performance data to evaluate MCO, line of business (LOB), and statewide performance. AHCCCS will continue to prioritize meaningful measures that align with high priority agency initiatives.

AHCCCS conducted an analysis of program-level performance measure rates for Calendar Year (CY) 2020 (January 1, 2020 to December 31, 2020)[6], the most recent year for which final performance measure rates are available, for the following populations/lines of business:

1. ACC/KidsCare [Children's Health Insurance Program (CHIP)].
2. DCS CHP - *formerly known as the Comprehensive Medical Dental Program (CMDP) prior to April 1, 2021.*
3. ALTCS-EPD.
4. ALTCS-DD.
5. SMI.

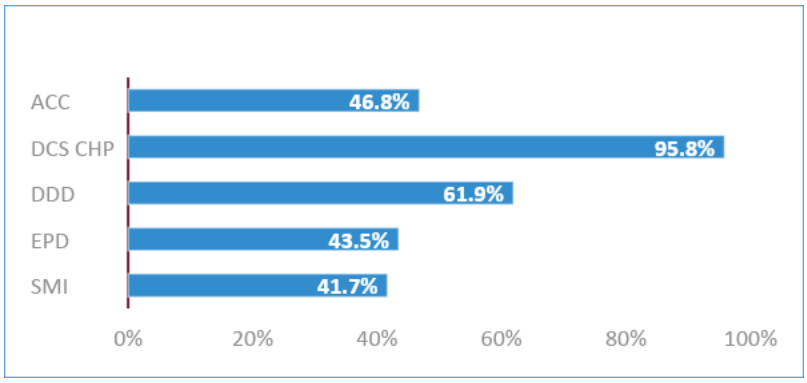
Beginning with CY 2020 performance measure rates, the performance measure data reflects combined rates/percentages for the Medicaid and CHIP populations, as applicable to each measure, with continuous enrollment based on member enrollment with each of the MCOs within the associated population/LOB.

Overall Performance Summary

AHCCCS' program-level CY 2020 performance measure rate analysis compared the program performance measure/sub measure rates with the associated NCQA Medicaid Mean, as appropriate. The DCS CHP program had the largest percentage of measures that met or exceeded the 2020 NCQA Medicaid Mean

[6] *Final Calendar Year (CY) 2022 Performance Measure rates anticipated to be available in March 2023.*

at 95.8%, followed by the ALTCS-DD program at 61.9%, then the ACC/KidsCare program at 46.8%, the ALTCS-EPD program at 43.5%, and the SMI program at 41.7%.



Refer to the following subsections for population/LOB-specific performance summaries and the Performance Measure Rates Tables for additional details related to rate reporting.

ACC/KidsCare

The ACC MCOs provide integrated care addressing the physical and behavioral health needs for the majority of Medicaid-eligible children and adults, as well as addressing the physical and behavioral health needs for the majority of KidsCare eligible children (under age 19).

ACC/KidsCare Performance Summary

AHCCCS conducted an analysis of the ACC/KidsCare program performance based on CY 2020 performance measure data. This analysis compared the ACC performance measure/sub measure rates with the associated NCQA Medicaid Mean, as appropriate. Due to a delay in the release of the *2020 Child and Adult Health Care Quality Measures Quality* data, an analysis of the ACC CY 2020 performance measures/sub measures compared with the CMS Medicaid Median was not able to be conducted. Of the 47 ACC CY 2020 performance measures/sub measures compared to the *NCQA State of HealthCare Quality Report*[7]46.8% of the performance measures reported met or exceeded the 2020 NCQA Medicaid Mean. Refer to the Performance Measure Rates Tables for additional details related to rate reporting.

Overall, the ACC/KidsCare program demonstrated strength for the following performance measures when compared to the 2020 NCQA Medicaid Mean:

- Annual Dental Visits,
- Follow-Up After Emergency Department (ED) Visit for Mental Illness - 7 Day,
- Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication,
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics, and
- Well-Child Visits in the First 30 Months of Life: 15 Months.

[7]National Committee for Quality Assurance. "State of Health Care Quality." Accessed October 28, 2022

When comparing the ACC/KidsCare program-level performance with the 2020 NCQA Medicaid Mean, the following program performance measure/sub measure rates were substantially below the associated NCQA Medicaid Mean and, as such, were identified as areas of opportunity.

- Adherence to Antipsychotic Medications in Adults with Schizophrenia,
- Cervical Cancer Screening,
- Childhood Immunization Status - Influenza and Combo 10,
- Controlling High Blood Pressure,
- Prenatal and Postpartum Care, and
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Body Mass Index (BMI) Percentile Documentation.

Of note, the associated methodologies and benchmark reporting allow for reporting based on either administrative or hybrid methodologies for the following measures: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Prenatal and Postpartum Care, Controlling High Blood Pressure, and Childhood Immunization Status; the ACC/KidsCare population/LOB rate utilized mixed methodologies as some of the MCOs utilized hybrid methodology whereas others utilized administrative methodology to calculate and report the measures. It is AHCCCS' expectation that the MCOs calculate and report all measures in accordance with AHCCCS instructions; this includes the use of hybrid methodologies to calculate measures where allowable in the associated technical specifications and required by AHCCCS. Inability or failure by an MCO to report rates in this manner may result in regulatory action.

