



## Quality Strategy

July 1, 2021



# AHCCCS Quality Strategy

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# AHCCCS Quality Strategy

## Executive Summary

In accordance with Code of Federal Regulations (CFR) 42 CFR 438.340 et. seq., the Arizona Health Care Cost Containment System (AHCCCS) Quality Strategy was first established in 2003. It has since been revised, as appropriate, to reflect innovative approaches to member care and continuous quality improvement efforts. AHCCCS' Quality Strategy is a coordinated, comprehensive, and proactive approach to drive improved health outcomes by utilizing creative initiatives, ongoing assessment and monitoring, and results-based performance improvement. It is designed to ensure that services provided to members meet or exceed established standards for access to care, quality of care, and service delivery. In addition, the Quality Strategy supports the identification and documentation of issues related to those standards.

The agency's Quality Strategy has shifted emphasis from process measurements to more comprehensive outcome-based measurements and innovative delivery system design. The Quality Strategy provides a framework for improving and/or maintaining members' health status as well as fostering the increased resilience and functional health status of members with chronic conditions. Members, the public, and stakeholders provide input and recommendations regarding the content and direction of the Quality Strategy through stakeholder presentations and public comments.

Through internal and external collaborations with partners, the agency is able to develop and implement key initiatives and address identified issues. AHCCCS has established the following Quality Strategy goals and objectives applicable to Arizona's managed care program (inclusive of Medicaid and CHIP members):

**Quality Goal 1:** Improve the member's experience of care, including quality and satisfaction.

### *Objectives:*

- Enrich the member experience through an integrated approach to service delivery,
- Improve information retrieval and reporting capability by establishing new, and upgrading existing, information technologies, thereby increasing responsiveness and productivity,
- Enhance current performance measures, PIPs, and best practice activities by creating a comprehensive quality of care assessment and improvement plan across AHCCCS programs, and
- Drive the improvement of member-centered outcomes using nationally recognized protocols, standards of care, and benchmarks, as well as the practice of collaborating with MCOs to reward providers based on clinical best practices and outcomes (as funding allows).

**Quality Goal 2:** Improve the health of AHCCCS populations.

### *Objectives:*

- Increase member access to integrated care that meets the member's individual needs within their local community,
- Support innovative reimbursement models, such as Alternative Payment Models (APMs), while promoting increased quality of care and services, and
- Build upon prevention and health maintenance efforts through targeted medical management:
  - o Emphasizing disease and chronic care management,
  - o Improving functionality in activities of daily living,
  - o Planning patient care for special needs populations,

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- o Identifying and sharing best practices, and
- o Expanding provider development of Centers of Excellence (COEs).

**Quality Goal 3:** Reduce the growth in healthcare costs and lower costs per person.

*Objectives:*

- Increase analytical capacity to make more informed clinical and policy making decisions, and
- Develop collaborative strategies and initiatives with state agencies and other external partners, such as:
  - o Strategic partnerships to improve access to health care services and affordable health care coverage,
  - o Partnerships with sister government agencies, MCOs, and providers to educate Arizonans on health issues,
  - o Effective medical management for at-risk and vulnerable populations, and
  - o Building capacity in rural and underserved areas to address both professional and paraprofessional shortages.

**Quality Goal 4:** Enhance data system and performance measure reporting capabilities.

*Objectives:*

- Evaluate current data system infrastructure,
- Identify system and process limitations impacting performance measure reporting and analysis,
- Leverage various data sources to produce comprehensive reliable data,
  - o Collaborate with external stakeholders to facilitate access to supplemental data sources, and
  - o Explore means for collecting and reporting performance measure data utilizing electronic health record (EHR) methodologies, and
- Drive continuous delivery system performance through advanced data analytics and disparity analyses.

A comprehensive and thoughtful Quality Strategy is a key priority for AHCCCS. AHCCCS continues to collaborate with stakeholders to optimize both the experience and health outcomes of Arizonans accessing Medicaid managed care.

# AHCCCS Quality Strategy

## 1. AHCCCS Overview

As a delivery system that serves more than 2.2 million Arizonans with a budget of more than \$18.3 billion, it is critical that AHCCCS pursue a broad array of strategies that are focused on creating a sustainable program while maintaining its member-centered focus. AHCCCS has established the following to demonstrate its commitment to serving members and providing high quality care and services:

**Agency Vision:** Shaping tomorrow's managed care... from today's experience, quality, and innovation.

**Agency Mission:** Reaching across Arizona to provide comprehensive, quality health care for those in need.

**Agency Values:** Passion, Community, Quality, Respect, Accountability, Innovation, Teamwork, Leadership, and Courage.

**Agency Credo:** Our first care is your health care.

### 1.1 AHCCCS Strategic Plan Goals

The AHCCCS Strategic Plan identifies four multi-year strategies. These are:

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

**Strategic Goal 2:** Pursue continuous quality improvement.

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

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

### 1.2 Background

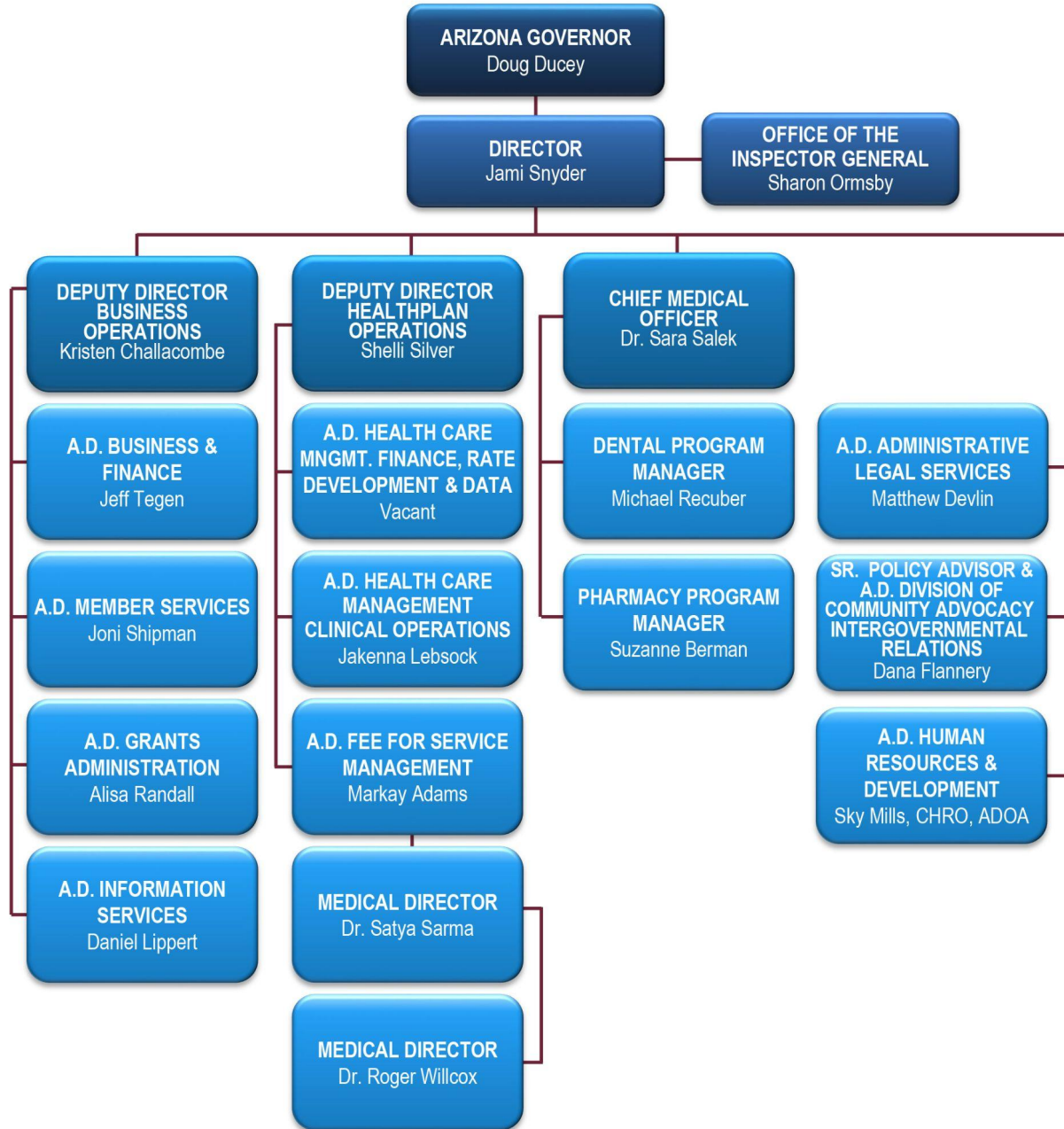
Since 1982, AHCCCS has been delivering high-quality, cost-effective health care services to Arizonans. The State of Arizona has the unique distinction of being the first state in the country to operate under a statewide managed care 1115 Waiver, and the only state to have done so from the start of its Medicaid program. This public-private partnership ensures that members receive high-quality care and that the agency maximizes efficiency and contains costs. In 1988, the 1115 Waiver was amended to add the Arizona Long Term Care System (ALTCSS) program, a fully integrated, managed care health plan for physical and behavioral health services, Long-Term Services and Supports (LTSS), serving individuals with intellectual and/or developmental disabilities, as well as those who are elderly and/or have a physical disability. AHCCCS believes that this health care delivery system design is essential to providing quality care that improves members' health outcomes while eliminating barriers to care and containing costs. By integrating physical and behavioral health services under a single MCO, AHCCCS is better able to address the whole health needs of the state's Medicaid population, reduce fragmentation within the system, and simultaneously improve service delivery to members. On October 1, 2018, AHCCCS fully integrated physical and behavioral health managed care contracts for 1.5 million managed care members. AHCCCS promotes integration at the provider level as well, supporting efforts to deliver integrated services through primary care, integrated clinics, health homes, and other models, and using innovative reimbursement models to improve health outcomes.

### 1.3 AHCCCS Organizational Overview

The AHCCCS organizational structure is designed to effectively implement and oversee various programs that serve its members. The executive management team, and specifically the Chief Medical Officer

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(CMO), oversees the Division of Health Care Management’s (DHCM) implementation of the Quality Strategy, as outlined in the agency administration and management organizational chart below.



- Director and the Executive Management Team: the director of AHCCCS has overall responsibility for ensuring that the agency meets the established goals of its Strategic Plan and maintains the administrative infrastructure to meet its needs. The director leads the executive management team (the deputy directors, CMO, and senior policy advisor) and the leadership team (agency assistant directors) to manage the business, develop and implement administrative policies and procedures, and support the delivery of quality health care services to more than 2 million Medicaid members.



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- Chief Medical Officer: the CMO is a key position within AHCCCS, working collaboratively across divisions to provide oversight and guidance of the quality and delivery of health care services as well as to develop and approve medical policy.
- Division of Health Care Management: the DHCM is responsible for developing policy, procuring MCO contracts, and overseeing and monitoring MCOs. All units within the DHCM play a role in development of and adherence to the agency's Quality Strategy. Key units include Clinical, Contract & Policy Unit, Finance & Reinsurance, Operations, and AHCCCS Office of Data Analytics.

### 1.4 Investigations - QM/OIG Relationship

The AHCCCS Office of Inspector General (OIG) coordinates with the DHCM on different aspects of the quality strategy. Any potential quality of care issues are forwarded from the OIG to the DHCM, Quality Management (QM) unit for its review. The OIG also receives referrals for any matters that QM identifies, which may indicate fraud, waste, or abuse. The OIG coordinates with the DHCM for any areas of concern, operational reviews (ORs) of the MCO for program integrity requirements, and MCO compliance with technical assistance.

Once the OIG notifies the QM unit of the need to suspend and/or terminate a provider, the QM unit contacts each MCO to identify how many members are assigned and/or receiving services from the provider. MCOs are also queried regarding network capacity to transition members to an appropriate provider that can meet their needs as well as the anticipated time frames for safe member transition. AHCCCS QM tracks all MCO notifications and member transitions; the OIG and QM provide bi-directional updates throughout the process. The OIG also coordinates the same questions and processes through the Division of Fee-for-Service Management (DFSM) for populations not served by the MCOs.

### 1.5 Populations Served

#### *a. AHCCCS Complete Care (ACC)*

The ACC program provides physical and behavioral health care services to Arizona residents who are eligible, based on the Federal Poverty Level (FPL) categories. To qualify, children and/or adults must:

- Be a citizen or qualified immigrant,
- Have a social security number or apply for one, and
- Apply for all cash benefits that one may be entitled to, such as pensions or Veteran Assistance benefits.

#### *b. CHIP (KidsCare)*

To qualify, an individual must:

- Be under 19 years of age,
- Live in a household with an income under 200 percent of the FPL,
- Be a citizen or qualified immigrant, and
- Have a social security number or apply for one.

#### *c. Arizona Long Term Care System (ALTCS)*

ALTCS provides long-term care services and supports to financially and medically eligible Arizona residents who are elderly, blind, have a disability, or those who have an intellectual/developmental disability. Financial eligibility compares the individual's income to 300% of the Federal Benefit Rate (FBR) and involves a resources test. To qualify for ALTCS, in addition to meeting financial and medical eligibility criteria, the individual must:

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- Be in need of a nursing home level of care as determined by AHCCCS,
- Be a citizen or qualified immigrant,
- Have a social security number or apply for one,
- Be a resident of Arizona and apply for all cash benefits that one may be entitled to, such as pensions or Veteran Assistance benefits, and
- Live in an approved setting, such as one's own home, an AHCCCS certified nursing facility, or assisted living facility.

### *d. AHCCCS Fee-for-Service (FFS)*

While the vast majority of the AHCCCS populations are managed under a MCO, approximately 12 percent of AHCCCS membership is under FFS management. The DFSM is responsible for the clinical, administrative, and claims functions of the FFS population of more than 275,000 members. This includes American Indians enrolled in the American Indian Health Program (AIHP) for integrated acute physical and behavioral health services, members enrolled with the Tribal Regional Behavioral Health Authorities (TRBHAs) for behavioral health care coordination services, members enrolled with the Tribal Long Term Care programs (Tribal ALTCS), and individuals in the Federal Emergency Service (FES) program.

#### **AHCCCS American Indian Health Program (AIHP)**

AIHP is a FFS program that provides medically necessary physical and behavioral health services. Enrolled members may receive health care services from IHS/638 health programs and Urban Indian health clinics and from other AHCCCS-registered providers. Members are not limited to a network and may switch their enrollment between the AIHP and an MCO at any time; however, a member can change from one MCO to another only once a year. AIHP members must meet the same eligibility requirements in either sections a or b as outlined above.

#### **Tribal ALTCS**

Tribal ALTCS is a FFS program that provides medically necessary physical health, behavioral health, and long term care services. An AI/AN member will be enrolled with a Tribal ALTCS Program if he/she lives on or lived on a reservation prior to admission into an off-reservation facility. Enrolled AI/AN members may receive health care services from IHS/638 health programs and Urban Indian health clinics and from other AHCCCS-registered providers. Members must meet the same eligibility requirements as outlined in section c above.

#### **Federal Emergency Services (FES)**

AHCCCS provides emergency health care services through the FES program for qualified and nonqualified individuals, as specified in 8 USC 1611 et seq. who meet all requirements for Title XIX eligibility as specified in the State Plan except for citizenship. All services for FES must undergo medical review conducted by DFSM.

The DFSM contracts with a Pharmacy Benefits Manager (PBM) for its FFS programs. In April 2019, Indian Health Service (IHS) and Tribal 638 (IHS/638) pharmacies began submitting their claims through the PBM, which provides AHCCCS with more data on American Indian/Alaska Native (AI/AN) members filling a prescription with an IHS/638 facility, including both FFS and MCO enrolled AI/ANs. AHCCCS is also able to implement point of sale safety edits, as well as perform concurrent and retrospective utilization review, to assist in ensuring coordination of care and best practices in prescribing for FFS members and comply with the opioid drug utilization review provisions.

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### 2. Population Management

Population management looks at the structures and processes in place to enhance clinical health outcomes through improved care coordination and member engagement. As part of the agency's population management efforts, the agency has implemented the following:

#### 2.1 State Procedures for Identifying Race, Ethnicity, and Primary Language of Each Member

AHCCCS receives member race, ethnicity, and primary language information through the eligibility screening process, which collects such information at the time of application. This information, along with other demographics, is systematically updated on the AHCCCS member record file and transmitted daily to the MCO on the member enrollment roster. Changes to this information are also updated and transmitted to the MCO. MCOs are responsible for providing any updated information to AHCCCS that differs from the initial documentation provided for each member. AHCCCS updates the member information, as appropriate. Member information is included on the data exchange file received from the Social Security Administration. If any information is missing, the system will default to unknown or unspecified. If the member does not provide or does not wish to provide this information, the member will be designated as unknown/unspecified.

Currently, there are codes for 40 languages that can be captured electronically. AHCCCS periodically assesses the language data to determine any need to expand possible language categories. In addition, AHCCCS evaluates prevalent languages for the AHCCCS populations at the state and MCO levels.

