Arizona Health Care Cost Containment System

Contract Year Ending 2022 External Quality Review Annual Technical Report

for

Regional Behavioral Health Authorities (RBHAs)

April 2023

HSAG HEALTH SERVICES ADVISORY GROUP

Contents

1. Executive Summary

Background

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

- Identify areas for quality improvement
- Ensure alignment among the Contractors' quality assessment and performance improvement (QAPI) requirements, the State's Quality Strategy, and the annual EQR activities
- Provide high-value care
- Enhance performance of its healthcare delivery system for Medicaid and CHIP members
- Improve AHCCCS' ability to oversee and manage the contracted MCOs (also referred to as Contractors in this report)
- Help Contactors improve their performance with respect to Quality, Timeliness, and Accessibility of care

This report addresses the AHCCCS Regional Behavioral Health Authority (RBHA) Program.

[1-1] Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: July 27, 2022.

[1-2] Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care. Available at: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care. Accessed on: July 27, 2022.

Contractors Reviewed

RBHA Program

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

Table 1-1—RBHA Program Contracted MCOs

RBHA Program Contractors	
Contractor Name	**Contractor Abbreviation**
Arizona Complete Health – Complete Care Plan	AzCH-CCP RBHA
Health Choice Arizona	HCA RBHA
Mercy Care	Mercy Care RBHA

Program-Level Summary of Findings and Assessment

In this section, HSAG presents program-level strengths, weaknesses (referred to in this report as opportunities for improvement), and recommendations. Each strength, opportunity for improvement, and recommendation is derived from HSAG's review of the EQR activity results.

RBHA Program

Table 1-2 presents program-level strengths, opportunities for improvement, and recommendations for the RBHA Program based on all EQR activities conducted. Contractor-specific strengths, opportunities for improvement, and recommendations by EQR activity are provided in Section 5. RBHA Program Contractor-Specific Results.

Table 1-2—RBHA Program Strengths, Opportunities for Improvement, and Recommendations

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths related to performance measure validation (PMV): • All three RBHA Program Contractors' measure rates as well as the RBHA Program Aggregate rates met or exceeded the National Committee for Quality Assurance (NCQA) Quality

Strengths, Opportunities for Improvement, and Recommendations

Compass®,[1-3] national Medicaid health maintenance organization (HMO) mean for Healthcare Effectiveness Data and Information Set (HEDIS®)[1-4] measurement year (MY) 2021 for the:

- *Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug (AOD) Abuse or Dependence—7-Day Follow-Up—Total and 30-Day Follow-Up—Total* measure rates **[Quality, Timeliness, Access]**
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total* measure rates **[Quality, Timeliness, Access]**
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure rates **[Quality, Timeliness, Access]**

- Two of the three RBHA Program Contractors' measure rates and the RBHA Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 for the:
  - *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure rate **[Quality, Timeliness, Access]**
  - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* measure rate **[Quality]**

HSAG identified the following strengths related to performance improvement projects (PIPs):

- RBHA Program Contractors developed and implemented PIP interventions that may lead to improvement in select PIP indicator outcomes **[Quality]**
- The *Preventive Screening* PIP is in an intervention phase and will offer an opportunity to improve select performance measures related to preventive healthcare for AHCCCS members **[Quality]**

HSAG identified the following strengths related to compliance reviews:

- The RBHA Program Contractors' average compliance score was at or above 95 percent in the following Focus Areas:
  - Corporate Compliance (CC) **[Quality, Access]**
  - Claims and Information Standards (CIS) **[Access]**
  - General Administration (GA) **[Timeliness, Access]**
  - Grievance Systems (GS) **[Timeliness, Access]**
  - Medical Management (MM) **[Timeliness, Access]**
  - Member Information (MI) **[Quality]**
  - Quality Management (QM) **[Quality]**
  - Quality Improvement (QI) **[Quality, Access]**

[1-3] Quality Compass® is a registered trademark of NCQA.
[1-4] HEDIS® is a registered trademark of NCQA.