AHCCCS identified an opportunity for improvement in well-child, adolescent well-care, and dental visit rates for MCOs providing care and services to children and adolescents. As such, AHCCCS implemented a "Back to Basics" Performance Improvement Project (PIP) in CYE 2019 which aims to improve the overall well-being of children and adolescents. This PIP focuses on improving the rates of Well-Child Visits in the First 30 Months of Life: Rate 1 (15 Months); Child and Adolescent Well-Care Visits; and Annual Dental Visits. Increasing the rates for these measures may impact other measures and focus areas including, but not limited to, childhood and adolescent immunizations, weight assessment and counseling for nutrition and physical activity, sealants for children at elevated caries risk, and developmental screenings.

AHCCCS identified an opportunity for improvement related to prenatal and postpartum visits. As such, AHCCCS implemented a Prenatal and Postpartum Care PIP in CYE 2022 which aims to improve the number and percent of members with live birth deliveries that 1) received a prenatal care visit, and 2) received a postpartum visit. AHCCCS anticipates having baseline data, reflective of CY 2022 performance, available in December 2023.

In addition to the above PIPs, AHCCCS included the Cervical Cancer Screening performance measure as part of its Value Based Purchasing (VBP) initiative for the ACC LOB starting in CY 2021.

DCS CHP

Children in foster care began receiving care and services through an integrated delivery model beginning April 1, 2021. Prior to this date, Arizona children involved in the foster care system received physical health care services through the DCS CHP and behavioral health care through the RBHAs.

DCS CHP Performance Summary

AHCCCS conducted an analysis of the DCS CHP performance based on CYE 2020 performance measure data. This analysis compared the DCS CHP performance measure rates with the associated NCQA Medicaid Mean, as appropriate. Due to a delay in the release of the 2020 Child and Adult Health Care Quality Measures Quality data, an analysis of the DCS CHP CY 2020 performance measures/sub measures compared with the CMS Medicaid Medians was not able to be conducted. Of the 24 DCS CHP performance measures/sub measures compared to the NCQA State of HealthCare Quality Report, 95.8 percent of the performance measures reported met or exceeded the 2020 NCQA Medicaid Mean. Refer to the Performance Measure Rates Tables for additional details related to rate reporting.

Overall, the DCS CHP program demonstrated strength when compared to the ACC program performance as 96.6% of the performance measure rates met or exceeded the ACC program aggregate. The DCS CHP program demonstrated strengths for the following performance measures when compared to the 2020 NCQA Medicaid Mean:

- Annual Dental Visits,
- Child and Adolescent Well-Care Visits,
- Childhood Immunization Status, and
- Immunizations for Adolescents.

In addition, the DCS CHP behavioral health services exceeded the NCQA Medicaid Mean for all behavioral health measures, at times exceeding the NCQA Medicaid Mean by more than 25%.

Noted areas of opportunity include the following performance measure:

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Body Mass Index (BMI) Percentile Documentation.

The DCS CHP population is included in the Back-to-Basics PIP which aims to improve the rates of Well-Child Visits in the First 30 Months of Life: Rate 1 (15 Months); Child and Adolescent Well-Care Visits; and Annual Dental Visits. Increasing the rates for these measures may impact other measures and focus areas including, but not limited to, childhood and adolescent immunizations, weight assessment and counseling for nutrition and physical activity, sealants for children at elevated caries risk, and developmental screenings.

ALTCS-EPD

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

ALTCS-EPD Performance Summary

AHCCCS conducted an analysis of the ALTCS-EPD program performance based on CY 2020 performance measure data. This analysis compared the ACC performance measure/sub measure rates with the associated NCQA Medicaid Mean, as appropriate. Due to a delay in the release of the *2020 Child and Adult Health Care Quality Measures Quality* data, an analysis of the ALTCS-EPD CY 2020 performance measures/sub measures compared with the CMS Medicaid Median was not able to be conducted. Of the 23 ALTCS-EPD performance measures compared to the *NCQA State of HealthCare Quality Report*, 43.5% of the performance measures reported met or exceeded the 2020 NCQA Medicaid Mean.

Overall, the ALTCS-EPD program demonstrated strength for the following performance measures when compared to the 2020 NCQA Medicaid Mean:

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia,
- Antidepressant Medication Management,
- Controlling High Blood Pressure, and
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications.

Noted areas of opportunity include the following performance measures:

- Breast Cancer Screening,
- Cervical Cancer Screening,
- Follow-Up After Hospitalization for Mental Illness, and
- Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment - Engagement of AOD (Total).

AHCCCS implemented a Breast Cancer Screening PIP for the ALTCS-EPD program aimed at improving the rates of breast cancer screening in members.