#### 2.2 Disability Status

AHCCCS utilizes its Medicaid Management Information System records of eligibility to identify disability status. Individuals defined by the state as having a disability include the following:

- A person who has been determined to have a qualifying disability by the Social Security Administration or the Department of Economic Security (DES), Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(3)(A) through (E),
- A person who has been determined to meet the criteria for blindness by the Social Security Administration or the DES, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(2),
- A person who is determined by an authorized entity contracted with AHCCCS to have a serious mental illness (SMI) as defined in Arizona Revised Statutes (A.R.S.) § 36-501,
- A person who at the time of a regularly scheduled continuing disability review is determined by the DES, Disability Determination Services Administration to no longer have a qualifying disability, but continues to have a severe medically determinable impairment, as determined under Social Security Act section 42 U.S.C. 1396a(a)(10)(A)(ii)(XVI),
- A person who is determined eligible for services by the DES Division of Developmental Disabilities (DDD) and determined by AHCCCS through a Pre-Admission Screening assessment to be at immediate risk of institutionalization in either a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), and
- A person who is determined by AHCCCS through a Pre-Admission Screening assessment to be at immediate risk of institutionalization in either a nursing facility or an ICF/IID.

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### 2.3 Health Equity

AHCCCS seeks to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status.

#### *a. AHCCCS Health Equity Committee*

Formally established in July 2020, the [Health Equity Committee](#) is tasked with understanding health disparities and developing strategies to ensure health equity for all AHCCCS members. The committee is responsible for overseeing and managing health equity considerations as they relate to policy, data, MCO oversight, and emerging health care innovation strategies for over 2 million Arizonans.

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

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

#### *b. Health Disparity Summary & Evaluation Report*

Beginning CYE 2021, MCOs shall be required to annually submit a Health Disparity Summary & Evaluation Report intended to provide:

- An analysis of the effectiveness of implemented strategies and interventions in meeting health equity goals and objectives during the previous calendar year,
- A detailed overview of the MCO’s identified health equity goals/objectives for the upcoming calendar year, and
- Targeted strategies/interventions planned for the upcoming calendar year to achieve health equity goals.

### 2.4 Transition of Care

AHCCCS has a Member Transition policy that applies to all AHCCCS MCOs and FFS programs. The policy provides detailed requirements to ensure that member access to services remains consistent throughout the transition process. Requirements for member transitions are identified for the following:

- Transitions between MCOs and FFS programs and FFS members,
- Transitions between ALTCS and non-ALTCS MCOs [ACC, Regional Behavioral Health Authorities (RBHA)],
- Transitions between ALTCS Elderly and Physical Disabilities (ALTCS EPD) and ALTCS Developmental Disabilities (ALTCS DD),
- Transitions across Geographic Service Areas (GSAs), and
- Transition age youth to adult delivery systems.

Contractors are required to have policies and procedures to address transitions for members with special circumstances including, but not limited to:

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- Pregnancy,
- Major organ or tissue transplantation services that are in process,
- Chronic illness, for members in a high-risk category, currently hospitalized or place in nursing or other facilities,
- Significant medical or behavioral health conditions,
- Chemo or radiation therapy,
- Dialysis,
- Members with ongoing needs (e.g., ventilator, pain management, durable medical equipment, and prescriptions),
- Human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), and
- Members with an SMI designation.

MCOs are required to ensure that care is coordinated between MCOs as well as between the providers that are involved in member care. MCOs and providers are expected to provide appropriate notifications of enrollment changes via a standardized Enrollment Transition Information (ETI) form which includes information, such as pending authorizations, for services or medications, outpatient treatment, and disposition of medical equipment and supplies. AHCCCS provides an Electronic Transfer for capturing key pieces of information for the transition process. AHCCCS also shares Medicaid claims data from IHS and Tribal facilities for AI/AN members enrolled with the health plans and requires that each health plan employ a Tribal Liaison in order to work through any continuity of care issues that may arise.

### 2.5 AHCCCS Initiatives and Best Practices

AHCCCS has deemed several initiatives as best practices for populations served. These efforts show a committed focus to stakeholder engagement, system accountability, and reducing service fragmentation with the ultimate goal of improving member experiences and health outcomes. AHCCCS highlights current ongoing initiatives on the [AHCCCS Initiatives and Best Practices](#) web page that includes links to more detailed information.

### 2.6 Integrated Health Care

One of the primary strategic goals of AHCCCS is to reduce system fragmentation and develop systems of care that are easy for members to navigate.

#### *a. AHCCCS Complete Care*

The ACC program was implemented October 1, 2018 to ensure that MCOs deliver integrated physical and behavioral health services to address whole health needs of AHCCCS members and improve member experience. The MCOs are expected to continuously add value to the program by exhibiting recognition of the following:

- The importance of an integrated delivery system for physical and behavioral health services,
- The critical importance of care coordination through organizational design and operational processes,
- Medicaid members entitled to care and assistance in navigating the service delivery system,
- Health care providers as an essential partner in the delivery of physical and behavioral health care services,

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- Performance improvement is both clinical and operational in nature,
- The program is publicly funded and is subject to public scrutiny, and
- The importance of the system values and guiding principles.

In addition, MCOs are expected to continuously add value to the program by implementing the following:

- Focused strategies and approaches to ensure coordinated service delivery to members,
- Organizational design and operational processes that demonstrate the critical importance of care coordination,
- Special efforts throughout their operations to assure members receive necessary services,
- Care coordination to Medicaid members with special health care needs (SHCN) or chronic health conditions requiring care coordination,
- Operation of the health plans in a manner that is efficient and effective for health care providers as well as the MCO,
- Self-monitoring and self-correcting as necessary to improve contract compliance and/or operational excellence, and
- Operating in a manner that promotes cost containment and efficiency.

### *b. ALTCS*

Since its inception in 1989, the ALTCS EPD program has been a fully integrated product. EPD members receive all services through their MCOs, and many are aligned to receive their Medicare benefits through the MCO's D-SNP plan, which allows for enhanced care coordination. Beginning October 2020, the ALTCS MCO for individuals with intellectual and developmental disabilities created a partially integrated health program by sub-contracting with health plans to provide physical and behavioral health services, Children's Rehabilitation Services (CRS), and limited LTSS while maintaining the responsibility for the provision of the majority of LTSS, including case management support coordination. In serving ALTCS members, the case managers shall promote the values of dignity, independence, individuality, privacy, choice and self-determination, and adhere to the following guiding principles:

- Member-centered case management,
- Member directed options,
- Person-centered planning,
- Consistency of services,
- Accessibility of network,
- Most integrated setting, and
- Collaboration with stakeholders.

### *c. Members Living with an SMI*

Members enrolled in managed care that are not eligible for the ALTCS program and have an SMI designation receive all their acute care and behavioral health services through a RBHA. Members with an SMI designation who reside in Maricopa County (central region) began receiving integrated care on April

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1, 2014. Integration efforts expanded to northern and southern regions on October 1, 2015, transitioning members with an SMI designation into an integrated delivery system.

### *d. Medicare and Medicaid Dually Eligible Members*

As of October 1, 2015, dually eligible members (individuals eligible for both Medicaid and Medicare) enrolled in managed care but not eligible for the ALTCS program began receiving behavioral health services from their enrolled Acute Care MCO. In addition to integration of Medicaid services, AHCCCS promoted extensive alignment efforts between Medicaid and Medicare. As of November 2020, approximately 47 percent of full benefit dually enrolled members are in aligned plans.

### *e. American Indian Medical Home (AIMH)*

Arizona is home to over 350,000 AI/AN individuals, approximately half of whom are enrolled in AHCCCS. Significant health disparities exist for the AI/AN population. For instance, the average age of death for American Indians is 17.5 years lower than the general population, and American Indians experience higher death rates from preventable diseases. Whereas the American Indian population accounts for less than 2 percent of the national population and 4 percent of the Arizona population, it accounts for approximately 10 percent of the AHCCCS population. Recognizing its unique role in addressing the health needs of Arizona's AI/AN population, AHCCCS launched a relatively new effort to improve the health outcomes of tribal members by identifying critical population needs and collaborating with tribes, tribal health partners, community organizations, and state and federal agencies to enhance care coordination.

To that end, CMS approved Arizona's State Plan Amendment for the American Indian Medical Home (AIMH) program for the AI/AN members enrolled in the AIHP. The AIMH program supports Primary Care Case Management (PCCM), diabetes education, and care coordination for the AIHP enrolled members. The AIMHs help address health disparities between American Indians and other populations in Arizona by enhancing case management and care coordination. IHS/638 facilities that choose to become an AIMH must obtain Primary Care Medical Home (PCMH) status through an appropriate accreditation body or provide an annual attestation of its participation in the IHS Improving Patient Care (IPC) model, in addition to providing 24-hour telephonic access to the care team. The AIMH PCCM program is a voluntary program. AIHP enrolled members can select an AIMH site by accessing a participating AIMH provider or by contacting AHCCCS Member Services, where they will be enrolled through the AHCCCS online portal. The AIMH Member Sign-Up forms are available at AIMH sites and on the AHCCCS website and are processed by AHCCCS on a monthly basis. The AIMH member sign-up form identifies benefits of the program, the right to disenroll or select a different AIMH provider at any time, and any other information required by federal and state regulations including 42 CFR 438.54(c)(3). As of May 2021, approximately 25% of AIHP members are empaneled in an AIMH.

### *e. Targeted Investments (TI) Program*

The Targeted Investments (TI) Program is AHCCCS' strategy to provide financial incentives to eligible AHCCCS providers to develop systems for integrated care. In accordance with 42 CFR 438.6(c) and the 1115 Waiver, managed care plans will provide financial incentives to eligible Medicaid providers who meet certain benchmarks for integrating and coordinating physical and behavioral health care for Medicaid beneficiaries. The TI Program aims to:

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



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## 2.7 Long Term Care Supports and Services

### *a. Long Term Care Case Management*

Each member enrolled in ALTCS receives case management services provided by a qualified case manager. ALTCS case managers utilize a person-centered approach and maximize member/family self-determination while promoting the values of dignity, independence, individuality, privacy, and choice. Case managers conduct regular on-site, face-to-face visits with members to:

- Ensure quality services are provided without gaps,
- Determine the services necessary to meet the member’s needs,
- Provide member specific education to the member and their family, and
- Introduce alternative models of care delivery, when appropriate.

The person-centered planning meetings conducted by the case managers are intended to result in a mutually agreed upon, appropriate, and cost-effective individualized, person-centered service plan that meets the medical, functional, social, and behavioral health needs of the member in the most integrated and least restrictive setting. The following are examples of how case managers execute the roles and responsibilities included above:

- **Member-Directed Options Information:** case managers regularly inform members about member-directed options and assist members and their families to make informed decisions about the service delivery model of care.
- **Cost Effectiveness Analysis:** case managers assess the continued suitability, appropriateness, and cost effectiveness of the member’s in-home services. Home and community based services placement is the goal for ALTCS members, as long as cost effectiveness standards and the member’s medical, functional, social, and behavioral health needs can be met in that setting. The case manager regularly assesses the cost of the home and community based services and compares them to the estimated cost of institutionalized care. Home and community based services placement is considered cost-effective if the cost of home and community based services for a member does not exceed 100 percent of the net cost of institutional care.
- **Non-Medicaid Service Coordination:** case managers identify and integrate non-ALTCS covered community resources/services as appropriate, based on the member’s needs. Case managers are also responsible for assisting members to identify independent living/personal goals while providing them with local resources that may help transition members towards greater self-sufficiency in the areas of housing, education, employment, recreation, and socialization.
- **End of Life (EOL) Care:** case managers are required to educate members/family on EOL care which encompasses all health care and support services provided at any age or stage of an illness. EOL care goals focus on comfort and quality of life. Services include advance care planning, palliative care, supportive care, and hospice.
- **Person-Centered Service Planning (PCSP):** in an effort to enhance the person-centered approach and further maximize member/family self-determination, AHCCCS initiated a process to:
  - o Create alignment of practices, forms, and monitoring of PCSP approach and personal goal development,
  - o Support members to have the information and supports to maximize member-direction and determination, and



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- o Develop processes to document health and safety risks, and safeguard against unjustified restrictions of member rights, in accordance with the Home and Community Based Settings Rules (HCBS Rules).

### *b. Home and Community Based Services*

AHCCCS has maintained a consistent trend of home and community based services member placements (considering increases in population) either plateauing or increasing yearly. Specifically, over a decade ago (2009) the proportion of members residing in their own homes was as low as 49 percent and has currently grown to 72 percent, while the proportion of the members residing in institutions declined from 31 percent (2009) to the current 9 percent. The proportion of members residing in alternative residential settings remains stable at 19 percent. These placement rates are largely attributable to the service options and HCBS Rules activities available which demonstrates the program's commitment to advancing initiatives which result in the shift of placement for members to community-based placements.

The HCBS Rules afford Arizona the opportunity to reinforce the priority of serving members in the least restrictive setting while formalizing a new priority to ensure members are actively engaged and participating in their communities. On January 16, 2014, CMS released final rules regarding requirements for HCBS operated under section 1915 of the Social Security Act. The rules mandate certain requirements for residential and non-residential settings where Medicaid members receive long-term care services and supports. Specifically, the rules establish requirements for settings to ensure that individuals receiving services are integrated into their communities and have full access to the benefits of community living. In Arizona, these requirements impact ALTCS program members receiving services in the following residential and non-residential settings:

#### Residential

- Assisted Living Facilities,
- Group Homes,
- Adult and Child Development Homes, and
- Behavioral Health Residential Facilities.

#### Non-Residential

- Adult Day Health Programs,
- Day Treatment and Training Programs,
- Center-Based Employment Programs, and
- Group-Supported Employment Programs.

Between November 2014 and May 2015, AHCCCS conducted a systemic assessment of Arizona's HCBS to determine current level of compliance, provide recommendations for identified variances, and outline a process for continuous monitoring. The systemic assessment process included a review of A.R.S., Arizona Administrative Code (A.A.C.) (licensing rules), and AHCCCS and MCO policies and contracts.

AHCCCS engaged various stakeholders in the assessment process and in the development of the transition plan. The purpose of these meetings was to dialogue with, and solicit input from, stakeholders regarding the preliminary assessment findings and draft recommendations to ensure compliance with the HCBS Rules. AHCCCS revised the Assessment and Transition Plan based upon the input received. The meetings also served as an orientation for stakeholders and a strategy to support stakeholders in

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providing informed public comment during August 2015. Following the stakeholder meetings, AHCCCS enacted an official public comment period from August 1, 2015 through August 31, 2015, which included eight public forums hosted by AHCCCS throughout the state. AHCCCS published the draft Systemic Assessment of Arizona's HCBS and the draft Transition Plan for bringing the settings into compliance. After review and consideration of all public comments, AHCCCS finalized the Assessment and Transition Plan and submitted it to CMS for approval in October 2015. The final Transition Plan is available on the AHCCCS [Home and Community Based Settings Rules](#) web page.

The Transition Plan outlines strategies the state will use to make sure all HCBS settings come into compliance by March 2022. AHCCCS engaged in multiple meetings and/or correspondence with CMS, pertaining to the Transition Plan, for the period of September 2017 through February 2019. The updated Transition Plan posted on the AHCCCS website contains revisions to the Transition Plan made in response to CMS feedback during that period. In February 2019, CMS confirmed the current revisions to the Transition Plan to-date are satisfactory. CMS will not officially approve Arizona's Systemic Assessment and Transition Plan until after the first round of site-specific assessments have been completed, a public comment period is held, and the State's reports to CMS are satisfactory. In March 2019 through May 2019, AHCCCS held a public comment period including stakeholder forums, statewide, to provide information on updates made to the Transition Plan and solicit comments that will be used to help inform the implementation of the Transition Plan.

AHCCCS is currently working in partnership with the MCOs, the provider community, and CMS to modify the quality monitoring tools and process that accommodates COVID-19 mitigation strategies while also ensuring the integrity of the HCBS Rules. Consistent with AHCCCS' ongoing efforts to be transparent and accountable to the general public during the implementation of the Assessment and Transition Plan, AHCCCS will post reports on the [Home and Community Based Settings Rules](#) web page to delineate progress with quarterly and annualized milestones. AHCCCS will continue to solicit, receive, and incorporate public input regarding progress made on the Transition Plan implementation.

With respect to individual member experiences, the case manager will play a critical role in assessing and addressing barriers to members accessing community living benefits. The Person-Centered Service Plan has been modified to support the case manager in ascertaining the member experience and feedback regarding provider compliance with the HCBS Rules requirements. MCOs shall also assess the member experience through member interviews conducted as a part of annual quality and contract monitoring of the settings noted above.

### *c. Electronic Visit Verification (EVV)*

Pursuant to Section 1903 of the Social Security Act (42 U.S.C. 1396b), AHCCCS is mandated to implement Electronic Visit Verification (EVV) for non-skilled in-home services (attendant care, personal care, homemaker, habilitation, respite), and for in-home skilled nursing services (home health) by January 1, 2023. The EVV system must, at a minimum, electronically verify the:

- Type of service performed,
- Individual receiving the service,
- Date of the service,
- Location of service delivery,
- Individual providing the service, and
- Time the service begins and ends.

AHCCCS' goals for instituting EVV include:

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- Helping to make sure that members get the services they need, when they need them, through the use of scheduling, contingency planning, and reporting,
- Supporting provider business choices and reducing administrative burden associated, and
- Preventing, detecting, and recovering improper payments due to fraud, waste, and abuse.