Strengths, Opportunities for Improvement, and Recommendations
– Reinsurance (RI) **[Quality]** – Third-Party Liability (TPL) **[Quality, Timeliness, Access]** – Integrated Systems of Care (ISOC) **[Quality, Access]** HSAG identified the following strengths related to network adequacy validation (NAV): • HSAG found that the applicable RBHA Program Contractors met all minimum time/distance network standards in assigned counties for both quarters in calendar year ending (CYE) 2022, except Gila and La Paz counties
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement related to PMV: • The rates for all three RBHA Program Contractors and the RBHA Program Aggregate rate did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and fell below the 25th percentile for: – *Breast Cancer Screening* **[Quality]** – *Cervical Cancer Screening* **[Quality]** Recommendation: HSAG recommends that the RBHA Program Contractors conduct a root cause analysis or focus study to determine why not all female members were receiving timely screenings for breast and cervical cancer. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, the RBHA Program Contractors should implement appropriate interventions to improve performance related to preventive screenings. (Of note, the RBHA Program Contractors are currently conducting the *Preventive Screening* PIP, which includes a root cause analysis and interventions to address these measures.) • For CY 2022 performance measure reporting, race and ethnicity stratifications (RES) will be required based on NCQA HEDIS specifications Recommendation: HSAG recommends that the RBHA Program Contractors explore data sources for the capture of race/ethnicity data to support future performance measure reporting that may require stratifications related to RES. The RBHA Program Contractors should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race/ethnicity data and explore other methods to augment enrollment data information. HSAG identified the following opportunities for improvement related to PIPs: • Overall, rates for PIP indicator 1 demonstrated a decline for both intervention years compared to baseline year indicator 1 rates. The noted decline in indicator rates may indicate that the coronavirus

Strengths, Opportunities for Improvement, and Recommendations
disease 2019 (COVID-19) public health emergency (PHE) had a significant impact on the rates of compliance with breast cancer screenings. **[Quality]** Recommendation: To support successful progression of the PIP in the next CY, HSAG recommends that the RBHA Program Contractors: • Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary • Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available • Develop and document plans for sustaining the improvement for any demonstrated improvement in indicator rates HSAG identified the following opportunities for improvement related to compliance reviews: The RBHA Program Contractors' average compliance score was below 95 percent in the following Focus Areas: • Delivery Systems (DS) **[Timeliness, Access]** • Adult; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT); and Maternal Child Health (MCH) **[Quality, Timeliness, Access]** • Division of Grant Administration (DGA) **[Quality]** Recommendation: HSAG recommends that in advance of the forthcoming AHCCCS Complete Care (ACC)-RBHA compliance review, the RBHA Contractors conduct a self-assessment of the DS, MCH, and DGA Focus Area requirements. HSAG identified no opportunities for improvement related to NAV. Recommendation: Although HSAG identified no opportunities for improvement, HSAG recommends that the RBHA Program Contractors: • Seek support from AHCCCS as needed to continue to monitor and maintain current compliances • Continue to monitor their processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS

2. Introduction to the EQR Technical Report

This section provides the purpose and overview of this annual EQR technical report; Centers for Medicare & Medicaid Services (CMS) definitions for Quality, Timeliness, and Access; and an overview of how this EQR technical report is organized.

Description of EQR Activities

Table 2-1 presents the EQR activities reviewed in this report for RBHA Program Contractors.

Table 2-1—EQR Activities Presented in the CYE 2022 External Quality Review Annual Technical Report for the RBHA Program

Contractors Reviewed	Performance Measure Validation (PMV)*	*Preventive Screening* Performance Improvement Project (PIP) Validation**	Compliance Reviews (Operational Reviews)**	Network Adequacy Validation (NAV)**
AzCH-CCP RBHA	✓	✓	✓	✓
HCA RBHA	✓	✓	✓	✓
Mercy Care RBHA	✓	✓	✓	✓

*See performance measure list on page 4-1.

**For additional information and Contractor-specific findings for PIP validation, compliance reviews, and network adequacy validation, see Section 5. RBHA Program Contractor-Specific Results.

Assessing Quality, Timeliness, and Access

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

Quality

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

> Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in 438.310[c][2]) increases the likelihood of desired outcomes of its enrollees through:

- Its structural and operational characteristics
- The provision of services that are consistent with current professional, evidence-based knowledge
- Interventions for performance improvement[2-1]

Timeliness

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

> "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[2-2] NCQA further states that the intent of this standard is to minimize any disruption in the provision of healthcare. HSAG extends this definition of "Timeliness" to include other managed care provisions that impact services to enrollees and that require timely response by the MCO/PIHP—e.g., processing appeals and providing timely care.