In addition to the above PIP, AHCCCS included the Breast Cancer Screening performance measure as part of its VBP initiative for the ALTCS-EPD LOB starting in CY 2021.

ALTCS-DD

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

ALTCS-DD Performance Summary

AHCCCS conducted an analysis of the ALTCS-DD program performance based on CY 2020 performance measure data. This analysis compared the ALTCS-DD performance measure/sub measure rates with the associated NCQA Medicaid Mean, as appropriate. Due to a delay in the release of the 2020 Child and Adult Health Care Quality Measures Quality data, an analysis of the ALTCS-DD CY 2020 performance measures/sub measures compared with the CMS Medicaid Medians was not able to be conducted. Of the 42 ALTCS-DD performance measures/sub measures compared to the *NCQA State of HealthCare Quality Report*, 61.9 percent of the performance measures reported met or exceeded the 2020 NCQA Medicaid Mean.

Overall, the ALTCS-DD program demonstrated strength for the following performance measures when compared to the 2020 NCQA Medicaid Mean:

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia,
- Antidepressant Medication Management,

- Asthma Medication Ratio,
- Comprehensive Diabetes Care- Hemoglobin A1c (HbA1c) Poor Control (>9.0%),
- Controlling High Blood Pressure,
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication,
- Follow-Up After ED Visit for Mental Illness, and
- Follow-Up After Hospitalization for Mental Illness.

Noted areas of opportunity include the following performance measures:

- Cervical Cancer Screening,
- Childhood Immunization Status – Rotavirus (RV) and Combo 10,
- Chlamydia Screening in Women, and
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics.

The ALTCS-DD population is included within the Back-to-Basics PIP which aims to improve the rates of Well-Child Visits in the First 30 Months of Life: Rate 1 (15 Months); Child and Adolescent Well-Care Visits; and Annual Dental Visits. As with other populations/lines of business, increasing the rates for these measures may impact other measures and focus areas including, but not limited to, childhood and adolescent immunizations, weight assessment and counseling for nutrition and physical activity, dental sealants for children at elevated caries risk, and developmental screenings.

SMI

During CYE 2022, members with an SMI designation received integrated physical and behavioral health services through the RBHAs.

SMI Performance Summary

AHCCCS conducted an analysis of the SMI program performance based on CY 2020 performance measure data. This analysis compared the SMI program performance measure/sub measure rates with the associated NCQA Medicaid Mean, as appropriate. Due to a delay in the release of the 2020 Child and Adult Health Care Quality Measures Quality data, an analysis of the SMI program CY 2020 performance measures/sub measures compared with the CMS Medicaid Median was not able to be conducted. Of the 24 SMI program performance measures compared to the NCQA State of HealthCare Quality Report, 41.7 percent of the performance measures reported met or exceeded the 2020 NCQA Medicaid Mean.

Overall, the SMI program demonstrated strength for the following performance measures when compared to the 2020 NCQA Medicaid Mean:

- Follow-Up After ED Visit for AOD Abuse or Dependence, and
- Follow-Up After ED Visit for Mental Illness,
- Follow-Up After Hospitalization for Mental Illness.

Noted areas of opportunity include the following performance measures:

- Breast Cancer Screening, and
- Prenatal and Postpartum Care.

With the identified areas of opportunity noted above, AHCCCS implemented a Preventive Screening PIP for the SMI Integrated population which aims to improve the rates of breast cancer and cervical cancer screenings.

The SMI population is included within the Prenatal and Postpartum Care PIP which aims to improve the number and percent of members with live birth deliveries that 1) received a prenatal care visit, and 2) received a postpartum visit. AHCCCS anticipates having baseline data, reflective of CY 2022 performance, available in December 2023.

Form MS-416

AHCCCS Medicaid and KidsCare rates for Early and Periodic Screening, Diagnostic, and Treatment (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 2021 (October 1, 2020 to September 30, 2021) and is inclusive of the information reported to CMS on the annual Form CMS-416 Report. 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 2020	CYE 2021
ACC CMS-416 Rates		
EPSDT Participation (%)	43.2%	45.9%
Total Eligibles Receiving Preventive Dental Services (%)	42.0%	44.8%
Total Eligibles Receiving Any Dental Services (%)	43.6%	46.2%
KidsCare CMS-416 Rates		
EPSDT Participation (%)	52.4%	51.6%
Total Eligibles Receiving Preventive Dental Services (%)	45.6%	47.7%
Total Eligibles Receiving Any Dental Services (%)	48.5%	50.3%

March 2020 marked the beginning of the COVID-19 public health emergency (PHE). Based on analysis of the CYE 2020 and CYE 2021 data, the COVID-19 PHE negatively impacted Form CMS-416 rates, most notably for EPSDT participation.

Performance Improvement Projects

AHCCCS had the following PIPs in place during CYE 2021 (October 1, 2020 to September 30, 2021):

Back to Basics PIP

Population: ACC/KidsCare, DCS CHP, and ALTCS-DD

The purpose of this PIP 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.