AHCCCS is employing a number of strategies/activities to ensure the EVV system meets both federally mandated and AHCCCS requirements. In order to make an informed decision on the EVV system requirements, AHCCCS engaged in a number of stakeholder engagement and public comment activities, including the formation of a multi-disciplinary steering committee composed of internal and external parties (members, providers, MCOs, etc.). Additionally, AHCCCS has engaged stakeholders to provide public comment. In-person forums were facilitated for members and their families, while providers simultaneously had an opportunity to submit public comments through a Request for Information process. AHCCCS implemented EVV on January 1, 2021 (for both personal care and home health services) with the state-wide EVV vendor and data aggregator through Sandata Technologies. AHCCCS continues to meet with several provider cohorts and MCOs to discuss operational issues and will continue to meet to analyze the data and create performance measures to evaluate and incentivize provider compliance.

### 2.8 Centers of Excellence

Starting October 1, 2015, AHCCCS required all contracted MCOs to develop approaches for identifying and contracting with COEs. The Centers are facilities that are recognized as providing the highest levels of leadership, quality, and service. They align physicians and other providers to achieve higher value through greater focus on appropriateness of care, clinical excellence, and patient satisfaction. Designation as a COE is based on criteria, such as procedure volumes, clinical outcomes, treatment planning, and coordination. Each MCO was required to submit a report identifying why it selected a procedure or condition, how it identified and selected providers to address them, how the MCO shall drive utilization to the providers, and any barriers or challenges in the development of the COE.

MCOs employed a variety of approaches in developing and maintaining their COEs. All seven ACC plans formed a COE Collaborative Workgroup to establish a set of standardized criteria for COE statewide with the intent of avoiding provider abrasion in responding to seven different sets of criteria for each of the COE to be developed/established. As a result, the workgroup criteria were developed for the following COE: autism spectrum disorder (ASD), integrated pain management, substance use, adolescents, and transition aged youth. The workgroup will next work to complete the COE for members aged birth to five years.

Once an MCO has designated a provider a COE, the MCO takes steps to ensure the COE maintains quality standards. For example, one MCO identified a variety of COEs with diverse specializations offering services such as ASD, peer and family support, and sleep disorders. While the MCO originally planned to implement standardized criteria and reporting across its COE network, it determined it needed to develop specialized metrics for each COE type. After implementing these metrics, the MCO is currently meeting quarterly with each COE to review performance concerns, and annually makes decisions about the COE designation.

Another MCO incorporates monitoring through incorporating COEs into its Value-Based Purchasing (VBP) arrangements. COEs sign a Value-Based contract, which allows the MCO's Value-Based department to monitor the COEs, along with all other Value-Based contracts on a monthly or quarterly basis. Quality and utilization metrics outlined in the contract are measured in graphical format and reviewed with the COE at monthly/quarterly Joint Operating Committee (JOC) meetings. COE performance is reviewed and areas for improvement are discussed in order to meet minimum performance standards. Depending on

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the nature of the service, providers receive some or all of the following reporting: Quality performance trend graphs, daily discharges, monthly gaps in care, newborn report, inpatient census, and quarterly utilization. Some partners also receive claims, pharmacy, and lab data monthly.

AHCCCS continues to improve its COE program. Starting in 2017, rather than submitting a separate update for its COE program, AHCCCS required the MCOs to incorporate COE program updates with their Annual Network Development and Management Plan. It is AHCCCS' intent that these programs be integrated into the context of each MCO's overall network strategy.

### 2.9 Residential Facilities and Oversight

AHCCCS monitors residential facilities in a variety of ways. One way is to provide oversight of MCO adherence to network standard requirements, as outlined in the AHCCCS Contractor Operations Manual (ACOM) Policy 436. Another way is to ensure a general assessment of network adequacy for member service needs. AHCCCS has partnered with MCOs to undertake a network analysis in order to identify the specialized treatment and program options for various populations to better understand the capacity for treating individuals with complex needs. The network is validated by the AHCCCS External Quality Review Organization (EQRO). AHCCCS also closely evaluates monitoring of treatment settings for clinical and quality performance. AHCCCS regularly monitors MCO prior authorization requirements and issues requests to MCOs with specific requirements for auditing and reporting.

To further enhance monitoring efforts, AHCCCS collaborates with the Arizona Department of Health Services (ADHS) for those facilities licensed by the ADHS. AHCCCS has continued to engage with MCOs to better clarify the expectations around treatment provided within residential facilities and to align with licensure requirements by the ADHS.

The AHCCCS Office of Human Rights (OHR) and the Office of Individual Family Affairs (OIFA) both engage with community members on an ongoing basis. It is through this work that many system concerns are identified. Once identified, these issues are brought forward for resolution within the appropriate AHCCCS division.

### 2.10 Prevention Efforts and Attention to the Overuse of Opioids

Arizona, like most states in the country, has witnessed the rising tide of opioid-related deaths. In 2018, more than three Arizonans died each day due to opioid-related causes, with a quadrupling in the number of deaths due to heroin since 2012. In an effort to combat the opioid epidemic, AHCCCS developed an Opioid Strategic Plan in 2016 and has been implementing three major strategies with MCOs, providers, and community champions across several impacted sectors. The overarching goals of the AHCCCS Opioid Initiative are as follows:

- Enhance harm reduction strategies to prevent overdose,
- Enhance access to Medication Assisted Treatment (MAT) for individuals with opioid use disorder (OUD), and
- Promote responsible prescribing and dispensing policies and practices.

The implementation plan includes a blend of objectives designed to increase coordinated and integrated care, recovery support services, and prevention activities to reduce the prevalence of OUDs and opioid-related overdose deaths. The project approach includes developing and supporting state, regional, and local level collaborations as well as service enhancements to develop and implement best practices to comprehensively address the full continuum of care related to opioid misuse, abuse, and dependency.

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### Strategies to Combat Opioid Abuse:

- **Increase access to Naloxone:** Conduct community-based education and naloxone distribution; encourage co-prescribing of Naloxone for all members prescribed greater than 90 Morphine Equivalent Daily Doses and for any situations involving combinations of opioids and benzodiazepines.
- **Increase access, participation, and retention in Medication Assisted Treatment (MAT):** Increase provider capacity among Opioid Treatment Programs, Office Based Opioid Treatment providers, and Residential settings that allow all three forms of MAT; increase 24/7 access to care sites through identified 24/7 Access Points, previously known as Centers of Excellence; increase navigation to treatment and retention in treatment through expansion of peer supports and care coordinators; increase the ability to identify and assist with the navigation of justice-involved individuals, pregnant and parenting women to MAT.
- **Promote responsible prescribing and dispensing policies and practices:** Reduce the number of opioid-naïve members unnecessarily started on opioid treatment by limiting initial opioid fills for first acute episodes to no more than five (5) days; promoting the Arizona Opioid Prescribing Guidelines and opioid prescribing education; non-opioid best practices for effective pain management; use of mental health, trauma, and substance use screenings prior to prescribing opioids; and opioid risk education materials for members; improve care processes for chronic pain and high-risk members by using data to identify problematic prescribing patterns and coordinating provider education; using data to identify high-risk members and coordinating to appropriate care; use of the Controlled Substance Prescription Monitoring Program; promote e-prescribing of controlled substances; increase access to non-opioid methods for managing chronic pain; incentivize for integrated behavioral health and pain management; increase options for complex case consults.

### 2.11 Foster Care Youth

AHCCCS is committed to providing comprehensive, quality health care for children in foster, kinship, and adoptive care. Children in foster/kinship placements are eligible for medical and dental care, behavioral health, and other services through the Department of Child Safety Comprehensive Health Plan (DCS CHP). Adoptive children are typically AHCCCS eligible and are enrolled into an integrated health plan, similar to any Medicaid-eligible child. On April 1, 2021, physical and behavioral health were integrated under Mercy Care DCS CHP as the single sub-contractor providing services to members in DCS CHP.

System improvements include availability of frequently asked questions documents and behavioral health and crisis services flyers for foster and kinship caregivers, as well as the streamlining of MCO deliverables. AHCCCS created a dashboard to track and trend utilization for children in foster care. This dashboard report is posted to the AHCCCS website. Furthermore, AHCCCS hired Mercer Government Human Services Consulting (Mercer) to perform an analysis for implementing an integrated health plan for children in foster care. The analysis was designed to identify the necessary operational and ongoing infrastructure requirements of an integrated health plan administered through DCS CHP.

AHCCCS ACOM Policy 449: Behavioral Health Services for Children in Department of Child Safety Custody and Adopted Children, was developed to implement House Bill 2442 (also known as Jacob's Law) legislative requirements. Additionally, a dedicated web page hosts helpful information and resources to support the families, community, and providers involved in the care and treatment of foster and adoptive children. Jacob's Law mandates include the following:

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- Designated points of health plan and AHCCCS contacts,
- An assessment of the child (must be conducted within 72 hours after being notified that a child has been placed out of home),
- A mobile team assessment within two hours, as indicated, in the event of a crisis or urgent need,
- An initial evaluation of the child must be completed within seven calendar days after a referral or request for services,
- The health plan must respond to a request for residential placement due to threatening behavior within 72 hours,
- If a foster child is moved to a different county, they may continue to receive treatment in the previous county or seek treatment in the new county, and
- An initial behavioral health appointment must be provided within 21 calendar days after the initial evaluation.

In the event the initial behavioral health appointment is not provided within 21 calendar days, the out of home placement or adoptive parent must notify the health plan and AHCCCS, and the guardian may access the service directly from any AHCCCS-registered provider regardless of whether the provider is contracted with the health plan. The AHCCCS Foster Care Liaison also conducts Jacob's Law training sessions for the public.

### 2.12 Justice Population

Approximately 120,000 individuals are released from Arizona jails and prisons each year and over 70 percent have a substance use and/or mental health disorder. The volume of complex needs within this population makes it difficult to provide high-touch care to all who need it. Despite the challenges, AHCCCS is actively engaged with the Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) and most of Arizona's county jails, including Maricopa and Pima, in a data exchange process which suspends health plan enrollment upon incarceration, instead of terminating AHCCCS coverage. This data exchange agreement allows the ADCRR and county jails to electronically transmit custody dates for AHCCCS members, which simplifies the process of transitioning members directly back into care following release. Additionally, AHCCCS MCOs (including RBHAs) are required to provide "reach-in" care coordination to identify incarcerated members with complex health needs and connect them with case managers, prerelease, to provide information and schedule appointments with Primary Care Physicians (PCP) and behavioral health providers, as appropriate.

AHCCCS has intergovernmental agreements implemented with the ADCRR and most Arizona counties, to provide services to incarcerated individuals temporarily admitted into an inpatient hospital setting outside the correctional institution. This process involves the correctional institution, or its designee, assisting the incarcerated individual with submitting an application for temporary AHCCCS coverage and an expedited review from specialized units which determine eligibility and the specific period of the hospital stay. When determined eligible, the medical services performed during the hospital stay will be covered by AHCCCS.

AHCCCS has additional agreements with the ADCRR and most Arizona counties, including Maricopa and Pima, granting special permissions in the AHCCCS online application portal [Health-e-Arizona Plus (HEAplus)] to assist uninsured individuals in applying for AHCCCS coverage prior to release. The application is submitted in HEAplus approximately 30 days prior to release and will be reviewed by a specialized eligibility unit. The eligibility determination process is expedited to help ensure that qualified individuals who need critical care may be enrolled in AHCCCS immediately following release.



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Incarcerated individuals at risk of needing an institutional level of care upon release may receive a Pre-admission Screening assessment while incarcerated and, when eligible, may apply for ALTCS upon release.

### 2.13 Suicide Prevention in Arizona

As ADHS reported on its website, suicide was the 10th leading cause of death nationally and the eighth leading cause of death in Arizona in 2018. Of the 1,432 deaths by suicide in Arizona, 55.9 percent of the methods used were firearms. When stratified, communities most impacted were males, Native Americans, rural areas, those aged 45 and older, and veterans. AHCCCS publishes an annual [Suicide Prevention Action Plan](#) highlighting populations at risk and community partnerships. AHCCCS works with the Arizona Coalition for Suicide Prevention to disseminate information and resources regarding suicide prevention. Additionally, all MCOs are required to address suicide prevention in their policies and to provide suicide prevention training to their front-line staff. The suicide prevention team includes a suicide prevention specialist, an epidemiologist, and two grant-funded positions. One grant specialist works with the Arizona Department of Education (ADE) on the Substance Abuse and Mental Health Services Administration (SAMHSA)-funded Project AWARE. The five-year grant targets school districts with suicide prevention and behavioral health resources. The second grant-funded position works on a SAMHSA-funded suicide prevention/domestic violence project in Pima County. Since the creation of the team in 2018, Arizona has seen a 41 percent decrease of youth suicides, and a decrease among all ages in 2020 (Arizona Child Fatality Review Team 35).

### 2.14 System of Care Oversight

The System of Care team is responsible for oversight of AHCCCS MCOs adherence to contract and policy requirements to ensure services are delivered in line with the Arizona Vision (12 Principles and Adult Service Delivery System and 9 Guiding Principles), as well as the integration of physical and behavioral health services at the point of care. These oversight activities include monitoring of contract and policy requirements that ensure adequate, timely, and effective service delivery to aid members to achieve success in school/work, to live independently within their community, to avoid delinquency, and to achieve their vision of recovery.

#### *a. Fidelity Review*

The Western Interstate Commission for Higher Education (WICHE), a national expert in the four SAMHSA evidence-based practices (EBP), conducts annual fidelity monitoring of services provided to individuals with an SMI designation. These reviews focus on four service types: Assertive Community Treatment, Supported Employment, Supportive Housing, and Peer and Family Services. Fidelity reviews include fidelity scales and review of all EBP materials including interview guides, scoring protocols and forms, fidelity report templates, provider notification, and preparation letters. These tools continue to be utilized.

- Reviews are conducted in a team of two reviewers. Each team has a lead reviewer in charge of preparation correspondence, provider scheduling, and writing the report.
- Following the one-to-four-day reviews, each team member completes individual scores, and the team then consolidates final consensus scores.
- A detailed fidelity report with scoring rationale and recommendations is drafted by the review team.
- Following discussion and any needed input from respective expert consultant(s), the report with the fidelity scale score sheet is delivered to providers.

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- A follow-up call with providers and the RBHA may be scheduled to discuss the review findings and answer specific questions regarding the report upon request by the provider.

Mercer Government Human Services Consulting (Mercer) conducts an annual quality service review (QSR) and conducts an annual evaluation of individuals with an SMI designation. The purpose of the review is to identify strengths, service capacity and gaps in areas where members receive their services. The QSR includes an evaluation of nine targeted behavioral health services that includes the following: Case Management, Peer Support, Family Support, Supported Housing, Living Skills Training, Supported Employment, Crisis Services, Medication and Medication Services and Assertive Community Treatment Services. Mercer conducts the QSR of the targeted services using a number of evaluation techniques.

### *b. Behavioral Health Clinical Chart Audit*

The Behavioral Health Clinical Chart Audit has historically been utilized to audit provider charts, with the focus on processes related to initial and ongoing assessment and service planning. Each of the RBHAs conducted its audits utilizing its own unique tool that comported with required AHCCCS policies. However, the use of distinct audit tools did not allow for data analysis at a statewide level. Therefore, beginning in 2018 and with the advent of the ACC plans, AHCCCS began working with the RBHAs and ACC plans to develop a unified tool for utilization throughout Arizona by all MCOs. The audit tool was formally implemented on October 1, 2019. The first round of results was reported as of April 2020, but further auditing was suspended due to the COVID-19 Public Health Emergency (PHE). AHCCCS intends to continue evaluation of the Behavioral Health Chart Audit process to ensure a more focused view of the outcomes of members who have received behavioral health services.

### 2.15 Division of Grants Administration

The Division of Grants Administration has applied for, and been awarded, several key grants that help achieve the agency's mission and vision for individuals who are either under or uninsured. The federal grants received by AHCCCS have a narrowly defined purpose for a demonstrated need. The current grants focus on substance use disorders (SUDs), mental health, homelessness, OUD, Crisis Counseling Program, suicide prevention, COVID-19, and ongoing prevention and treatment for adolescents and adults.

### 2.16 Housing

AHCCCS recognizes the importance of housing as a social risk factor to health and is working to integrate housing strategies into its larger health management strategies. Housing is currently one of the three primary focus areas in AHCCCS' Whole Person Care Initiative (WPCI) to address social risk factors to health. Additionally, AHCCCS provides housing subsidies and supports for persons with an SMI designation [and a smaller number of members with general mental health/substance use (GMHSU) needs] through Non-Title XIX/XXI funds and through Title XIX/XXI funding for those support services which are Medicaid compensable. To implement its housing strategies, AHCCCS follows the Permanent Supportive Housing (PSH) model endorsed by SAMHSA, Housing and Urban Development (HUD), and CMS.

Under the PSH model, there are two components to an effective housing strategy: provision of safe, appropriate, and affordable housing that meets the member's/resident's need, and the availability of effective, individualized wrap around supportive services to assist the individual or household attain and maintain their housing placement while addressing other service plan goals. These services are provided to help a member secure appropriate housing and stay housed in a stable environment.