Access

CMS defines "Access" in the 2016 regulations at 42 CFR §438.320 as follows:

> Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 42 CFR §438.68 (Network adequacy standards) and 42 CFR §438.206 (Availability of services).[2-3]

Overview of the Report Sections

Section 1—Executive Summary describes the authority under which the report must be provided, as well as the Contractors reviewed during CYE 2022. In addition, this section includes a program-level summary of strengths, opportunities for improvement, and HSAG's recommendations for program-level performance improvement.

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

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.
[2-2] National Committee for Quality Assurance. 2013 Standards and Guidelines for the Accreditation of Health Plans.
[2-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

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

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

Section 4—RBHA Program-Level Comparative Results includes comparative results organized by EQR-related activity, strengths, opportunities for improvement, and HSAG's recommendations for program-level performance improvement.

Section 5—RBHA Program Contractor-Specific Results provides (by Contractor) activity-specific strengths, opportunities for improvement, and HSAG's recommendations for performance improvement. This section also includes information about the extent to which each Contractor was able to address prior year's recommendations and Contractor best practices.

Appendix A—Methodology presents, for each EQR activity:

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

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

Appendix B—Acknowledgements and Copyrights

3. Overview of AHCCCS

This section provides a description of AHCCCS':

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

AHCCCS Medicaid Managed Care Program History

Since 1982, AHCCCS, the single state Medicaid agency for Arizona, has operated under the authority of the federal Medicaid Demonstration 1115 Waiver under Section 1115 of the Social Security Act, which has allowed for the operation of an integrated managed care model. AHCCCS uses State, federal, and county funds to administer pediatric, acute, long-term, and behavioral healthcare programs to the State's Medicaid members. AHCCCS has an appropriated budget of approximately $18.3 billion to administer its programs, which provide services for over two million individuals and families in Arizona through a provider network credentialed and contracted by its Contractors. The AHCCCS Acute Care Program began in 1982 and in 1988, AHCCCS added the Arizona Long Term Care System (ALTCS) Program for individuals with developmental disabilities, and then expanded the program in January 1989 to include the elderly and/or physical disabilities (EPD) populations. ALTCS provides acute care, behavioral health services, LTC, and case management to AHCCCS members who are elderly, physically disabled, or developmentally disabled and who meet the criteria for receiving care in a home and community based setting. Services for individuals with developmental disabilities in ALTCS are offered through the Arizona Department of Economic Security, Division of Developmental Disabilities (DES/DDD). The ALTCS members account for less than 4.0 percent of the AHCCCS population, with approximately 28 percent of the costs. American Indian/Alaskan Native (AI/AN) members may choose to receive services through the managed care structure or may opt to receive services through the fee-for-service program. Services for children in the foster care system are offered through the DCS CHP Program (previously Comprehensive Medical and Dental Program or CMDP).

In October 1990, AHCCCS began coverage of comprehensive behavioral health services for children with a serious emotional disturbance (SED) younger than 18 years of age who required residential care. Through further expansion, AHCCCS added comprehensive behavioral health coverage for all Medicaid-eligible individuals. CHIP was incorporated in Arizona in 1998 and is known as KidsCare. In 2009, due to a persistently severe budget shortfall, a freeze was placed on enrollment in KidsCare. In 2016, Governor Ducey signed Senate Bill (SB) 1457 into law, ending the enrollment freeze on the KidsCare Program. Children who qualify for this program receive care through AHCCCS Contractors. In October 2013, children enrolled in the Acute Care Program who had a Children's Rehabilitative

Services (CRS) qualifying diagnosis were enrolled into one integrated CRS Contractor, UHCCP. This was done to decrease fragmentation and reduce member confusion; ensure optimal access to primary, specialty, and behavioral care; enhance coordination of all service delivery; improve member outcomes and satisfaction; and streamline administration. At the same time, children with CRS qualifying conditions and enrolled in the ALTCS Program, other than in DDD, were fully integrated into their ALTCS Contractors' provided services, including all primary, specialty, long-term, and behavioral healthcare related to the members' CRS conditions.