Back to Basics	CYE 2019 Rate	CYE 2022 Rate	CYE 2023 Rate	Year to Year Change[1]
ACC/KidsCare				
Well-Child Visits: 15 Month Rate	64.1%	Rate Pending	Rate Pending	Not Available
Child and Adolescent Well-Care Visits	49.9%	Rate Pending	Rate Pending	Not Available
Annual Dental Visits	60.1%	Rate Pending	Rate Pending	Not Available
DCS CHP				
Well-Child Visits: 15 Month Rate	N/A	Rate Pending	Rate Pending	Not Available
Child and Adolescent Well-Care Visits	72.6%	Rate Pending	Rate Pending	Not Available
Annual Dental Visits	74.7%	Rate Pending	Rate Pending	Not Available
ALTCS-DD				
Well-Child Visits: 15 Month Rate	N/A	Rate Pending	Rate Pending	Not Available
Child and Adolescent Well-Care Visits	50.7%	Rate Pending	Rate Pending	Not Available
Annual Dental Visits	52.7%	Rate Pending	Rate Pending	Not Available

[1] *Year to Year Change is not available.*

Breast Cancer Screening PIP

Population: ALTCS-EPD

The purpose of this PIP is to increase the number and percentage 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.

Breast Cancer Screening	CYE 2019 Rate	CYE 2022 Rate	CYE 2023 Rate	Year to Year Change[1]
ALTCS-EPD				
Breast Cancer Screening	36.5%	Rate Pending	Rate Pending	Not Available

[1] *Year to Year Change is not available.*

Preventive Screening PIP

Population: SMI

The purpose of this PIP is to increase the number and percentage 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.

Preventive Screening	CYE 2019 Rate	CYE 2022 Rate	CYE 2023 Rate	Year to Year Change[1]
SMI				
Breast Cancer Screening	36.9%	Rate Pending	Rate Pending	Not Available
Cervical Cancer Screening	43.2%	Rate Pending	Rate Pending	Not Available

[1] *Year to Year Change is not available.*

Additionally, AHCCCS initiated the following Performance Improvement Project with a baseline year of CY 2022.

Prenatal and Postpartum Care PIP

Population(s): ACC and SMI

To improve health outcomes for members and infants, this performance improvement project focuses on increasing the number and percent of members with live birth deliveries that 1) received a prenatal care visit, and 2) received a postpartum visit. The goal of this project is to demonstrate a statistically significant increase in the number and percent of members with live birth deliveries that 1) received a prenatal care visit, and 2) received a postpartum visit, followed by sustained improvement for one consecutive year.

Performance Measure Rates Tables

The following tables include performance measure data for each population/LOB as well as the associated 2020 NCQA Medicaid Mean data published and accessible through the *NCQA State of HealthCare Quality Report*.

ACC Performance Measure Rates	CY 2020 Rates	2020 NCQA Medicaid Mean
Adherence to Antipsychotic Medications in Adults with Schizophrenia	50.4%	61.6%
Adults' Access to Preventive/Ambulatory Health Services	72.5%	NA
Ambulatory Care: ED Visits[1] - Rate Per 1,000 Member Months	37.1	NA
Annual Dental Visits	49.8%	42.8%
Antidepressant Medication Management - Effective Acute Phase Treatment	54.2%	57.3%
Antidepressant Medication Management - Effective Continuation Phase Treatment	38.5%	41.6%
Asthma in Younger Adults Admission Rate - Reported Per 100,000 Member Months	4.3	NA
Asthma Medication Ratio[1]	66.1%	65.4%
Breast Cancer Screening	49.5%	53.7%
Cervical Cancer Screening	49.3%	56.8%
Child and Adolescent Well-Care Visits (Total)	42.8%	46.1%
Childhood Immunization Status - Combo 10	32.7%	38.9%
Childhood Immunization Status - Combo 2	69.9%	70.4%
Childhood Immunization Status - Combo 3	66.9%	67.6%
Childhood Immunization Status - Diphtheria, Tetanus, Acellular Pertussis (DTAP)	72.1%	73.9%
Childhood Immunization Status - Hepatitis A (HEP A)	84.1%	84.1%