In addition to Title XIX/XXI funding, AHCCCS receives a state funded annual allocation of approximately \$28 million for non-Medicaid compensable housing subsidies and supports. Since 2014, AHCCCS utilizes



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housing funds in all Arizona GSAs and uses a small portion of housing funds to serve persons diagnosed as GMHSU. AHCCCS prioritizes persons experiencing homelessness for housing subsidy. At present, AHCCCS housing funds provide housing subsidies to an average of 2,800 households statewide each month. Housing funds also support operating expenses for an additional 1,500 persons with an SMI designation and who were experiencing homelessness but now reside in HUD Continuum of Care subsidized PSH units. AHCCCS housing funding is currently awarded to the RBHA in each GSA based on the submission and approval of an annual Housing Spending Plan that documents local housing needs, waitlists, projects to be funded, service coordination strategies, and an annual housing budget. The RBHAs must also provide monthly utilization/vacancy and housing inventory reports, as well as other ad hoc reports as required in contract, which are used to monitor housing performance. Contracts require each RBHA to employ at least one (1) Housing Administrator to coordinate the RBHA housing activities related to AHCCCS funds including monitoring of housing providers, ensuring performance of key housing operational activities (e.g., inspections, rent subsidy determinations, service coordination, grievances, and reporting), and the RBHA housing policy maintenance.

Additionally, the Arizona State Legislature allocates \$2 million annually to a SMI Housing Trust Fund. With these dollars, the RBHAs and TRBHAs can purchase and renovate properties (with some limitations) for individuals with a SMI designation. Properties purchased or renovated with these dollars are limited to the use of those individuals with an SMI designation through Covenants, Conditions, and Restrictions (CC&Rs) on the funded projects for a period ranging from 15-30 years.

Statewide, Arizona is in the midst of an affordable housing crisis. Arizona's dramatically increasing population, limited development of affordable units, and a strong job market, has left rental vacancies at historic lows. Some cities report less than a three percent vacancy rate for all units. This has put upward pressure on rents. In Maricopa County, according to the HUD Office of Policy Development and Research, Fair Market Rents for an efficiency unit have increased over 25 percent (from \$744 to \$933 a month) and one-bedroom rates have increased almost 19 percent (from \$868 to \$1,032). The current COVID-19 crisis does not seem to have reduced the lack of affordable housing, to date. Other Arizona counties have shown rent increases as well. This is more complicated in Arizona's rural communities that may lack traditional rental units or where affordable housing may not be near other necessary resources. AHCCCS works closely with RBHAs, ALTCS providers, and MCOs to ensure adherence to follow national best practices regarding assessment and placement of homeless individuals. MCOs are required to use the Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT) to assess a member's housing needs and rank members accordingly on a housing wait list. Priority is given to persons experiencing homelessness. Housing staff are expected to be familiar with the Housing Quality Standard (HQS) inspection process to make sure members are being housed in safe environments. The RBHAs work closely with landlords and with developers to ensure available housing units are matched with members. Once matched, the member is provided supportive services to help keep him/her successfully housed. For chronically homeless individuals, the first 30 days are critical for supportive services to prevent eviction. The RBHAs work with other community housing providers when possible, including local Public Housing Authority, the three Arizona HUD approved Continua of Care, and other state agencies to secure both housing subsidies, as well as to develop additional affordable housing units for AHCCCS members.

Beginning October 2021, AHCCCS will consolidate administration of its housing funding with a statewide Housing Administrator. Arizona Behavioral Health Corporation (ABC) was selected through the Request for Proposals (RFP) process to standardize housing processes including referrals, waitlist management prioritization, voucher management, resident pre-tenancy briefings, landlord engagement, housing quality inspections, legal compliance, rent determinations, and subsidy payments. As part of this

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process, AHCCCS will increase accountability and reporting for housing performance including use of HUD and other PSH evaluation standards and benchmarks. Additionally, AHCCCS will continue to work on the quality of services provided by standardizing programmatic language and reporting, implementing the permanent supportive housing fidelity review statewide, reducing barriers to housing, strengthening relationships with homeless outreach teams, and encouraging developers to be mindful of the Medicaid and vulnerable populations when developing new properties. AHCCCS has created an internal Housing Workgroup that will coordinate these efforts.

### 2.17 Workforce Development

Workforce Development (WFD) is the process of recruiting, selecting, developing, deploying, and retaining a sufficiently staffed, qualified, and capable workforce. Within the AHCCCS system, the WFD function is described in ACOM Policy 407. The policy differentiates the responsibilities of the three types of organizations (AHCCCS, MCOs, and providers) comprising the system and describes the collaborative approach to WFD:

- Providers directly acquire, develop, deploy, and retain a qualified and capable workforce,
- MCOs monitor and ensure that providers maintain a workforce that possesses the required qualifications, staffing capacity, and skill capability needed to deliver AHCCCS services. In addition, MCOs must develop detailed WFD plans to strengthen the workforce capacity and capability of providers within their networks. These network specific plans often include specific assistance MCOs provide to their provider organizations. MCOs also participate in joint WFD planning with AHCCCS and other MCOs designed to address statewide WFD challenges.
- AHCCCS analyzes current and future healthcare workforce trends, forecasts and describes workforce requirements, and generates policies to manage the development and deployment of the healthcare workforce.

Monitoring the activities and intended accomplishments described in the Annual WFD Plan is the primary way AHCCCS evaluates the productivity and success of the MCOs' WFD programs. Workforce development directly affects the health care members receive, as well as the health outcomes they experience. Services must be provided by a sufficiently skilled workforce who is capable of meeting member needs in the most interpersonally, clinically, and culturally appropriate manner possible. AHCCCS, MCOs, and leaders from the provider community and industry groups are working collaboratively to strategize, develop measures and methods for analyzing the needs, and action planning on how to attract and retain the desired workforce. Specifically, AHCCCS is working towards:

- Increasing its capacity to collect workforce data, analyze workforce trends, facilitate workforce planning, and mobilize human, educational, and community resources needed to both attract and prepare qualified workers to deliver contracted services,
- Enabling MCOs to better assist providers to enhance their WFD programs by strengthening the internal relationship and collaboration between networks, quality, customer service, and culturally competent units, and
- Developing partnerships with communities, industry group, and educational resources to develop regional approaches to recruit talented individuals (including current AHCCCS members), to join the integrated healthcare workforce, preventing, reducing or eliminating health professional shortages in key areas and to improve the efficacy of the state's education, training, and development programs.

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### 2.18 Employment Support

AHCCCS believes that every individual with a disability can work competitively in the community when the right kind of job and work environment is found. Competitive Integrated Employment is work that is performed on a full-time or part-time basis for which an individual is: compensated at or above minimum wage and comparable to the customary rate paid to persons without disabilities performing similar duties and with similar training and experience; receiving the same level of benefits provided to other employees without disabilities in similar positions; at a location where the employee interacts with other individuals without disabilities; and presented opportunities for advancement similar to other employees without disabilities in similar positions. Self-employment, in many cases, is also considered Competitive Integrated Employment.

The RBHAs are required to maintain subcontracted arrangements with at least one fully dedicated employment/rehabilitation provider staff at each clinic whose only duties include employment and rehabilitation-related activities, such as meaningful community involvement activities. AHCCCS tracks the utilization of covered services.

For individuals with an SMI designation, AHCCCS and the Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA) [which includes the State Vocational Rehabilitation (ADES/VR) program], have an established Interagency Service Agreement (ISA) to provide specialty employment services and supports. AHCCCS provides funds toward this agreement that the ADES/RSA uses as a state match to draw down additional federal monies. The overall funding is used toward client services, staffing, and training. The VR submits quarterly deliverables that include client progress statuses and staffing capacity. Some of the special requirements within the ISA are:

- Vocational Rehabilitation Counselors (VRCs) have specialized caseloads consisting of individuals with psychiatric disabilities. ADES/VR counselors are cross-trained in the area of psychiatric disabilities to effectively serve the individual needs of the clients,
- The federally mandated, 60-day eligibility requirement for ADES/VR applicants is modified to 30-days; ADES/VR Counselors and RBHA provider employment staff have weekly consultations regarding the progress of mutual program participants, and
- The ISA also requires quarterly ISA Advisory Committee meetings with AHCCCS, RBHAs, and RSA/VR and bi-annual regional ISA Coordination meetings for collaboration with all stakeholders in efforts to enhance program delivery methods and increase successful employment outcomes. The AHCCCS contract with the RBHA mandates its adherence to the ISA.

AHCCCS is expanding employment requirements beyond the RBHAs by including employment requirements for MCOs more generally. AHCCCS is educating MCOs on the usage of Medicaid covered employment services. For the ALTCS and DCS CHP contracts, plans are required to employ staff designated as the subject matter expert (SME) on employment and employment services. Their role is to assist case managers with up-to-date information designed to aid members in making informed decisions about their independent living options, including employment. For ACC (effective October 1, 2018), the integrated MCOs shall be required to maintain subcontracted arrangements with at least one fully dedicated employment/rehabilitation provider staff at each clinic whose only duties are to include employment and rehabilitation-related activities. Deliverables will be attached to the ACC contract around employment.

AHCCCS has also begun efforts to help transform the employment system by coming into compliance with the CMS HCBS Rules specific to employment services (Center-Based Employment and Group Supported Employment). The purpose of the rule is to ensure that individuals receiving home and

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community-based services are integrated into their communities and have full access to the benefits of community living, including employment settings. By March 17, 2023, through the help of a workgroup facilitated by the AHCCCS Employment Administrator, Arizona will need to be compliant with HCBS Rules, so that all members have the opportunity to seek competitive employment in the most integrated setting and to the same degree of access as individuals not receiving home and community-based services.

### 3. AHCCCS Quality Strategy and Evaluation

AHCCCS performs most of the External Quality Review (EQR) functions at the MCO level using an EQRO to evaluate whether the work that AHCCCS completes complies with federal requirements. The EQRO is tasked with preparing independent Annual EQR Technical Reports that summarize each MCO's compliance, strengths, weaknesses, implementation of corrective actions, identification of best practices, and improvement opportunities. The Quality Strategy is considered a companion document to the EQR reports.

#### 3.1 External Quality Review (EQR)

Over the past 35 years, AHCCCS has developed significant in-house resources, processes, and expertise in monitoring its MCOs. EQRO feedback is used to assess effectiveness of the current quality goals and strategies, as well as provide a roadmap for considerations and potential changes to the agency's Quality Strategy. This Quality Strategy is closely aligned and interfaces with the EQR mandatory requirements defined in 42 CFR 438.358, which includes:

- Review of MCO compliance with specified standards for quality program operations,
- Validation of state-required performance measures,
- Validation of state-required performance improvement projects (PIPs), and
- Validation of MCO compliance with network adequacy requirements.

AHCCCS utilizes Operational Reviews (ORs) to evaluate MCO operations and performance related to compliance with federal and state laws, rules and regulations, and AHCCCS contract and policy. These ORs provide information to the EQRO for its use in its annual report of AHCCCS and MCO compliance. EQR reports are posted on the AHCCCS website and made available in accordance with 42 CFR 438.364.

##### *a. Non-Duplication of Efforts*

42 CFR 438.360 allows the use of information from a Medicare or private accreditation review of a MCO to provide information for the annual EQR instead of conducting one or more of the EQR activities. As part of the agency's direction in requiring its MCOs to obtain National Committee for Quality Assurance (NCQA) Accreditation specific to their Medicaid line of business by October 1, 2023, AHCCCS will review and evaluate which NCQA Accreditation activities are considered deemable and able to be used for the purpose of providing information for the annual EQR reporting (in lieu of the EQRO conducting one or more of the mandatory EQR activities).

##### *b. EQRO Process*

Through the procurement process, AHCCCS ensures the qualifications of its CMS-required EQRO for both competence and independence as outlined in 42 CFR 438.354. This review provides an outside analysis and assessment of the MCOs' performance as well as recommendations to improve the MCOs' performance, as applicable. The technical reports provide the following elements by line of business (e.g., ACC and ALTCS):

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- A description of the EQR activities,
- An overview of the AHCCCS program history and a summary of AHCCCS' Quality Strategy goals and objectives,
- An overview of AHCCCS' statewide quality initiatives across its Medicaid managed care programs and those specific to each MCO,
- An overview of the MCOs' best and emerging practices,
- Network adequacy,
- Organizational assessment and structure performance,
- Performance measure results and analysis, and
- Performance improvement project results and analysis.

### 3.2 Quality Strategy Scope and Objectives

The AHCCCS Quality Strategy is a coordinated, comprehensive, and proactive approach designed to drive quality throughout the AHCCCS delivery system. AHCCCS achieves goals outlined in the Quality Strategy through:

- Combined methods of partnership with and regulatory oversight of contracted MCOs,
- Value-based program development, and
- Focus on outcomes and optimized member health.

AHCCCS clearly outlines expectations for quality care/service delivery and has structured a thorough, multi-faceted approach for monitoring compliance to expectations, including on-going member and stakeholder feedback/engagement and numerous MCO-based activities.

The scope of the Quality Strategy is designed to incorporate the requirements outlined in 42 CFR 438.340 and 42 CFR 457.1240(e). AHCCCS requires transparency for the quality of health care and services it provides to its members, the community, and its stakeholders. AHCCCS has developed quality initiatives and strategies for evidence-based outcomes that:

- Reward quality of care, integrated service delivery, member safety, and member satisfaction outcomes,
- Support best practices in disease management and chronic care,
- Provide feedback on quality and outcomes to MCOs and providers, and
- Provide comparative information to potential members, members, and stakeholders.

The agency's Quality Strategy is focused on continuous quality improvement based on the Triple Aim framework of healthcare. The Triple Aim was developed by the Institute for Healthcare Improvement (IHI) in 2007 and has been widely adopted by governmental and commercial organizations as a mechanism to improve both the member's healthcare experience and the system performance simultaneously. In order to achieve the Triple Aim, AHCCCS has formulated strategies intended to simultaneously improve care, improve population health, and reduce costs. With these concepts in mind, AHCCCS has established the following Quality Strategy goals and objectives applicable to Arizona's managed care program (inclusive of Medicaid and CHIP members):

**Quality Goal 1:** Improve the member's experience of care, including quality and satisfaction.

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### Objectives:

- Enrich the member experience through an integrated approach to service delivery,
- Improve information retrieval and reporting capability by establishing new and upgrading existing information technologies, thereby increasing responsiveness and productivity,
- Enhance current performance measures, PIPs, and best practice activities by creating a comprehensive quality of care assessment and improvement plan across AHCCCS programs, and
- Drive the improvement of member-centered outcomes using nationally recognized protocols, standards of care, and benchmarks, as well as the practice of collaborating with MCOs to reward providers based on clinical best practices and outcomes (as funding allows).

### Quality Goal 2: Improve the health of AHCCCS populations.

#### Objectives:

- Increase member access to integrated care that meets the member's individual needs within their local community,
- Support innovative reimbursement models, such as Alternative Payment Models (APMs), while promoting increased quality of care and services, and
- Build upon prevention and health maintenance efforts through targeted medical management:
  - o Emphasizing disease and chronic care management,
  - o Improving functionality in activities of daily living,
  - o Planning patient care for special needs populations,
  - o Identifying and sharing best practices, and
  - o Expanding provider development of COE.

### Quality Goal 3: Reduce the growth in healthcare costs and lower costs per person.

#### Objectives:

- Increase analytical capacity to make more informed clinical and policy making decisions, and
- Develop collaborative strategies and initiatives with state agencies and other external partners, such as:
  - o Strategic partnerships to improve access to health care services and affordable health care coverage,
  - o Partnerships with sister government agencies, MCOs, and providers to educate Arizonans on health issues,
  - o Effective medical management for at-risk and vulnerable populations, and
  - o Building capacity in rural and underserved areas to address both professional and paraprofessional shortages.

### Quality Goal 4: Enhance data system and performance measure reporting capabilities.

#### Objectives:



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- Evaluate current data system infrastructure,
- Identify system and process limitations impacting performance measure reporting and analysis,
- Leverage various data sources to produce comprehensive reliable data,
  - o Collaborate with external stakeholders to facilitate access to supplemental data sources, and
  - o Explore means for collecting and reporting performance measure data utilizing EHR methodologies, and
- Drive continuous delivery system performance through advanced data analytics and disparity analyses.

A comprehensive and thoughtful Quality Strategy is a key priority for AHCCCS as the agency continues to collaborate with stakeholders to optimize both the experience and health outcomes of Arizonans accessing Medicaid managed care.

### 3.3 Methods and Processes for Quality Strategy Development

AHCCCS strives to ensure that the voice of the community is heard. Quality is a community process that is continuously informed and shaped by the voices and choices made by internal and external stakeholders. AHCCCS ensures agency transparency and incorporates community feedback into its Quality Strategy development through support of the following structures.

#### *a. Public Information*

The AHCCCS Public Information Officer (PIO) is the information messenger to the public. This office distributes public-facing information about the agency's programs using traditional external communication techniques, including press releases, website content, public and media relations, email newsletters, and social media. In addition, the PIO interfaces with external stakeholders including businesses, students, and AHCCCS members.

AHCCCS employs a social media strategy to increase public access to information, generate positive public relations, interface with the media, support MCO community efforts, gather information to increase business intelligence, and bolster employee recruiting efforts. Twitter posts at @AHCCCS.gov amplify external messages, support partner organizations, answer member questions, and drive traffic to the AHCCCS blog and website. Posts on LinkedIn promote agency business initiatives. The AHCCCS Facebook page is a source for member-directed content. Public video content is posted on the agency's YouTube channel.