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

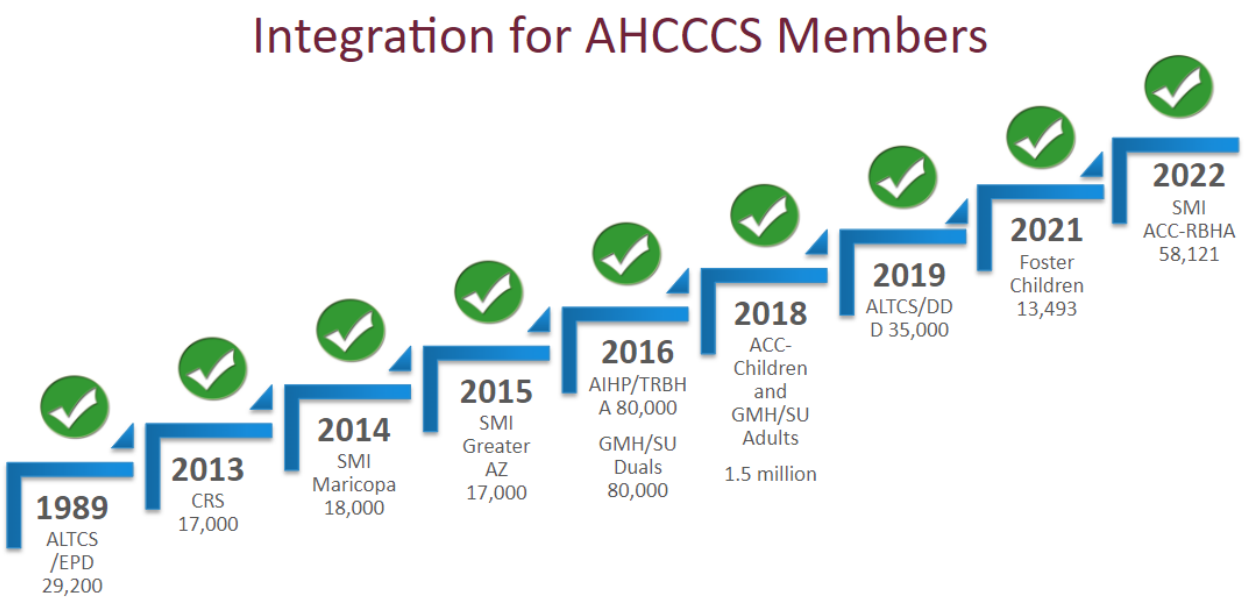
On April 1, 2014, approximately 17,000 members with SMI residing in Maricopa County were transitioned to a single plan, Mercy Maricopa Integrated Care, to manage both their behavioral and physical healthcare needs. Beginning October 1, 2015, members residing in other counties were transitioned to one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

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

Effective October 1, 2018, AHCCCS implemented a delivery system reform that allows members who are not enrolled in an ALTCS-EPD Program to access physical as well as general mental health and substance use behavioral healthcare services, previously provided through a RBHA, through a single integrated delivery system model, ACC, with seven health plans. In addition, on October 1, 2018, service delivery was restructured into three geographic service areas (GSAs): North, Central, and South. Members continue to have a choice of health plans in their geographic service areas and to have access to a network of providers and the same array of covered services.

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

Effective October 1, 2022, AHCCCS expanded three ACC contracts to include RBHA services, thus furthering integration efforts, under the ACC-RBHA line of business (LOB). ACC-RBHAs continue to provide specific services to individuals with an SMI designation who are not in an ALTCS Program, as well as the first 24 hours of crisis services.[3-1]



American Indian members have the choice of enrolling in an ACC managed care plan or the American Indian Health Program (AIHP) and a Tribal RBHA when available. American Indian members have the same access to Indian Health Service (IHS) providers, Tribal 638 providers, and Urban Indian Health providers regardless of whether they are receiving services through managed care or the fee-for-service program.

[3-1] Effective October 1, 2022, the acronym 'RBHA' changed from Regional Behavioral Health Authority to Regional Behavioral Health Agreement. Services are provided by AHCCCS Complete Care Contractors with Regional Behavioral Health Agreements (ACC-RBHAs).