ACC Performance Measure Rates	CY 2020 Rates	2020 NCQA Medicaid Mean
Childhood Immunization Status - Hepatitis B (HEP B)	85.8%	87.3%
Childhood Immunization Status - Haemophilus Influenza Type B (HiB)	85.1%	85.9%
Childhood Immunization Status - Influenza	41.6%	50.7%
Childhood Immunization Status - Inactivated Poliovirus (IPV)	86.2%	87.7%
Childhood Immunization Status - Measles, Mumps, Rubella (MMR)	85.7%	87.6%
Childhood Immunization Status - Pneumococcal Conjugate (PCV)	73.6%	75.6%
Childhood Immunization Status - RV	69.7%	71.2%
Childhood Immunization Status - Varicella (VZV)	84.9%	87.0%
Chlamydia Screening in Women[1]	51.9%	54.5%
Comprehensive Diabetes Care - Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	45.8%	45.4%
Concurrent Use of Opioids and Benzodiazepines	6.5%	NA
Contraceptive Care - All Women - Long-Acting Reversible Contraceptive (LARC) Ages 15-20	3.2%	NA
Contraceptive Care - All Women - LARC Ages 21-44	5.2%	NA
Contraceptive Care - All Women - Most of Moderately Effective Method of Contraceptive (MMEC) Ages 15-20	19.3%	NA
Contraceptive Care - All Women - MMEC Ages 21-44	24.3%	NA
Contraceptive Care - Postpartum Women - LARC Ages 15-20 - 3 Day	1.3%	NA
Contraceptive Care - Postpartum Women - LARC Ages 15-20 - 60 Day	8.9%	NA
Contraceptive Care - Postpartum Women - LARC Ages 21-44 - 3 Day	0.8%	NA
Contraceptive Care - Postpartum Women - LARC Ages 21-44 - 60 Day	7.7%	NA
Contraceptive Care - Postpartum Women - MMEC Ages 15-20 - 3 Day	2.6%	NA
Contraceptive Care - Postpartum Women - MMEC Ages 15-20 - 60 Day	26.7%	NA
Contraceptive Care - Postpartum Women - MMEC Ages 21-44 - 3 Day	8.0%	NA
Contraceptive Care - Postpartum Women - MMEC Ages 21-44 - 60 Day	28.3%	NA
Controlling High Blood Pressure	46.6%	55.9%
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate - Per 100,000 Member Months	25.5	NA
Developmental Screening in the First Three Years of Life (Total)	35.4%	NA
Diabetes Care for People with Serious Mental Illness- HbA1c Poor Control (>9.0%)	46.5%	NA
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medication	77.1%	76.7%
Diabetes Short-Term Complications Admission Rate - Per 100,000 Member Months	18.2	NA
Follow-Up After ED Visit for AOD Abuse or Dependence[1] - 30 Day	24.3%	20.2%
Follow-Up After ED Visit for AOD Abuse or Dependence[1] - 7 Day	17.7%	13.8%
Follow-Up After ED Visit for Mental Illness[1] - 30 Day	58.0%	54.4%
Follow-Up After ED Visit for Mental Illness[1] - 7 Day	47.6%	40.4%
Follow-Up After Hospitalization for Mental Illness[1] - 30 Day	59.8%	58.9%
Follow-Up After Hospitalization for Mental Illness[1] - 7 Day	43.6%	39.4%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	66.7%	53.5%
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	56.1%	43.9%

ACC Performance Measure Rates	CY 2020 Rates	2020 NCQA Medicaid Mean
Heart Failure Admission Rate - Per 100,000 Member Months	29.2	NA
Immunizations for Adolescents - Combo 2	43.2%	37.8%
Immunizations for Adolescents - Human Papillomavirus (HPV)	44.9%	39.9%
Immunizations for Adolescents - Meningococcal (MCV4)	87.5%	81.9%
Immunizations for Adolescents – Tetanus, Diphtheria Toxoids, Acellular Pertussis (TDAP)	88.5%	85.7%
Initiation and Engagement of AOD Abuse or Dependence Treatment[1] - Engagement of AOD (Total)	17.6%	14.1%
Initiation and Engagement of AOD Abuse or Dependence Treatment[1] - Initiation of AOD (Total)	46.8%	45.1%
Inpatient Utilization: Total Inpatient - Days per 1,000 Member Months	27.6	NA
Mental Health Utilization - Any Services (Total)	10.8%	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing	36.1%	32.1%
Plan All-Cause Readmissions - Observed Readmissions	9.5%	10%
Prenatal and Postpartum Care - Postpartum Care	64.6%	75.1%
Prenatal and Postpartum Care - Timeliness of Prenatal Care	77.3%	83.8%
Sealant Receipt on Permanent First Molars - All Four Molars Sealed	14.4%	NA
Sealant Receipt on Permanent First Molars - At Least one Sealant	23.9%	NA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	70.2%	60.1%
Use of Opioids at High Dosage in Persons Without Cancer	9.9%	NA
Use of Pharmacotherapy for Opioid Use Disorder	42.7%	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Body Mass Index (BMI) Percentile Documentation	58.3%	74.5%
Well-Child Visits in the First 30 Months of Life: 15 Months	60.6%	52.9%
Well-Child Visits in the First 30 Months of Life: 30 Months	66.1%	71.0%

[1] Age range reflective of NCQA Healthcare Effectiveness Data and Information Set (HEDIS®)[8] methodology