A public-facing blog profiles successful AHCCCS employees, health care initiatives, legislative updates, human interest stories about Medicaid issues, and health care-related community events. To increase transparency and information sharing, AHCCCS divisions publish various e-newsletters to which stakeholders and the public may subscribe.

#### *b. Division of Community Advocacy and Intergovernmental Relations (DCAIR)*

AHCCCS has a dedicated division that interfaces with members, peers, family members, and other stakeholders receiving physical and behavioral health services in Arizona's Medicaid managed care delivery system. Dedicated teams within the DCAIR include:

- **Office of Human Rights (OHR)**

The Office of Human Rights (OHR) is the State Advocacy Office, established by the A.A.C., R9-21-104, that focuses on direct advocacy to a population designated as Special Assistance.

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Special Assistance is a clinical designation that occurs when a member cannot participate effectively in his/her own treatment planning processes due to a cognitive or intellectual impairment and/or medical condition. Currently in Arizona, there are over 3,200 members who receive Special Assistance. The OHR also provides advocacy to individuals with an SMI designation. Staff provide assistance to help members understand and learn how to protect and exercise their rights, facilitate self-advocacy through education, and obtain access to behavioral health services within Arizona's publicly funded system.

### ▪ **Office of Individual and Family Affairs (OIFA)**

The Office of Individual and Family Affairs (OIFA) is staffed by peers and family members of persons receiving services in Arizona's behavioral health system. They bring their lived experiences to the forefront when making decisions, incorporating recovery and resiliency into all aspects of service delivery. Moreover, the OIFA:

- o Builds partnerships with individuals, families of choice, youth, communities, and organizations to promote recovery, resiliency, and wellness,
- o Collaborates with key leadership and community members in the decision-making process at all levels of the behavioral health system,
- o Advocates for the development of culturally inclusive environments that are welcoming to individuals and families,
- o Establishes structures to promote diverse youth, family, and individual voices in leadership positions throughout Arizona,
- o Deliver training, technical assistance, and instructional materials for individuals and their families, and
- o Ensures peer support and family support is available to all persons receiving services and their families and monitors MCO performance and measure outcomes.

### *c. Arizona State Medicaid Advisory Committee (SMAC)*

The State Medicaid Advisory Committee (SMAC) reviews and advises on the operations, programs, and planning for Arizona's Medicaid program. The Committee advises the Director of AHCCCS on policy, operations, and administrative issues of the Medicaid program, including issues of concern to the community. SMAC operates in accordance with 42 CFR 431.12 and the Medicaid State Plan. The bylaws for the committee were created in September 1992 and are reviewed annually, or as needed. The Committee is composed of the AHCCCS Director, the Director of the ADHS or a designee, the Director of the Arizona Department of Economic Security or a designee, and no less than 17 health care providers or professionals with a direct interest in the AHCCCS program. Members are appointed for two-year terms with appointments made on a staggered basis with half the public and professional/provider members completing their terms annually. SMAC meets quarterly, chaired by the AHCCCS Director, and meetings are open to the public with a public comment period at the end of the agenda.

### *d. Behavioral Health Planning Council*

The Arizona Behavioral Health Planning Council is required by 42 U.S. Code § 300x-3 to review Arizona's Mental Health Block Grant (MHBG) and the Arizona Behavioral Health Planning Council elects to review the Substance Abuse Block Grant (SABG) Services Plans for children and adults. This review must occur before it is submitted to the United States Department of Health and Human Services (DHHS). The council's membership reflects the diverse cultures in Arizona and includes behavioral health recipients,



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family members, advocates, state agencies, and community providers. The council and its committees meet monthly, either in-person or online, as appropriate.

The council is tasked with reviewing the MHBG and the SABG plans provided by AHCCCS and submitting to the state any council recommendations for modifications to the plans. It also serves as an advocate for adults with an SMI designation, children with a severe emotional disturbance, and other individuals with mental health or emotional problems. The council reviews and evaluates the allocation and adequacy of behavioral health services within the state, not less than once each year.

### *e. ALTCS Advisory Council*

The ALTCS Advisory Council consists of ALTCS members, their family members/representatives, ALTCS MCOs, providers, state and advocacy agencies, and advocacy program representatives. The council assists the ALTCS program to develop a work plan that addresses opportunities for new service innovations or systemic issues impacting ALTCS members. Council members advise on activities directed at system improvements. Individual council members provide input and feedback on ALTCS program activities from their own personal or professional experience, expertise, and/or perspective.

### *f. Tribal Consultation*

AHCCCS recognizes the unique government-to-government relationship that exists between American Indian tribes and federal and state governments. At minimum, AHCCCS conducts tribal consultation on a quarterly basis to strengthen the special relationship between tribal nations and the AHCCCS administration. The goal is to ensure that AHCCCS provides reasonable notice and opportunity for consultation with tribal nations prior to implementing policy changes that may be likely to have a direct effect on one or more tribal communities and its members, on the relationship between the State of Arizona and tribal nations, or on the distribution of responsibilities between the State of Arizona and tribal nations. AHCCCS has a designated tribal liaison who is responsible for tribal consultation and serves as the primary point of contact for tribal issues.

### *g. AHCCCS Community Quality Forum*

The AHCCCS Community Quality Forum occurs once every four months and focuses on the evaluation of health system performance for physical and behavioral health care in alignment with the agency's integrated care model and drives system improvement through collaboration and consultation with community stakeholders. Participants include CMOs and Quality Management staff from all MCOs, tribal affiliates, consumers representing the community of members, and mental health advocacy organizations, such as National Alliance on Mental Illness (NAMI) and Mental Health America (MHA).

### *h. Liaison to Independent Oversight Committees (IOC)*

The Independent Oversight Committees (IOCs) were created by the Arizona Legislature to assist AHCCCS, DDD, and the RBHAs in promoting and protecting the rights of children and adults diagnosed with special health care conditions [i.e. members with intellectual and developmental disabilities (I/DD)] and/or who receive publicly funded behavioral health services. The committees provide independent oversight to ensure members' rights are protected.

The IOCs are composed of volunteers with an array of expertise, including providers, members, family members, tribal representatives, advocates, I/DD professionals and/or mental health professionals, and representatives from state agencies. The IOCs review, monitor, and evaluate the adequacy of relevant services as well as agency handling of significant incidents and quality of care concerns. These volunteers are supported by the Community Affairs Liaison within DHCM as required by the A.A.C.

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### 3.4 Process for Quality Strategy Review and Update

AHCCCS established the 2021 Quality Strategy Workgroup with the goal of updating its Quality Strategy to:

- Develop and draft the Quality Strategy Evaluation,
- Outline significant changes faced by the agency over the past three years,
- Outline future goals and objectives, and
- Incorporate the updated Medicaid and CHIP managed care regulations.

This workgroup consisted of a core team tasked with the oversight and management of the organization's efforts to update this document by providing a robust and comprehensive program description and evaluation that supports the quality focused managed care regulations, with necessary approvals and posting on the AHCCCS website, completed no later than July 1, 2021. AHCCCS executive management provided essential guidance and feedback related to the structure and contents of the document, serving as the 2021 Quality Strategy Workgroup authority. In addition, an extended team composed of AHCCCS personnel, identified as SMEs, was established to document and highlight key aspects for meeting the aforementioned goals.

Throughout the 2021 Quality Strategy Workgroup efforts, AHCCCS engaged and solicited feedback from external stakeholders and, when possible, incorporated the feedback offered into the development, review, and revision efforts used to create the finalized AHCCCS 2021 Quality Strategy. Examples of external stakeholder feedback opportunities built into the project management timeline included, but were not limited to, tribal consultation meetings, ALTCS advisory council, SMAC, and public comment period (30-day public comment period seeking public input, as posted online, with notification and distribution occurring through a list serve public notice system). In addition, AHCCCS involved the MCOs throughout the Quality Strategy development process via written communication and discussion at various meetings which included:

- **Quality Management/Maternal Child Health (QM/MCH) Contractor Meeting:** meetings conducted in collaboration with the AHCCCS QM and Quality Improvement staff that involve ongoing participation of the MCO quality-focused staff members.
- **Community Quality Forum:** meetings conducted every four months to evaluate health system performance for physical and behavioral healthcare, in alignment with the agency's integrated care model, and drive system improvement through collaboration and consultation with community stakeholders.
- **AHCCCS MCO Update Meeting:** meetings to interact with AHCCCS leadership; the agency hosts the AHCCCS MCO Update Meetings with contracted MCOs, state agencies, and RBHAs/TRBHAs. These meetings are typically held quarterly.
- **AHCCCS Medical Directors Meeting:** meetings conducted every month with the AHCCCS MCO CMOs; topics vary with each meeting and include updates by agency area leads to proposed topics from the medical directors.

### 3.5 Quality Strategy Evaluation

The Quality Strategy is reviewed, at a minimum, once every three years or as needed, based on significant program changes. Significant changes would include revisions to delivery system models, fundamental shifts in quality approaches, and/or changes that significantly impact the manner in which members receive care and services. The review process focuses on the previous three years or less.

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Within the quality review structure, the Quality Strategy Evaluation team members seek to determine if a substantial change was made toward meeting the identified target area(s). The results of the Quality Strategy Evaluation and the updated Quality Strategy are submitted to CMS for comment and feedback prior to adopting the changes. In addition, these documents are posted on the [AHCCCS Quality Strategy](#) web page and made available in accordance with 42 CFR 438.340 and 42 CFR 457.1240(e).

### 3.6 Quality Strategy Effectiveness

Data collection and analysis, in addition to other evaluation activities, are utilized to assess the value of the strategies described in this Quality Strategy. The analysis includes trends and comparisons with established goals and benchmarks. Examples of these data include results of performance measures and PIPs, as well as other data reported by MCOs, such as quality of care concerns.

The Quality Strategy is considered a companion document to the EQR reports. As mentioned above, the EQR reports encompass specific details of the assessment, results, and recommendations related to the goals and strategies found in this document. This information is used to assess the efficacy of current goals and strategies, and to provide a roadmap for potential changes and development of new goals/strategies. Quality Strategy effectiveness, progress, and updates are also reported in the AHCCCS 1115 Waiver Quarterly Report. AHCCCS' quarterly quality assurance/monitoring activities are described in this report, as well as summarized in the agency's annual report to CMS, as required by the state's 1115 Waiver.

## 4. MCO Program Requirements

The purpose of the contract between AHCCCS and the MCO is to delineate MCO requirements. The MCOs shall be responsible for the performance of all contract requirements as it implements and operates the ACC, DCS CHP, ALTCS EPD, ALTCS DD, and/or RBHA Programs pursuant to A.R.S. and 42 CFR 438 Managed Care.

### 4.1 State Verification that Sub-Part E Provisions of the Managed Care Regulations are Included in Medicaid Contract Provisions

In its contracts with MCOs, AHCCCS incorporates the CFR requirements regarding MCO establishment and implementation of ongoing comprehensive Quality Management/Performance Improvement (QM/PI) programs for services provided to members. The contracts between AHCCCS and its MCOs define the standards for access, structure, operations, quality measurement, and quality improvement. The AHCCCS Medical Policy Manual (AMPM), the ACOM, and other AHCCCS policies and manuals are incorporated by reference as part of the MCO contracts and provide more detailed standards, information, and requirements. MCO contract provisions require all MCOs to:

- Establish and implement an ongoing comprehensive QM/PI Program,
- Implement mechanisms to assess the quality and appropriateness of care furnished to members with SHCN, as defined by the state in the Quality Strategy,
- Conduct PIPs,
- Collect and submit performance measurement data,
- Implement mechanisms to detect both underutilization and overutilization of services,
- Collect data from providers in standardized formats (to the extent feasible and appropriate), including secure information exchanges/technologies utilized for state Medicaid quality improvement and care coordination efforts,

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- Track and trend member and provider issues, and
- Implement written policies regarding member rights and responsibilities.

In addition to the requirements outlined above, contract provisions for MCOs providing LTSS require the MCO to:

- Implement mechanisms to assess the quality and appropriateness of care provided to members utilizing LTSS, including the assessment of care between care settings as well as a comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable, and
- Participate in efforts by the state to prevent, detect, and remediate critical incidents.

### 4.2 Quality Management/Performance Improvement (Quality Assessment and Performance Improvement) Requirements

Within its MCO contracts, AHCCCS outlines QM/PI Program requirements. The MCO's QM/PI Program shall be designed to achieve and sustain, through ongoing measurements and intervention, significant improvement in the areas of clinical care and nonclinical care, which is expected to have a favorable effect on health outcomes and member satisfaction. These QM/PI requirements include, but are not limited to:

- Implementation, monitoring, evaluation, and compliance with applicable program requirements,
- Provision of quality care and services to eligible members, regardless of payor source and eligibility category,
- Contractor written policies and training in regards to preventing abuse, neglect, and exploitation, ensuring incident stabilization (member(s) immediate health and safety is secured, and immediate care and recovery needs are identified and provided), reporting incidents, and conducting investigations,
- Monitoring for provider compliance with policies, training, and signage requirements aimed at preventing and reporting abuse, neglect, and exploitation,
- Mechanisms to assess the quality and appropriateness of care furnished to members with SHCN,
- Demonstration of improvement in the quality of care and services provided to members through established QM/PI processes,
- Analysis of the effectiveness of implemented interventions, including targeted interventions, to address the unique needs of populations and subpopulations served,
- Participation in community initiatives, events, and/or activities, as well as implementation of specific interventions to address overarching community concerns, including applicable activities of the Medicare Quality Improvement Organization (QIO),
- Written policies regarding member rights and responsibilities,
- Protection of medical records, any other personal health, and enrollment information that identifies a particular member, or subset of members, in accordance with federal and state privacy requirements,
- Development and maintenance of mechanisms to solicit feedback and recommendations from key stakeholders, subcontractors, members, and family members to monitor service quality, and

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develop strategies to improve member outcomes and quality improvement activities related to quality of care and system performance,

- Tracking and trending of member and provider issues, which includes, but is not limited to, investigation and analysis of quality of care issues, abuse, neglect, exploitation, and unexpected deaths,
- QM/PI Program monitoring and evaluation activities, which include Peer Review and Quality Management Committees that are chaired by the MCO's local CMO, and
- Performance measurement and PIPs.

MCOs are required to develop a written QM/PI Program Plan that specifies the objectives of the MCOs' QM/PI Programs and addresses the MCOs' proposed approaches to meet or exceed the performance standards and requirements specified in the contract and AHCCCS policy. The QM/PI Program Plans (inclusive of program narrative, work plan, and work plan evaluation) are submitted annually and describe how program activities shall improve the quality of care, service delivery, and satisfaction for members.

### 4.3 Assessment of Quality and Appropriateness of Care/Services for Routine and Special Health Care Needs Members

The MCOs are required by contract to identify children and adults with special health care needs (SHCN). The qualifying criteria is defined in the contract as, "Members who have serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally." A member is considered as having SHCN if the medical condition simultaneously meets one or more of the following criteria:

- Actively engaged in a transplant process plus one-year post transplant,
- ALTCS DD,
- ALTCS EPD,
- Autism/at risk for Autism,
- Arizona Early Intervention Program (AzEIP),
- Mercy Care DCS CHP and up to one year after transition from Mercy Care DCS CHP,
- CRS,
- Early Childhood Service Intensity Instrument (ECSII)/Child and Adolescent Level of Care Utilization System score of 4 or higher,
- High needs and high costs HIV/AIDS,
- Severe Combined Immunodeficiency (SCID),
- SED/Neonatal Abstinence Syndrome (NAS), or
- An SMI designation.

#### *a. Identification*

Members with SHCN are identified through a review of utilization data to identify diagnoses, services, and medications specific to a member with SHCN, new member health risk assessments, concurrent review, prior authorization, and/or a review of Early and Periodic Screening Diagnosis and Treatment (EPSDT) tracking forms. The identification (not available for all categories of SHCN) that designates a

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member as having SHCN is entered into the Pre-paid Medical Management Information System (PMMIS) mainframe database.

### *b. Assessment*

MCOs are required to comprehensively assess each member identified as having SHCN, in order to identify any ongoing special conditions of the member that require a course of treatment, regular care management, or transition to another AHCCCS program [42 CFR 438.208(c)(2) and 42 CFR 438.240(b)(4)]. The assessment mechanisms must use appropriate health care professionals with the appropriate expertise [42 CFR 438.240(c)(2) and 42 CFR 438.208(c)(2)]. The MCO must share the results of its identification and assessment of that member's needs with other entities providing services to that member to avoid unnecessary duplication of effort [42 CFR 438.208(b)(4) and 42 CFR 438.208(c)(3)].

The MCO must ensure that members with special health care needs have an individualized clinical and behavioral treatment or service plan. Further, the MCO shall conduct multidisciplinary staffing for members with challenging behaviors or health care needs [42 CFR 438.208(c)(3)].

### *c. Access to Care*

Recognizing that Medicaid members with SHCN or chronic health conditions require care coordination, AHCCCS requires MCOs to provide appropriate coordination. The contracts between AHCCCS and its MCOs require and define standards for access to specialists (e.g., through a standing referral or an approved number of visits), and structure of programs and operations in order to serve the member's condition and identified needs in accordance with 42 CFR 438.208(c)(4). Additionally, the MCOs must have a methodology to identify providers willing to provide medical home services and make reasonable efforts to offer access to these members.