AHCCCS Waivers and Legislative Updates

1115 Waiver Update

CMS approved Arizona's request for a five-year extension of its 1115 Waiver. This 1115 Waiver approval continues the long-standing authorities and programs that have made Arizona's Medicaid program innovative, effective, and efficient, including integrated managed care for AHCCCS populations through ACC, ALTCS, the DCS CHP Program for children in foster care, and RBHAs, which provide integrated care for individuals with an SMI designation. In addition, CMS continued Arizona's waiver of retroactive eligibility, which authorizes AHCCCS to limit retroactive coverage to the first day of the month of application for all Medicaid members, except for pregnant women, women who are 60 days or less postpartum, and children under 19 years of age. In addition to renewing these historic programs, this 1115 Waiver includes approval for transformative projects intended to advance member health outcomes, including the 2.0 Targeted Investments Program (TI 2.0) and Housing and Health Opportunities (H2O) initiative.

Targeted Investments (TI) Program 2.0 Approved

AHCCCS partners with more than 120,000 registered providers across the state to provide healthcare services to Medicaid members. For the last five years, the Targeted Investments Program has helped providers integrate physical and behavioral healthcare at the point of service, increasing members' access to a full array of services and demonstrating significant improvements in health outcomes. TI 2.0 will extend the program to additional providers and continue provider incentive funding to further integration efforts, including a range of initiatives aimed at addressing social drivers of health and inequitable health outcomes.

Housing and Health Opportunities (H2O) Approved

CMS approved the new Housing and Health Opportunities project to further address health-related social needs for vulnerable populations and ensure their access to healthcare. For many years, Arizona has prioritized housing and used State General Fund dollars to support rental subsidies for nearly 3,000 individuals experiencing homelessness each year. AHCCCS and its contracted health plans have successfully leveraged this experience to expand the reach of housing opportunities, improve member health outcomes, and reduce overall healthcare costs. Recognizing that stable housing is an important component of overall health, CMS approved the H2O Program to strengthen outreach to vulnerable Medicaid members, including those experiencing homelessness, those living with an SMI, and young adults transitioning out of the foster care system. AHCCCS will be able to reimburse for up to six months of medically necessary transitional housing specifically for individuals transitioning out of institutional care or congregate settings such as nursing facilities, large group homes, congregate residential settings, institutions for mental diseases (IMDs), correctional facilities, and hospitals; individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter as

defined by 24 CFR 91.5; and enhance those services that support a member's success in housing, like tenant rights education, eviction prevention, housing transition navigation services, and medically necessary home modifications.

Tribal Dental Benefit Added

In 2020, the Arizona State Legislature approved a dental benefit expansion for American Indian/Alaska Native (AI/AN) members over the age of 21 receiving dental services at Indian Health Service (IHS) or Tribal 638 facilities. The benefit expansion removes the $1,000 limit on both the adult emergency dental benefit and the separate $1,000 limit on routine dental services rendered to adult AI/AN members enrolled in the Arizona Long Term Care System (ALTCS), when these services are rendered by Indian Health Service or Tribal 638 facilities.

This waiver approval allows AHCCCS to reimburse Indian Health Services and Tribal 638 facilities for medically necessary, AHCCCS covered dental services provided to AI/AN adult members beyond the existing $1,000 limits. The $1,000 adult emergency benefit limit and the $1,000 ALTCS adult routine benefit limit remains in place for dental services provided to American Indian/Alaska Native (AI/AN) members outside of the Indian Health Service (IHS) or Tribal 638 system.

Negotiations Continue on Traditional Healing and In-Reach Services

In its approval notice, CMS recognized the State's continued interest in reimbursing for traditional healing services offered by tribal nations. In their approval letter, CMS committed to further conversations aimed at approval for Arizona's traditional healing waiver request. Additionally, CMS noted its willingness to further explore reimbursement for pre-release services for individuals in federal, state, local, and tribal correctional facilities.

The Waiver approval is effective October 14, 2022, through September 30, 2027. All documents, including the original and amended waiver applications and the approval letter from CMS, are posted on the AHCCCS 1115 Waiver web page.[3-2]

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

- Strengthen the provider workforce and remove barriers to care for AHCCCS members
- Enhance Medicaid services and supports for vulnerable members for the duration of the emergency period and

[3-2] Arizona Section 1115 Demonstration Waiver. Available at: https://www.azahcccs.gov/Resources/Federal/waiver.html. Accessed on Nov 29, 2022.