NA has been included for data that are not available

DCS CHP Performance Measure Rates[1]	CY 2020 Rates	2020 NCQA Medicaid Mean
Ambulatory Care: ED Visits[2] - Rate Per 1,000 Member Months	27.9	NA
Annual Dental Visits	69.2%	42.8%
Asthma Medication Ratio[2]	86.8%	65.4%
Chlamydia Screening in Women[2]	59.9%	54.5%
Developmental Screening in the First Three Years of Life (Total)	46.6%	NA
Inpatient Utilization: Total Inpatient - Days per 1,000 Member Months	14.8	NA
Child and Adolescent Well-Care Visits (Total)	66.2%	46.1%
Well-Child Visits in the First 30 Months of Life: 15 Months	53.9%	52.9%
Well-Child Visits in the First 30 Months of Life: 30 Months	76.9%	71.0%
Sealant Receipt on Permanent First Molars - At Least one Sealant	65.6%	NA
Sealant Receipt on Permanent First Molars - All Four Molars Sealed	42.1%	NA

[8] *The Healthcare Effectiveness Data and Information Set (HEDIS) is a registered trademark of NCQA.*

DCS CHP Performance Measure Rates[1]	CY 2020 Rates	2020 NCQA Medicaid Mean
Childhood Immunization Status - Influenza	52.8%	50.7%
Childhood Immunization Status - Combo 10	42.7%	38.9%
Childhood Immunization Status - Combo 2	80.5%	70.4%
Childhood Immunization Status - Combo 3	79.7%	67.6%
Childhood Immunization Status - DTAP	84.1%	73.9%
Childhood Immunization Status - HEP B	97.2%	87.3%
Childhood Immunization Status - HiB	97.2%	85.9%
Childhood Immunization Status - IPV	97.2%	87.7%
Childhood Immunization Status - MMR	93.5%	87.6%
Childhood Immunization Status - PCV	85.8%	75.6%
Childhood Immunization Status - VZV	93.5%	87.0%
Childhood Immunization Status - HEP A	90.7%	84.1%
Childhood Immunization Status - RV	81.7%	71.2%
Immunizations for Adolescents - MCV4	97.4%	81.9%
Immunizations for Adolescents - TDAP	96.4%	85.7%
Immunizations for Adolescents - HPV	61.9%	39.9%
Immunizations for Adolescents - Combo 2	60.3%	37.8%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Body Mass Index (BMI) Percentile Documentation	33.0%	74.5%

[1] *Population primarily includes members under 18 years of age with some exceptions*

[2] *Age range reflective of NCQA HEDIS® methodology*

NA has been included for data that are not available

DCS CHP General Mental Health Performance Measure Rates[1]	CY 2020 Rates	2020 Medicaid Mean
Follow-Up After ED Visit for Mental Illness[2] - 30 Day	85.8%	54.4%
Follow-Up After ED Visit for Mental Illness[2] - 7 Day	69.8%	40.4%
Follow-Up After Hospitalization for Mental Illness[2] - 30 Day	83.4%	58.9%
Follow-Up After Hospitalization for Mental Illness[2] - 7 Day	63.1%	39.4%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase Cross LOB	96.9%	53.5%
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase Cross LOB	90.1%	43.9%
Initiation and Engagement of AOD Abuse or Dependence Treatment – Engagement of AOD[2] (Total)	16.4%	14.1%
Initiation and Engagement of AOD Abuse or Dependence Treatment – Initiation of AOD[2] (Total)	51.8%	45.1%
Mental Health Utilization - Any Service (Total)	70.5%	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing Cross LOB	37.7%	32.1%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics Cross LOB	87.7%	60.1%

[1] *Population primarily includes members under 18 years of age with some exceptions*

[2] Age range reflective of NCQA HEDIS® methodology

NA has been included for data that are not available

Cross LOB: Rates reported reflect services rendered through both physical and behavioral health plan enrollment