### *d. Monitoring*

AHCCCS monitors quality and appropriateness of care and services for members, including members with SHCN, through annual MCO ORs, review of required MCO deliverables set forth in contract, program specific performance measures, and PIPs. AHCCCS tracks and trends member grievances to identify potential access to care issues and/or the need for corrective actions and monitors the outcomes of required corrective actions.

## 4.4 Member Information Requirements

AHCCCS requires MCOs, as specified in the contract and in AHCCCS policy, to provide members with information including, but not limited to the following:

- Covered services,
- How to obtain services,
- How to choose a provider,
- A member's rights with respect to grievances and state fair hearings,
- Prior authorization processes and requirements,
- Advance directives,
- What constitutes an emergency,
- Language and cultural competency requirements, and
- Member financial responsibilities.

This information is required to be included in each MCO Member Handbook.

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The contracts between AHCCCS and its MCOs define the standards for access, structure, operations, and quality measurement and improvement. The AMPM and ACOM, as well as other AHCCCS Policies and Manuals, are incorporated by reference as part of the MCO contracts and provide more detailed standards information and requirements.

Requirements for enrollee information dissemination (42 CFR 438.10 and 42 CFR 457.110) as set forth for both AHCCCS and its MCOs are required to be adhered to; moreover, AHCCCS processes and protocols ensure that:

- The Application for Benefits complies with the information requirements for potential enrollees,
- The eligibility staff has access to the provider listing by MCO for their Geographic Service Area (GSA) and will share the MCOs' websites with the applicant,
- All enrollees and potential enrollees are informed of their enrollment rights as they pertain to their specific GSA and circumstances, and
- The beneficiary support system is available for all enrollees and potential enrollees to assist in making an informed decision when selecting their MCOs.

When enrollees and potential enrollees need help selecting a health plan, they may:

- Visit [www.azahcccs.gov/choice](http://www.azahcccs.gov/choice), or
- Speak to a Beneficiary Support Specialist by calling 602-417-7100 from area codes 480, 602, and 623 or 1-800-334-5283 from area codes 520 and 928.

AHCCCS also provides links to the AHCCCS MCO websites, member handbooks, provider searches, and drug formularies. This enables applicants to view the MCO networks from the AHCCCS website.

A variety of language assistance services, as well as auxiliary aids and related services, are available to individuals at no cost. Written materials for the AHCCCS program are available in both English and Spanish. In addition, bilingual staff are employed throughout AHCCCS to assist individuals who speak Spanish, to answer their questions and provide information. AHCCCS also utilizes a vendor to provide oral interpretation services for all languages. Additional communication accommodations, such as large print eligibility letters, are provided for applicants and members who have visual, auditory, and/or other impairments. All vital materials include taglines, printed in a conspicuously visible font size, in a variety of the most common non-English languages spoken in the state. Vital documents also provide information about the availability of written translation and oral interpretation services, how to request auxiliary aids and services, and how to obtain information in alternative formats.

With regard to MCOs, AHCCCS imposes stringent requirements regarding availability of language assistance services and auxiliary aids and services at no cost. Written materials that are critical to obtaining services are made available in each prevalent non-English language in the MCO's service area and oral interpretation services are available in all languages. Tagline documents and information describing availability of auxiliary aids and services are also mandatory requirements for MCOs.

### 4.5 Evidence-Based Clinical Practice Guidelines

AHCCCS requires MCOs, as specified in the contract, to develop, manage, and monitor provider use of the Evidence Based Programs and Practices (EBPP), including but not limited to the following:

- Intake, assessment, engagement, treatment planning, harm reduction efforts, data and outcome collection, and post discharge engagement,



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- EBPPs used by all providers for the treatment of SUD and MAT integrated into services as appropriate,
- Trauma informed care,
- Gender-based treatment,
- Lesbian, Gay, Bisexual, Transgender, and/or Queer/Questioning (LGBTQ),
- Culturally appropriate,
- Criminal involvement,
- Adolescent specific, and
- Development and use of promising practices, if no EBPP is available.

AHCCCS requires MCOs, as specified in AHCCCS AMPM Policy 1020, to develop or adopt and disseminate practice guidelines for physical and behavioral health services that are based on valid and reliable clinical evidence, consider the needs of the MCOs' members, and adopt in consultation with MCOs and National Practice Guidelines. MCOs must disseminate EBPP to all affected providers upon request to members/Health Care Decision Makers and potential members upon request. AHCCCS requires MCOs to annually evaluate the guidelines through the Medical Management Committee to determine if the guidelines remain applicable, represent the best practice standards, and reflect current medical standards [42 CFR 457.1233(c) and 42 CFR 438.236(b)(4)].

### 4.6 Sharing Best Practices

AHCCCS actively seeks to identify local, state, and national evidence-based best practices that promote and support member health outcomes. This includes MCO initiated programs and practices as identified by AHCCCS or self-reported by the MCO annually via the Contractor Best Practices & Follow Up on Previous Year's EQR Report Recommendations submission. Identified best practices are shared with the EQRO for inclusion within the Annual EQR Technical Reports.

The MCO representatives are invited to share best practices at the QM/MCH Contractor Meetings and the Community Quality Forum to facilitate discussion and system wide process improvement efforts within the practice area being addressed. In addition, AHCCCS routinely invites external SMEs to present information and best practices that pertain to key AHCCCS initiatives. Technical assistance is offered upon MCO request or upon AHCCCS direction based on MCO performance.

### 4.7 Sanction Philosophy and Notice to Cure

AHCCCS collaborates closely with its MCOs to ensure compliance with contractual and policy requirements and provides technical assistance whenever necessary to educate and train MCOs on specific requirements. AHCCCS does have the authority to issue administrative actions and sanctions to a MCO for failing to demonstrate compliance with contractual requirements. Each occurrence of non-compliance will be evaluated for possible administrative action. Administrative actions may include issuing of any of the following: Notice of Concern, mandate for Corrective Action Plan (CAP), Notice to Cure, and/or Sanctions.

With few exceptions, the AHCCCS Compliance Committee evaluates recommendations for proposed sanctions, considers relevant factors, and determines the appropriate sanction to be imposed. The Compliance Committee may also consider less severe administrative actions that do not include a sanction, such as a Notice of Concern, a Notice to Cure, or a requirement of a CAP as part of their review process. ACOM Policy 408, Sanctions, describes the types of sanctions and subsequent monetary penalties or other actions that may result if an MCO fails to adhere to the provisions of the Medicaid



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managed care program or contract requirements. The policy also identifies the committee membership and considerations for determination of appropriate sanctions.

AHCCCS may impose monetary sanctions, suspend any or all further member enrollment, and/or suspend, deny, refuse to renew, or terminate a contract in accordance with A.A.C., R9-22-606, and the terms of the contract and applicable federal or state regulations. Written notice is provided to the MCO specifying the sanction to be imposed, the grounds for the sanction, and either the length of suspension or the amount of capitation to be withheld. The MCO may appeal the decision to impose a sanction in accordance with 9 A.A.C. 34. Intermediate sanctions may be imposed for, but are not limited to, the following actions:

- Substantial failure to provide medically necessary services that the MCO is required to provide to its enrolled members under the terms of its AHCCCS Contract,
- Imposition of premiums or charges in excess of the amount allowed under the 1115 Waiver,
- Discrimination among members based on their health status or need for health care services,
- Misrepresentation or falsification of information furnished to CMS or AHCCCS,
- Misrepresentation or falsification of information furnished to an enrollee, potential enrollee, or provider,
- Failure to comply with the requirement for physician incentive plan as delineated in contract,
- Distribution directly, or indirectly, through any agent or independent contractor, of marketing materials that have not been approved by AHCCCS or that contain false or materially misleading information,
- Failure to meet quality of care and quality management requirements,
- Failure to meet AHCCCS encounter standards,
- Violation of other applicable state or federal laws or regulations,
- Failure to fund the accumulated deficit in a timely manner,
- Failure to increase the Performance Bond in a timely manner, and
- Failure to comply with any other contract provisions.

AHCCCS may impose the following types of intermediate sanctions:

- Civil monetary penalties,
- Appointment of temporary management of an MCO,
- Allow members the right to terminate enrollment without cause and notify affected members of their right to disenroll,
- Suspension of all new enrollment, including auto assignments,
- Suspension of payment for recipients enrolled after the effective date of the sanction until CMS or AHCCCS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur, and
- Additional sanctions to allow under statute or regulation that address areas of noncompliance.

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### 5. MCO Performance Monitoring

AHCCCS provides regulatory oversight and conducts performance monitoring of its MCOs through a variety of methods.

#### 5.1 Performance Measurement

AHCCCS establishes performance standards, goals, and benchmarks based on national standards, such as the NCQA National Medicaid Means, whenever possible. AHCCCS and MCOs regularly evaluate metrics and other performance monitoring tools in order to ensure that there are effective and meaningful performance measurement techniques in place for populations served.

#### 5.2 Performance Measures

AHCCCS utilizes performance measures to monitor MCO compliance in meeting contractual requirements related to the delivery of care and services to members. In developing the performance measure set, AHCCCS considers the goals of the “Triple Aim for Populations”. As referenced in Section 3 of this document, the AHCCCS Quality Strategy is based firmly in the Triple Aim concepts for quality and effective health care delivery.

AHCCCS performance measures are based on the CMS Core Measure Sets, NCQA Healthcare Effectiveness Data and Information Set (HEDIS)<sup>®</sup> measures, SAMHSA quality measures, and other resources. AHCCCS performance measures are integral to each MCO’s QM/PI Program and may focus on clinical and non-clinical areas. MCOs are required to report on performance measures as identified in the contract. MCOs that provide LTSS shall also include LTSS-specific performance measures that examine, at a minimum, members’ quality of life and the MCOs’ rebalancing and community integration outcomes. Performance measures specific to members selecting a self-directed option may also be developed. The measures will consider underlying performance, performance gaps, reliability and validity, feasibility, and alignment. Performance measures are also evaluated based on a number of demographics in order to reduce, to the extent practical, health disparities based on age, race, ethnicity, sex, primary language, and disability status. The measures will support and align with the MCOs’ QM/PI Programs [42 CFR 438.330(c)(1)(ii)].

The AHCCCS performance measures are used to evaluate whether MCOs are fulfilling key contractual obligations. Such performance measures, established or adopted by AHCCCS, are also an important element of the agency’s approach to transparency in health services and VBP. MCO performance is publicly reported on the AHCCCS website (e.g., report cards and rating systems), as well as other means, such as the sharing of data with state agencies and other community organizations and stakeholders. MCO performance is compared to AHCCCS requirements, with the national NCQA Medicaid Mean (for NCQA HEDIS<sup>®</sup> measures) and the CMS Medicaid Median (for CMS Core Set Only measures) for the associated measurement period serving as the performance target for each contractually required performance measure.

MCOs are expected to achieve the established performance standards for performance measures. Performance measure reports may compare the MCOs’ results with each other and with Medicaid national averages. The rationale for establishing these measures is for MCOs to develop methods to continuously increase the well-being of their respective populations through the removal of barriers to care and ongoing process improvement. AHCCCS participates in national efforts focused on developing Medicaid and CHIP Core Measures to allow comparability across state programs.

#### 5.3 Performance Improvement Projects (PIPs)

Each MCO is expected to conduct PIPs in clinical and/or non-clinical areas that are expected to have a favorable impact on health outcomes and member satisfaction. AHCCCS mandates that MCOs participate

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in PIPs selected by the agency. MCOs must also select and design additional PIPs specific to needs and data identified through internal surveillance of trends. PIPs are developed according to 42 CFR 438.330, Quality Assessment, and Performance Improvement Program. PIPs are designed to correct significant system problems and/or achieve significant improvement in health outcomes as well as enrollee satisfaction, that is sustained over time, through the:

- Measurement of performance using objective quality indicators,
- Implementation of interventions to achieve improvement in access to and quality of care,
- Evaluation of the effectiveness of the interventions based on the performance measures, and
- Planning and initiation of activities for increasing or sustaining improvement [42 CFR 438.330(d)(2)].

AHCCCS-mandated PIP topics are selected through the analysis of internal and external data/trends and may include MCO input. Topics take into account comprehensive aspects of member needs, care, and services for a broad spectrum of members or a focused subset of the population, including those members with special health care needs or receiving LTSS (42 CFR 438.330). AHCCCS may also mandate that a PIP be conducted by one MCO, or group of MCOs, according to standardized methodology developed by AHCCCS. In addition, MCOs are required to identify and implement additional PIPs based on self-identified opportunities for improvement, as supported by root cause analysis, external/internal data, surveillance of trends, or other information available to the MCO.

For each AHCCCS-mandated PIP, AHCCCS develops a methodology to measure performance, collect data, and conduct analysis in a standardized way across MCOs. Utilizing financial, population, disease-specific data, and input from the MCOs, AHCCCS selects an indicator or indicators of performance improvement to be measured across MCOs. AHCCCS-mandated PIPs (historical and current) are posted on the [AHCCCS Quality & Performance Improvement](#) web page with applicable populations for each PIP defined within the PIP Methodology. MCO specific PIP interventions and results are outlined within the Annual EQR Technical Reports located on the [AHCCCS Health Plan Report Card](#) web page.

In consultation with states and other stakeholders, CMS may specify standardized performance measures and topics for PIPs to include alongside state-specified performance measures and PIP topics within state contracts [42 CFR 438.330(a)(2)]. MCOs are required to conduct PIPs, including PIPs required by the CMS, that focus on both clinical and nonclinical areas.

### 5.4 Regular Monitoring and Evaluation of MCO Performance

AHCCCS monitors and evaluates MCO compliance through ORs, the review and analysis of periodic reports as required in contract, program specific performance measures, and PIPs. Objectives of MCO monitoring and evaluation include:

- Determine if the MCO satisfactorily meets AHCCCS requirements as specified in contract, AHCCCS policies, A.R.S., A.A.C., and 42 CFR 438 Managed Care,
- Increase knowledge of the MCOs' operational encounter processing procedures,
- Provide technical assistance and identify areas where improvements can be made and to identify areas of noteworthy performance and accomplishments,
- Review progress in implementing recommendations made during prior reviews,
- Determine if the MCO is in compliance with its own policies and to evaluate the effectiveness of those policies and procedures,

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- Perform MCO oversight required by CMS in accordance with the AHCCCS 1115 waiver, and
- Provide information to an EQRO for its use as described in 42 CFR 438.364.

### *a. On-Site Operational Reviews (ORs)*

AHCCCS conducts administrative ORs of each contracted MCO at least once every three years, utilizing the process to meet the requirements of the Medicaid managed care regulations (42 CFR 438.358), to determine the extent to which each health plan meets AHCCCS Contract requirements, AHCCCS policies, and additional federal and state requirements. AHCCCS establishes standards for operational, programmatic, and clinical standards. To evaluate the MCO's compliance with each standard, AHCCCS reviews the MCO's records, reports, and information systems, and interviews key health plan staff. Additionally, AHCCCS staff reviews the progress of implementing the recommendations made during prior ORs, determines each MCO's compliance with its own policies and procedures, and evaluates its effectiveness. Agency staff from the DHCM, the Office of Administrative and Legal Services (OALS), the Division of Business and Finance (DBF), the OIG, and the OIFA review the operations of the MCO, conduct file reviews, and interview key health plan staff.

To maintain compliance with regulatory requirements and AHCCCS contract standards, AHCCCS reviews the following areas (as applicable) at least every three years:

- Case Management,
- Corporate Compliance,
- Claims and Information Systems,
- Delivery Systems,
- General Administration,
- Grievance System,
- Adult, EPSDT, and Maternal Child Health,
- Medical Management,
- Member Information,
- Quality Management,
- Reinsurance, and
- Third Party Liability.

Upon completion of an OR, MCOs are required to submit CAPs in any areas receiving a score of less than 95 percent. AHCCCS expects the vast majority of these CAPs to be implemented and closed within six months of AHCCCS' acceptance of the CAP. MCOs are required to submit a CAP update along with documentation demonstrating compliance to close each CAP.

AHCCCS may choose to review specific areas more frequently depending on identified needs. For example, in 2015, AHCCCS conducted a mid-cycle review in areas identified as a heightened concern. AHCCCS also uses the OR to increase its knowledge of each MCO's operational procedures, provide technical assistance, identify areas for improvement, and identify areas of noteworthy performance and accomplishment.

As a condition of the 1115 Waiver, AHCCCS performs extensive data validation. Known as encounter data, records of services provided are submitted to AHCCCS for all covered services including

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institutional, professional, dental, and medication/pharmacy services, with each having its own format. AHCCCS also performs annual validation studies on MCO data to ensure that the data has been reported in a timely manner and is accurate and complete, since sanctions may be imposed on the MCO based on the results of the data validation studies. AHCCCS provides technical assistance and training to the MCOs to support the MCO's ability to meet AHCCCS requirements. OR and data validation results are reported to CMS in accordance with the 1115 Waiver's terms and conditions.