ALTCS-EPD Performance Measure Rates	CY 2020 Rates	2020 NCQA Medicaid Mean
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	84.7%	61.6%
Adults' Access to Preventive/Ambulatory Health Services	91.8%	NA
Ambulatory Care: ED Visits[1] - Rate Per 1,000 Member Months	48.9	NA
Antidepressant Medication Management - Effective Acute Phase Treatment	72.6%	57.3%
Antidepressant Medication Management - Effective Continuation Phase Treatment	63.0%	41.6%
Asthma Medication Ratio[1]	67.0%	65.4%
Breast Cancer Screening	36.3%	53.7%
Cervical Cancer Screening	28.3%	56.8%
Child and Adolescent Well-Care Visits (Total)	42.8%	46.1%
Chlamydia Screening in Women	18.7%	54.5%
Comprehensive Diabetes Care	39.4%	45.4%
Concurrent Use of Opioids and Benzodiazepines	19.2%	NA
Contraceptive Care - All Women - LARC Ages 21 - 44	3.7%	NA
Contraceptive Care - All Women - MMEC Ages 15 - 20	11.3%	NA
Contraceptive Care - All Women - MMEC Ages 21 - 44	15.6%	NA
Controlling High Blood Pressure	65.3%	55.9%
COPD or Asthma in Older Adults Admission Rate - Per 100,000 Member Months	50.1	NA
Diabetes Care for People with Serious Mental Illness- HbA1c Poor Control (>9.0%)	35.2%	NA
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	94.5%	76.7%
Diabetes Short-Term Complications Admission Rate - Per 100,000 Member Months	14.0	NA
Follow-Up After ED Visit for AOD Abuse or Dependence[1] - 30 Day	17.5%	20.2%
Follow-Up After ED Visit for Mental Illness[1] - 30 Day	57.8%	54.4%
Follow-Up After ED Visit for Mental Illness[1] - 7 Day	51.1%	40.4%
Follow-Up After Hospitalization for Mental Illness[1] - 30 Day	49.7%	58.9%
Follow-Up After Hospitalization for Mental Illness[1] - 7 Day	36.6%	39.4%
Heart Failure Admission Rate - Per 1,000 Member Months	126.6	NA
Immunizations for Adolescents - HPV	32.4%	39.9%
Immunizations for Adolescents - MCV4	64.7%	81.9%
Immunizations for Adolescents - TDAP	70.6%	85.7%
Initiation and Engagement of AOD Abuse or Dependence Treatment[1] - Engagement of AOD (Total)	4.3%	14.1%
Initiation and Engagement of AOD Abuse or Dependence Treatment[1] - Initiation of AOD (Total)	50.8%	45.1%
Inpatient Utilization: Total Inpatient - Days per 1,000 Member Months	205.1	NA
Mental Health Utilization - Any Service (Total)	22.8%	NA
Plan All-Cause Readmissions - Observed Readmissions	11.8%	10%
Use of Opioids at High Dosage in Persons Without Cancer	18.6%	NA

Use of Pharmacotherapy for Opioid Use Disorder	19.2%	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Body Mass Index (BMI) Percentile Documentation	73.7%	74.5%

[1] *Age range reflective of NCQA HEDIS® methodology*

NA has been included for data that are not available

ALTCS-DD Performance Measure Rates	CY 2020 Rates	2020 NCQA Medicaid Mean
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	89.0%	61.6%
Adults' Access to Preventive/Ambulatory Health Services	90.4%	NA
Ambulatory Care: ED Visits[1] - Rate Per 1,000 Member Months	28.0	NA
Annual Dental Visits	43.3%	42.8%
Antidepressant Medication Management - Effective Acute Phase Treatment	72.9%	57.3%
Antidepressant Medication Management - Effective Continuation Phase Treatment	69.7%	41.6%
Asthma Medication Ratio [1]	84.3%	65.4%
Breast Cancer Screening	47.4%	53.7%
Cervical Cancer Screening	22.9%	56.8%
Child and Adolescent Well-Care Visits (Total)	47.9%	46.1%
Childhood Immunization Status - Combo 10	34.4%	38.9%
Childhood Immunization Status - Combo 2	73.1%	70.4%
Childhood Immunization Status - Combo 3	70.6%	67.6%
Childhood Immunization Status - DTAP	80.6%	73.9%
Childhood Immunization Status - HEP A	87.5%	84.1%
Childhood Immunization Status - HEP B	84.4%	87.3%
Childhood Immunization Status - HiB	91.3%	85.9%
Childhood Immunization Status - Influenza	70.0%	50.7%
Childhood Immunization Status - IPV	88.1%	87.7%
Childhood Immunization Status - MMR	88.1%	87.6%
Childhood Immunization Status - PCV	74.4%	75.6%
Childhood Immunization Status - RV	48.1%	71.2%
Childhood Immunization Status - VZV	87.5%	87.0%
Chlamydia Screening in Women[1]	12.6%	54.5%
Comprehensive Diabetes Care- Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	24.2%	45.4%
Concurrent Use of Opioids and Benzodiazepines	14.0%	NA
Contraceptive Care - All Women - LARC Ages 15 - 20	1.8%	NA
Contraceptive Care - All Women - LARC Ages 21 - 44	1.6%	NA
Contraceptive Care - All Women - MMEC Ages 15 - 20	20.5%	NA
Contraceptive Care - All Women - MMEC Ages 21 - 44	26.7%	NA
Controlling High Blood Pressure	70.6%	55.9%
Developmental Screening in the First Three Years of Life (Total)	42.6%	NA
Diabetes Care for People with Serious Mental Illness- HbA1c Poor Control (>9.0%)	28.0%	NA
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	85.4%	76.7%
Follow-Up After ED Visit for Mental Illness[1] - 30 Day	76.8%	54.4%