### *b. Grievance and Appeals*

One of many critical objectives of the agency's grievance and appeals system is to advance and improve the quality, accessibility, and timeliness of health care services for AHCCCS members. AHCCCS has developed robust contractual requirements, which have been refined over time. Contracts dictate member-focused standards designed to support the timely provision by MCOs of medically necessary health care services, focusing on improvements in members' health and well-being. In addition to detailed contractual requirements that promote these objectives, AHCCCS also promulgated specific administrative regulations and clarified policies to which MCOs must adhere.

The OALS is responsible for oversight of the Title XIX/TXXI Grievance and Appeals system and the Grievance and Appeals system for members with an SMI designation. The OALS continually engages in the review of hearing cases resulting from appeals of adverse benefit determinations from managed care beneficiaries. Not only does AHCCCS monitor the number of beneficiary hearing requests filed against each MCO on a monthly basis, AHCCCS also reviews the categories of adverse benefit determinations to identify trends, outliers, and whether additional scrutiny of the MCOs service authorization process may be warranted. As mandated by 42 CFR 438.402, MCOs are permitted only one level of appeal.

Routinely, the agency's medical management department receives a listing of beneficiary requests for hearing from the OALS to review the adequacy of service authorization notices sent to beneficiaries pursuant to 42 CFR 438.404. Equally as important, each substantive hearing case resulting from the appeal of an adverse benefit determination is individually reviewed to evaluate MCO compliance from both a procedural standpoint and a clinical perspective. This scrutiny includes consideration of the MCOs' handling of grievances and appeals pursuant to 42 CFR 438.406 to ensure beneficiary access, meaningful participation, and effective MCO review. When deficiencies or concerns are identified, including those that pertain to quality of service, accessibility of service, and timeliness of service, or the adequacy or timeliness of the MCO notifications pursuant to 42 CFR 438.404 and 42 CFR 438.408, they are identified in the hearing decision or presented for follow-up through other mechanisms to achieve compliance.

Deficiencies and areas of concern are communicated to the appropriate divisions within the agency to be addressed. As a result, compliance actions may be instituted against MCOs, and corresponding policies and guidance may be developed or clarified. All hearing matters that present quality of care concerns regarding service delivery, accessibility, or timeliness are referred to the agency's quality management department for thorough investigation. In addition, findings from the OALS' reviews of MCO hearing cases and member concerns directed to the OALS are communicated within quarterly meetings to executive and management staff across the agency. These quarterly meetings are convened to evaluate MCO performance in a variety of operational areas. As part of the agency's continuing scrutiny of MCO quality, timeliness, and accessibility of health care delivery to members, staff from the OALS participate in ongoing ORs of each MCO's grievance and appeals system which evaluates, in part, MCO compliance with member Grievance and Appeals requirements.

A meaningful recordkeeping system is vital and fundamental to an effective grievance and appeals system. Thus, consistent with 42 CFR 438.416, each MCO must comply with detailed recordkeeping

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requirements for all grievances and appeals in order to inform its ongoing monitoring processes and the continual refinement of its quality strategies. Through its ORs and oversight activities, AHCCCS assesses each MCO's recordkeeping system to determine its efficacy.

### *c. Ongoing Review and Analysis of Deliverables*

To monitor compliance with rules, regulations, contracts, and policies on an ongoing basis, MCOs are required to submit a number of contract deliverables. Contract deliverables are due weekly, monthly, quarterly, annually, and on an ad hoc basis depending on the individual deliverable requirement. A chart of contract deliverables is included in the MCO contract; these deliverables may vary depending on the line of business.

### *d. Program Plans*

AHCCCS requires MCOs to submit annual Program Plan reports, which delineate implementation of the comprehensive approach utilized for ensuring high-quality and cost-effective services are provided for all Medicaid members within Arizona, including those with special health care and behavioral health needs. A distinct set of annual Program Plan reports summarize general QM/PI, maternity and family planning, and medical management strategies, as well as population specific requirements for EPSDT services (including dental services) mandated under CMS.

Each MCO is required to submit separate program plan reports for EPSDT, dental, maternity and family planning, medical management, and QM/PI. Each program plan must include a narrative, a prospective work plan, and a work plan evaluation. The narrative must identify operational and structural elements that shall ensure achievement of contractually required clinical, quality, and performance elements for all members under the care of an MCO. Prospective work plans focus on goals and methods for achieving performance and quality standards for the upcoming calendar year. Work plan evaluations offer an analysis of the previous year's activities related to quality and performance goals and strategies.

### *e. Quarterly Reports*

MCOs are required to submit Performance Measure Monitoring Reports to the AHCCCS Quality Improvement Team. These quarterly deliverables provide self-reported MCO data for contractually required performance measures. Each MCO utilizes its prospective Work Plan to identify performance goals/objectives and related interventions. Within the Performance Measure Monitoring reports, the MCOs include: an analysis of the results, an indication whether performance goals were met or not met, identified barriers, and identified opportunities for improvement.

In an effort to align MCO reporting across lines of business, the Performance Measure Monitoring Report template, attachment, and associated instructions provide essential guidance to effectively compare performance. In addition, a consolidated reporting format was created to efficiently facilitate AHCCCS Quality Improvement team review of Performance Measure Monitoring report submissions; format changes also expedited feedback provided to the MCOs.

### *f. Meetings and Staffings*

AHCCCS routinely conducts quality driven meetings that facilitate staff education and/or the wide-spread dissemination of quality-related information specific to MCO performance. These meetings include, but are not limited to, the following:

- **Clinical Oversight Committee:** quarterly meetings facilitated and managed by the clinical unit, which include the AHCCCS Director, executive management, and representatives across divisions, conducted to review MCO clinical and quality performance and discuss and review clinical initiatives.



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- **Operations Oversight Committee:** quarterly meetings facilitated and managed by the operations unit, which include the AHCCCS Director, executive management, and representatives across divisions, conducted to review MCO operational and financial performance.
- **Quarterly Quality Management MCO Meeting:** quarterly meetings facilitated by the clinical unit, which include representatives from MCO quality, MCH/EPSTD, behavioral health teams, and agency staff, to review quality objectives, policies and procedures, and provide resources and guest speakers who support overall quality efforts.
- **Quarterly Operations MCO Meetings:** quarterly meetings facilitated by the operations unit, for which over the course of a year, two of the annual meetings include only the DHCM representation and the other two meetings include attendance by the AHCCCS Director, executive management, and cross divisional representation. The MCOs provide overall updates on their operations, including clinical updates and updates on strategic initiatives.

### 5.5 Improvement/Interventions

To promote improvement at the MCO level, AHCCCS requires MCOs to participate in technical assistance or training sessions when opportunities for improvement are identified. MCOs are also encouraged to request technical assistance when questions arise. Additionally, AHCCCS conducts quality improvement and quality management related trainings at the quarterly Quality Management/Maternal Child Health meetings. AHCCCS has also established the following MCO requirements:

#### *a. Review and Analysis of Program Specific Performance Measures and Performance Improvement Projects*

AHCCCS reviews MCO performance measure results on a regular basis. Results are compared with established performance standards specified in contract and trends are identified. Results of measurements for PIPs are also reviewed and analyzed by MCO. Appropriate action is conducted depending on findings, such as requiring MCOs to implement CAPs and/or AHCCCS providing technical assistance to MCOs. Results are also analyzed by line of business and at the AHCCCS aggregate level, when possible, to identify systemic opportunities for improvement.

#### *b. Accreditation*

MCOs are required to inform AHCCCS as to whether they have been accredited by a private, independent accrediting entity and provide a copy of their most recent accreditation review, in accordance with managed care regulation requirements. Should the MCO renew or lose its accreditation, the MCO shall provide AHCCCS written notification (in the case of losing its accreditation) or a copy of the renewal certificate, as applicable, within 15 calendar days of notification or receipt from the accrediting entity. This information is available on the [AHCCCS Health Plan Report Card](#) web page.

AHCCCS added a contractual requirement that MCOs achieve NCQA First Accreditation, inclusive of the NCQA Medicaid Module, specific to their Medicaid line of business by October 1, 2023. MCOs with an ALTCS (EPD or DD) line of business shall also obtain the NCQA LTSS distinction prior to the date specified. While it is anticipated that accreditation activities should be initiated during CYE 2021 in accordance with AHCCCS direction, AHCCCS may delay the implementation of pre-accreditation activities and the NCQA accreditation requirement based on funding availability.

#### *c. Quality Rating System*

In accordance with the November 2020 updates to 42 CFR 438.334, AHCCCS intends to implement a Quality Rating System. Currently, AHCCCS utilizes its [AHCCCS Health Plan Report Card](#) to provide a comparison of MCOs by line of business related to the quality of care members enrolled in each MCO



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receive, how satisfied members are with their MCO, and how well the member's MCO met their expectations.

The AHCCCS Health Plan Report Card was enhanced during CYE 2018 based on internal and external stakeholder feedback. The AHCCCS Health Plan Report Card provides easy access to specific MCO related quality documents. AHCCCS looks forward to engaging with CMS in its development of mandatory measures and methodology to be included within the Medicaid Quality Rating Systems (QRS) as it looks to elect whether to utilize the CMS or a state alternative QRS framework.

### 6. Network Adequacy

In order to ensure MCO network adequacy, AHCCCS has developed a number of network adequacy and availability of services standards to address the requirements of 42 CFR 438.68 and 42 CFR 438.206, as outlined below:

#### 6.1 Provider Network Development and Management Plan (Network Plan)

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

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

- A formal attestation of the MCO's network adequacy,
- An evaluation of the previous contract year's network plan,
- How services are provided promptly and reasonably accessible in terms of location and hours of operation,
- How the MCO ties network implications from its Cultural Competency Plans to ensure cultural and linguistic needs are met,
- A summary and review of the MCO's VBP initiatives and COE programs, and
- The MCO's process for identifying and publicizing providers that offer reasonable accommodations for members such as physical access, accessible equipment, and culturally competent communications.

#### 6.2 Minimum Network Requirements Verification

Each quarter, the MCOs submit a completed Minimum Network Requirement Verification Report (Verification Report). The requirements for this report are outlined in ACOM Policy 436. In the Verification Report, MCOs describe their compliance with minimum network requirements, including time and distance requirements. These requirements identify 13 provider types for which AHCCCS has developed minimum time and distance standards to ensure geographic access to services. The Verification Report includes standards specific to all MCOs, as well as some standards specific to RBHA and ALTCS EPD MCOs. Moreover, some standards are measured against specific member populations

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and the standards vary by county. These standards, as well as other minimum network requirements that define network access, are identified in [ACOM Policy 436](#).

AHCCCS validates the Verification Report submissions by conducting an independent time and distance analysis of the MCOs' compliance. This analysis is completed through a contract with AHCCCS' EQRO. Each quarter, AHCCCS provides its EQRO with each MCO's Verification Report submission, the MCO's Provider Affiliation Transmission (PAT) file, the MCO's enrolled membership, and a file of all AHCCCS-registered providers. For each MCO, AHCCCS' EQRO produces a report comparing the Verification Report submissions with its validation.

### 6.3 Appointment Availability Monitoring and Reporting

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

### 6.4 Material Changes to the Provider Network

AHCCCS has established reporting requirements for when a significant change is made to an MCO's provider network in order to evaluate the impact of the change. As outlined in ACOM Policy 439, AHCCCS requires MCOs to evaluate changes made to their provider networks for materiality. A material change to provider network is defined as any change in the composition of, or payments to, the MCO's provider network that would cause or is likely to cause more than five percent of its members in a GSA to change where they receive services, or any change impacting fewer than five percent of members but involves a provider or provider group who is the sole source of a service, or operates in an area with limited alternate sources.

When the MCO identifies a material change to the provider network, the MCO submits an assessment of the impact of the change, how it will transition members, a communication plan regarding the change, and how the MCO will monitor the impact of the change after transition. After approval of a material change in provider network, AHCCCS commonly requires periodic reports on the status of transitioning members.

### 6.5 Provider Changes Due to Rates Reporting

The MCOs must identify when a provider leaves or reduces services due to rates, regardless of whether the change has a material impact on the provider network. Specifically, ACOM Policy 415 includes an attachment where plans report the name, type, whether the provider is a PCP, the region served, and number of members assigned to any provider leaving the network or reducing or diminishing their scope of services due to sufficiency of rates. The MCO must also conduct an analysis to determine if the loss is a material change and requires more in-depth reporting under ACOM Policy 439.

## 7. Value-Based Purchasing

AHCCCS is pursuing the implementation of long-term strategies that bend the cost curve while improving member health outcomes. A critical tool in achieving this strategic priority is VBP. The overall mission is

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to leverage the AHCCCS managed care model toward value-based health care systems where members' experience and population health are improved through:

- Aligned incentives with MCOs and provider partners, and
- A commitment to continuous quality improvement and learning.

VBP encompasses a variety of initiatives for payment reform, including APMs, Differential Adjusted Payments (DAP), E-Prescribing, and Directed Payments. The graphic display below outlines the long-term strategy AHCCCS employs to move along the continuum of APMs.

## Learning Action Network - Alternative Payment Model Framework Strategies

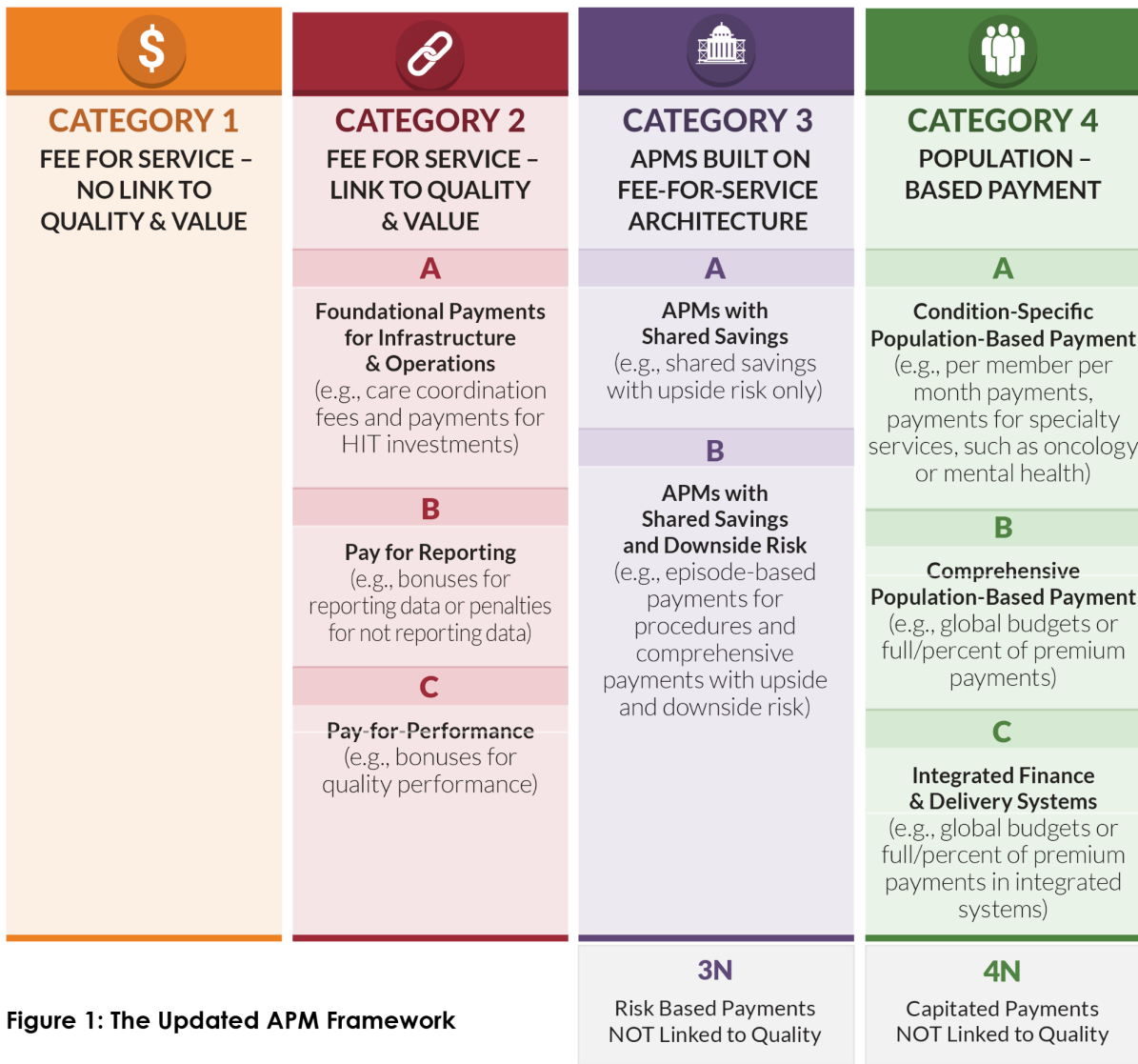


Figure 1: The Updated APM Framework

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Through VBP, AHCCCS is committing resources to leverage the State's successful managed care model to address inadequacies of the current health care delivery system such as fragmentation and paying for volume instead of quality.

AHCCCS has identified the following guiding principles for its VBP strategy:

- Engagement with stakeholders,
- Movement along the LAN-APM continuum,
- Balance prescriptive requirement while preserving MCO flexibility, and
- Data-driven decision making.

Through VBP, AHCCCS hopes to work toward achieving the following goals:

- Pay for value,
- Align payer and provider incentives,
- Innovate through competition,
- Improve quality, and
- Demonstrate results.

### 7.1 Alternative Payment Models

#### *a. LAN-APM Target Requirements*

AHCCCS is a committed partner in the [Health Care Payment \(HCP\) Learning and Action Network \(LAN\)](#) which strives to accelerate the health care system's adoption of effective APMs. Using LAN-APM Target Requirements, AHCCCS encourages contracted MCO activity in the area of quality improvement, specifically the development of initiatives conducive to improved health outcomes and cost savings.

AHCCCS has established contractually required targets for health plans to contract with providers at a selected percentage of overall medical spend under VBP/APM arrangements. Furthermore, AHCCCS has specified the sub-requirement for the proportion of those VBP/APM arrangements that must be under HCP LAN-APM Framework Categories 3 and 4. There is a LAN-APM Target Requirement and sub-requirement specific to each AHCCCS line of business. For example, the acceptable APM for MCOs includes pay for performance, shared savings, bundled payment, and capitation.

#### *b. Performance Based Payments*

AHCCCS employs its APM-Performance Based Payments (PBP) Initiative to encourage MCOs to develop initiatives designed to improve health outcomes and achieve cost savings by incentivizing providers to participate in APMs. PBPs are payments to providers for meeting certain performance measures targets that support LAN-APM initiatives. PBPs work to align incentives between MCOs and providers to increase the quality and efficiency of care by rewarding providers for improving performance across various quality measures to achieve cost savings and improve outcomes. MCOs are also able to pay out PBP based on Medical Loss Ratio (MLR) targets if linked to quality.

#### *c. Withhold and Quality Measure Performance Incentive*

The APM-Withhold and Quality Measure Performance (QMP) Incentive strives to encourage MCO activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, by aligning the incentives of the MCO and providers through APM strategies. AHCCCS implements this initiative under 42 CFR 438.6(b)(2) and 42 CFR 438.6(b)(3).

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AHCCCS withholds one percent of each MCO's prospective gross capitation. MCOs are then evaluated on AHCCCS-selected NCQA-HEDIS® performance measures where the MCOs are able to earn back their withhold amounts, as well as an additional incentive payment.

MCOs are evaluated on the following two items:

- Relative performance on NCQA HEDIS® performance measures to other MCOs, and
- Performance on NCQA HEDIS® performance measures compared to the NCQA Medicaid mean.

AHCCCS may consider in future years including a health equity component to the Withhold and QMP Incentive.

### 7.2 Differential Adjusted Payments (DAP)

Through DAP, AHCCCS is able to provide a uniform percentage increase to registered providers who provide a particular service under the contract and who meet specific criteria established by AHCCCS. The uniform percentage adjustment represents a positive increase to the AHCCCS FFS rates and MCOs' contracted rates. DAP aims to distinguish providers that have committed to supporting designated actions that improve members' care experience, improve members' health, and reduce cost of care growth.

AHCCCS began DAP in CYE 2017 and over the last four years has grown the program to support a variety of providers across the Arizona health care delivery system, including:

- Hospitals subject to All Patients Refined Diagnosis Related Groups (APR-DRG) reimbursement, excluding critical access hospitals,
- Critical access hospitals,
- Other hospitals and inpatient facilities,
- IHS/638 tribally owned and/or operated facilities,
- Nursing facilities,
- Integrated clinics,
- Behavioral health outpatient clinics,
- Physicians,
- Physician Assistants,
- Registered Nurse Practitioners,
- Dental providers, and
- HCBS providers.

Each DAP is time-limited for one year only, although a similar DAP may be implemented in the subsequent year. Providers must re-qualify for a DAP each year even when the DAP criteria remain the same. Examples of DAP criteria include: increasing the percent of electronic prescriptions prescribed to AHCCCS members, increasing the number of 6-week postpartum visits for obstetricians or gynecologists, and meeting or falling below the statewide average for the urinary tract infection (UTI) performance measure for nursing facilities. AHCCCS MCOs are required to pass DAP increases through to their contracted providers, maintaining rates to match the corresponding AHCCCS FFS rate increase percentages.

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### 7.3 E-Prescribing

E-Prescribing is a recognized and proven effective tool to improve members' health outcomes and reduce costs. Benefits afforded by the electronic transmission of prescription-related information include, but are not limited to, reduced medication errors, reductions of drug and allergy interactions, and therapeutic duplication, patient adherence, and increased prescription accuracy. AHCCCS MCOs are required to increase their E-Prescribing rate of original prescriptions. The goal percentage is specific to each AHCCCS line of business.

### 7.4 Directed Payment CMS Quality Criteria and Framework

42 CFR 438.6(c)(1)(iii)(B) provides AHCCCS with the flexibility to implement delivery system and provider payment initiatives under its MCO contracts. AHCCCS uses this federal authority to implement several directed payment initiatives for AHCCCS managed care programs.

Directed payments occur when AHCCCS directs its MCOs to pay specific amounts to providers under their managed care contracts. The directed payments work to advance delivery system reforms and/or performance improvement initiatives.

AHCCCS' directed payments focus on advancing the goals and objectives of AHCCCS' Quality Strategy to improve performance and provide high-quality services to AHCCCS members. AHCCCS is required to identify quality criteria and framework for each payment arrangement. AHCCCS uses goals and objectives outlined in AHCCCS' Quality Strategy to determine how each directed payment will be evaluated. When selecting performance measures for AHCCCS' directed payments, AHCCCS maintains its efforts to support the agency's Quality Strategy. AHCCCS works across divisions, as well as with external stakeholders through workgroups, when selecting performance measures to ensure that facilities required to report the data are able to do so.

Annually, AHCCCS is responsible for preparing CMS preprints for each of its directed payments for the following payment arrangements:

- Differential Adjusted Payments (DAP),
- Targeted Investments (TI),<sup>11</sup>
- Access to Professional Services Initiative (APSI),
- Pediatric Services Initiative (PSI),
- Hospitals Enhanced Access Leading to Health Improvements Initiative (HEALTHII), and
- Nursing Facilities Supplemental Payments (NF).

### 7.5 Targeted Investments Program

Integrating physical and behavioral health services is essential to reducing delivery system fragmentation. The TI Program provides financial incentives to eligible AHCCCS providers to develop systems for integrated care. In accordance with 42 CFR 438.6(c) and the 1115 Waiver, MCOs are required to provide financial incentives to eligible Medicaid providers who meet certain benchmarks for integrating and coordinating physical and behavioral health care for Medicaid beneficiaries. The TI Program aims to:

- Reduce fragmentation that occurs between acute care and behavioral health care,
- Increase efficiencies in service delivery for members with behavioral health needs, and

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<sup>11</sup> The TI preprint was approved as a multi-year preprint for the duration of the TI program.

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- Improve health outcomes for the affected populations.

The provider types that are eligible to participate in the TI Program include:

- Outpatient behavioral health clinics,
- Integrated clinics,
- Primary care practices, including: pediatricians, internal medicine practices, family practices, and nurse practitioners, and
- Hospitals.

Financial incentives are paid on an annual basis to participating provider practices, organizations, and hospitals based on requirements that vary over the five-year span of the TI Program.

At the end of Year One of the TI Program (October 1, 2016 through September 30, 2017), participating TI providers were eligible to receive payment following acceptance into the program. For Years Two and Three, directed incentive payments were tied to completing core components and related milestones. For Years Four and Five, payments are based on meeting or exceeding performance improvement targets for specified quality measures. The core components include the systems and process requirements that are intended to help further integration of primary care and behavioral health, requirements that TI participants must complete to receive incentive payments. TI participants are organized into adult primary care practice, adult behavioral health, pediatric primary care practice, pediatric behavioral health, justice, and hospital areas of concentration.

The core components and milestones focus on identifying high-risk AHCCCS members, including those with behavioral health needs, and connecting them to appropriate resources and services through enhanced care management and data sharing with both primary care and behavioral health providers. For example, core components common to several areas of concentration include establishing and using a high-risk registry, using care managers for individuals listed on the high-risk registry, using integrated care plans, and using protocols for two-way transmission of Admissions, Discharges and Transfer (ADT) information through the statewide Health Information Exchange (HIE). Additional core components focus on behavioral health and social determinants of health (SDOH) screening and follow up. It is believed these actions are improving care coordination and care outcomes. In the fourth and fifth program years, TI participants' performance is based on their performance on clinical outcome measures that are aligned with AHCCCS' Quality Strategy.

The measures of the systems of care established in the earlier years of the project were designed to improve care coordination and integration. The measures that were selected are intended to reflect Program participants' progress toward providing more coordinated and integrated care. The measures were selected from sources such as NCQA HEDIS® and the CMS Core Set measures and align with the AHCCCS quality measures.

### **8. Enabling Infrastructure: Data and Technology Systems**

AHCCCS performs extensive data validation of managed care data. Records of services provided (encounter data) are submitted to the agency for all covered services, including institutional, professional, dental, and medication/pharmacy services. These encounter data are submitted in standard Health Insurance Portability and Accountability Act of 1996 (HIPAA) and National Council for Prescription Drug Programs (NCPDP) formats and are subject to extensive data standards as well as extensive data quality editing. AHCCCS also performs annual validation studies on MCO encounter data to ensure that the data has been reported in a timely manner, is accurate, and is complete.



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### 8.1 Pre-paid Medical Management Information System

AHCCCS operates the Pre-paid Medical Management Information System (PMMIS), a mainframe database processing system made up of multiple subsystems, each with distinct functions supporting managed care as well as FFS processes. In 2020, AHCCCS began a modernization effort for its aging mainframe system by adding a vendor-hosted provider management system to integrate with the mainframe. This new “modular” approach, first proposed by CMS in 2016 as a way of improving systems, is the future of the AHCCCS PMMIS, where individual subsystems will be replaced by external modules until eventually the mainframe can be fully retired.

AHCCCS collects encounter data from all MCOs. An encounter is a record of a covered Medicaid service rendered by a registered AHCCCS provider to an AHCCCS member who is enrolled with a MCO on the date of service. MCOs are required to submit encounters for services provided to AHCCCS members for paid services, services eligible for processing with no financial liability (e.g., Medicare and third-party payer), prior period coverage (PPC), and administrative denials. Complete, accurate, and timely reporting of encounter data is critical for the program’s success. AHCCCS encounter formats follow national industry standards and code sets for encounter submissions and editing (837P/I/D and NCPDP PAH). All submitted encounters are subject to AHCCCS-specific requirements, as well as approximately 500 edits/audits, including federal coding standards (e.g., correct coding and medically unlikely edits). Data validation occurs in both a structured/formal process and on an ad hoc basis, as well as includes review by certified coders to ensure that encounter data is complete, accurate, and timely. Actuaries perform ad hoc analysis at least as often as each rate-setting period. In addition, Operational/Actuarial reports measure MCO encounter throughput by date of service and date of submission.

AHCCCS processes FFS claims submitted by providers; the claims are edited and priced within the claims system.

Data that is securely transferred to the CMS Transformed Medicaid Statistical Information System (T-MSIS) on a monthly basis. AHCCCS continues to work with CMS to ensure accuracy and validity of the state-reported data.

### 8.2 Data Warehouse

The AHCCCS Data Warehouse provides a timely and flexible way to monitor and analyze performance measure data. Utilization data may be reviewed by multiple characteristics, such as diagnosis, service, age, gender, or another characteristic type. The Data Warehouse is maintained on a regular basis by an in-house team of programmers and configuration specialists. The Information Services Division (ISD) fields requests for system changes, additions, and maintenance, and completes additions or changes according to policy, legislative, CMS, or other requirements.

### 8.3 Health Information Exchange (HIE)

Since 2006, AHCCCS providers and MCOs have supported a single statewide HIE called Health Current. Health Current has become an integral part of AHCCCS’ Quality Strategy and has grown to include 900 participating organizations representing laboratories, physical health and behavioral health providers, state agencies, and other payers, such as Accountable Care Organizations and for-profit health plans. These organizations represent thousands of healthcare practitioners and delivery sites across Arizona. For a complete list of participants, visit Health Current’s website at [www.healthcurrent.org](http://www.healthcurrent.org).

MCOs are using the clinical data that is available at Health Current to support their health care coordination and care management operations. MCOs have sent panels of their members to the HIE to receive a variety of alerts (including COVID-19 test results, hospital ADT, other inpatient, or discharge

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clinical event alerts), as determined by the MCOs. Health Current operates a Patient Centered Data Home (PCDH) alert when a member has been:

- Admitted to or discharged from an inpatient facility, or
- Registered at or discharged from an emergency department outside of Arizona.

A PCDH alert uses zip code mapping to send the alert from an out-of-state HIE to the MCO through Health Current. Having real time clinical information through these services is helping MCO with care continuity and management.

Health Current is working to improve provider workflow by offering more seamless ways for participants to integrate with the HIE via a direct EHR integration and a portal to improve access to registries, such as the Prescription Drug Monitoring Program (PDMP), the Arizona Immunization Registry, and the AZ-PIERS Registry for Emergency Medical Services (EMS) organizations. Strategic planning is underway with public health to expand the number of registries that are connected to the HIE to ease the reporting burden and to increase data sharing across the health care community. Health Current was awarded an Office of National Coordinator for Health Information Technology (ONC) grant in 2020 to enhance public health surveillance capability and plans to work with the ADHS to apply for other stimulus grants in 2021 and beyond.

Health Current supports multiple AHCCCS programs, including the DAP program, the Promoting Interoperability Program (formerly the EHRs' Incentive Program), the TI Program, and the agency's new WPCI. Working strategically with AHCCCS, the HIE sets exchange standards and data sets for its participants that can be used to improve the quality of the data that is available at Health Current for AHCCCS providers and MCOs.

Health Current announced a plan in September 2020 to merge with Colorado's HIE, CORHIO, to form a new regional organization which has the potential to create the largest health data utility in the western United States. AHCCCS anticipates being able to leverage the expertise in the newly formed organization to focus on electronic Clinical Quality Measures and greater support for electronic Performance Measure Management.

### 8.4 Telehealth

Telehealth is the use of digital technology, such as computers, telephones, smartphones, and tablets, to access health care services remotely. AHCCCS members who cannot travel to an office can use these devices from their homes to attend health care appointments with their providers. Telehealth can make access to health care more convenient, saving time and transportation costs. It allows people in rural communities, people with limited mobility, people in high-risk populations, and people with limited time or transportation to have options to access their PCPs and medical specialists, thereby eliminating barriers to care. It also helps to improve communication and coordination of care among members of the health care team and their patients.

AHCCCS covers all major forms of telehealth services, including telemedicine (real-time), asynchronous (store and forward), remote patient monitoring, and teledentistry. Telemedicine involves interactive audio and video in a real-time, synchronous conversation. It allows health care delivery, diagnosis, consultation, treatment, and transfer of medical data through interactive audio and video communications that occur in the physical presence of the patient. Asynchronous occurs when services are not delivered in real-time, but are uploaded by providers and retrieved, often through a secure online portal. Telephonic services (audio-only) use a traditional telephone to conduct health care appointments. AHCCCS also covers telehealth for remote patient monitoring and teledentistry.

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AHCCCS telehealth coverage and provider coding requirements, as well as additional telehealth resources, can be found on the AHCCCS [Telehealth Services](#) web page.

### 9. Conclusion

Improving and/or maintaining every member's health status, as well as increasing the potential for the resilience and functional health status of members with chronic conditions, is at the core of the Quality Strategy. AHCCCS uses a variety of modalities to drive quality through the system to achieve improvements and successes. AHCCCS' culture of quality is sustained by the combination of oversight and collaboration. Although AHCCCS has experienced significant quality improvements and successes, the agency and its MCOs continuously strive for:

- Improved performance by MCOs as a result of incentives, such as comparative reporting and financial incentives,
- Members who are better informed and who understand the value of preventive care,
- The ability for members with chronic diseases to maintain or improve their health,
- A physician community that is increasingly vested in the prevention of disease,
- Systematic research and sharing of best practices and lessons learned both locally and nationally,
- A significant reduction in the costs associated with treating disease and adverse health outcomes,
- Broader participation in collaborative community efforts to improve the health status of Arizonans,
- Identification of COE, and
- Provision of technical assistance programs with SMEs.

Built on a system of competition and choice, AHCCCS is a leader among the nation's Medicaid programs, operating a high-quality, cost-effective program with an average per enrollee, per year expense of only \$7,008 compared with the national average of \$8,057 in CYE 2019. Keeping a member-centered focus, AHCCCS will continue to work with partners and collaborate to advance innovative ideas that drive continuous improvement.

# AHCCCS Quality Strategy

## 10. Appendix

### 10.1 Links to Related Documents

#### *AHCCCS Contracts and Manuals*

[AHCCCS Contractor Operations Manual \(ACOM\)](#)

[AHCCCS Contracts](#)

[AHCCCS Medical Policy Manual \(AMPM\)](#)

#### *AHCCCS Reports*

[AHCCCS 1115 Waiver 2016-2021](#)

[AHCCCS Five Year Strategic Plan: 2018-2023](#)

[AHCCCS Quality & Performance Improvement – Performance Measures and Performance Improvement Projects](#)

[Annual Reports to CMS](#)

[External Quality Review Organization Reports](#)

[Quarterly Reports to CMS](#)

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