ALTCS-DD Performance Measure Rates	CY 2020 Rates	2020 NCQA Medicaid Mean
Follow-Up After ED Visit for Mental Illness[1] - 7 Day	60.2%	40.4%
Follow-Up After Hospitalization for Mental Illness[1] - 30 Day	87.3%	58.9%
Follow-Up After Hospitalization for Mental Illness[1] - 7 Day	68.9%	39.4%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	50.0%	53.5%
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	50.2%	43.9%
Heart Failure Admission Rate - Per 100,000 Member Months	5.9	NA
Immunizations for Adolescents - Combo 2	34.1%	37.8%
Immunizations for Adolescents - HPV	35.2%	39.9%
Immunizations for Adolescents - MCV4	83.6%	81.9%
Immunizations for Adolescents - TDAP	85.5%	85.7%
Initiation and Engagement of AOD Abuse or Dependence Treatment[1] - Initiation of AOD (Total)	38.8%	45.1%
Inpatient Utilization: Total Inpatient - Days per 1,000 Member Months	54.0	NA
Mental Health Utilization - Any Service (Total)	29.4%	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing	35.6%	32.1%
Plan All-Cause Readmissions - Observed Readmissions	8.0%	10%
Sealant Receipt on Permanent First Molars - All Four Molars Sealed	11.6%	NA
Sealant Receipt on Permanent First Molars - At Least one Sealant	18.8%	NA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	22.9%	60.1%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Body Mass Index (BMI) Percentile Documentation	74.1%	74.5%
Well-Child Visits in the First 30 Months of Life: 15 Months	26.2%	52.9%
Well-Child Visits in the First 30 Months of Life: 30 Months	61.9%	71.0%

[1] *Age range reflective of NCQA HEDIS® methodology*

NA has been included for data that are not available

SMI Performance Measure Rates[1]	CY 2020 Rates	2020 Medicaid Mean
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	56.9%	61.6%
Adults' Access to Preventive/Ambulatory Health Services	90.3%	NA
Ambulatory Care: ED Visits[2] - Rate Per 1,000 Member Months	98.7	NA
Antidepressant Medication Management - Effective Acute Phase Treatment	53.6%	57.3%
Antidepressant Medication Management - Effective Continuation Phase Treatment	40.3%	41.6%
Asthma in Younger Adults Admission Rate - Reported Per 100,000 Member Months	16.5	NA
Asthma Medication Ratio[2]	57.3%	65.4%
Breast Cancer Screening	37.0%	53.7%
Cervical Cancer Screening	49.9%	56.8%
Chlamydia Screening in Women[2]	53.0%	54.5%
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	45.2%	45.4%
Concurrent Use of Opioids and Benzodiazepines	13.4%	NA
Contraceptive Care - All Women - LARC Ages 15-20	7.5%	NA
Contraceptive Care - All Women - LARC Ages 21-44	3.6%	NA
Contraceptive Care - All Women - MMEC Ages 15-20	31.6%	NA
Contraceptive Care - All Women - MMEC Ages 21-44	20.2%	NA
Contraceptive Care - Postpartum Women - LARC Ages 21-44 - 60 Day	6.6%	NA
Contraceptive Care - Postpartum Women - MMEC Ages 21-44 - 3 Day	12.1%	NA
Contraceptive Care - Postpartum Women - MMEC Ages 21-44 - 60 Day	31.1%	NA
Controlling High Blood Pressure	49.1%	55.9%
COPD or Asthma in Older Adults Admission Rate - Per 100,000 Member Months	56.4	NA
Diabetes Care for People with Serious Mental Illness—HbA1c Poor Control (>9.0%)	36.9%	NA
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	74.1%	76.7%
Diabetes Short-Term Complications Admission Rate - Per 100,000 Member Months	49.0	NA
Follow-Up After ED Visit for AOD Abuse or Dependence[2] - 30 Day	30.1%	20.2%
Follow-Up After ED Visit for AOD Abuse or Dependence[2] - 7 Day	20.4%	13.8%
Follow-Up After ED Visit for Mental Illness[2] - 30 Day	75.2%	54.4%
Follow-Up After ED Visit for Mental Illness[2] - 7 Day	60.3%	40.4%
Follow-Up After Hospitalization for Mental Illness[2] - 30 Day	82.1%	58.9%
Follow-Up After Hospitalization for Mental Illness[2] - 7 Day	65.8%	39.4%
Heart Failure Admission Rate - Per 1,000 Member Months	41.4	NA
Initiation and Engagement of AOD Abuse or Dependence Treatment[2] - Engagement of AOD (Total)	11.4%	14.1%
Initiation and Engagement of AOD Abuse or Dependence Treatment[2] - Initiation of AOD (Total)	41.3%	45.1%
Inpatient Utilization: Total Inpatient - Days per 1,000 Member Months	83.0	NA
Mental Health Utilization: Any Service (Total)	85.5%	NA
Plan All-Cause Readmissions - Observed Readmissions	13.8%	10%
Prenatal and Postpartum Care - Postpartum Care	64.2%	75.1%
Prenatal and Postpartum Care - Timeliness of Prenatal Care	76.6%	83.8%

SMI Performance Measure Rates[1]	CY 2020 Rates	2020 Medicaid Mean
Use of Opioids at High Dosage in Persons Without Cancer	12.7%	NA
Use of Pharmacotherapy for Opioid Use Disorder	33.2%	NA

[1] *Population includes members 18 years of age and older*

[2] *Age range reflective of NCQA HEDIS® methodology*

NA ***has been included for data that are not available***