- Remove cost sharing and other administrative requirements to support continued access to services

CMS approved components of Arizona's requests under the 1135 Waiver, Appendix K, and the State Plan. Information regarding the status of AHCCCS Emergency Authority Requests (for the federally declared COVID-19 PHE) is available on the AHCCCS COVID-19 Federal Emergency Authorities Request web page.[3-3]

1115 Waiver Evaluation Update

In accordance with Special Terms and Conditions (STC) 59, AHCCCS must submit a draft Waiver Evaluation Design for its 1115 Waiver demonstration. In addition, AHCCCS is also required by CMS to submit an Interim Evaluation Report and a Summative Evaluation Report of the 1115 Waiver Demonstration by December 31, 2020, and March 30, 2023, respectively.

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

- ACC Program
- ALTCS Program
- CMDP
- RBHAs
- Targeted Investments (TI) Program
- Retroactive Coverage Waiver
- AHCCCS Works Program

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

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

Due to data limitations and operational constraints imposed by the COVID-19 pandemic, Arizona's previous interim evaluation report did not include data from all sources described in Arizona's

[3-3] COVID-19 Federal Emergency Authorities Request. Available at: https://www.azahcccs.gov/Resources/Federal/PendingWaivers/1135.html. Accessed on Nov 29, 2022.

evaluation design plan. Qualitative data based on key informant interviews and focus groups, as well as beneficiary survey data, were not collected.

For this reason, an updated interim evaluation report was developed and completed by August 30, 2021. HSAG's updated report contains results for additional years and includes findings-to-date from focus groups and qualitative interviews. In addition, the report used statistical techniques, where possible, to control for confounding factors and identify the impact of Arizona's demonstration initiatives on access to care, quality of care, and member experience with care. CMS approved AHCCCS' Interim Evaluation Report[3-4] on October 6, 2022.

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

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

Legislative Update

The Arizona State Legislature passed a number of House Bills (HBs) in the 2022 legislative session that will have impacts on the agency including:

- HB 2157 (supplemental appropriations; community-based services) provided expenditure authority to AHCCCS for implementation of its American Rescue Plan Act HCBS spending plan for SFY 2022, with certain reporting requirements and other provisions. HB 2157 was signed into law and went into effect on March 1, 2022.
- HB 2551 (CHIP; redetermination) requires AHCCCS to allow a member who is determined eligible for CHIP to maintain coverage for a period of 12 months, unless the member exceeds the age of eligibility during that 12-month period, with additional specific exceptions. Contingent upon CMS approval.
- HB 2622 (eligibility; AHCCCS) requires AHCCCS to annually renew eligibility of individuals within the foster care system until age 26, with certain specific exceptions, contingent upon CMS approval.
- HB 2691 (healthcare workforce; grant programs) creates a variety of programs to promote healthcare workforce development, including certain grant programs to be administered through AHCCCS,

[3-4] AHCCCS' Interim Evaluation Report. Available at: https://www.azahcccs.gov/Resources/Reports/federal.html. Accessed on Nov 29, 2022.

including the Student Nurse Clinical Rotation and Licensed or Certified Nurse Training Pilot Program and the Behavioral Health Pilot Program.

- HB 2862/HB 2863 (budget bills) contain appropriations for state agencies and programs. Specific to the AHCCCS Administration, the budget included the following items:
  - Additional funding for providers of services for elderly and physically disabled individuals
  - Additional funding for increased reimbursement rates for behavioral health outpatient services and the Global Obstetric Package
  - Expansion of covered services, to include chiropractic services and outpatient diabetes self-management training education, contingent upon CMS approval
  - Funding to extend postpartum eligibility to 12 months, contingent upon CMS approval
  - Funding for critical IT projects, such as a system integrator for AHCCCS' Medicaid Enterprise System (MES) Modernization, and funding to come into compliance with federal interoperability regulations

The Arizona Legislature adjourned Sine Die on June 24, 2022; the general effective date for legislation is September 24, 2022. The 2023 legislative session began January 9, 2023, and was underway at the time of writing this report.

AHCCCS' Strategic Plan

AHCCCS' Strategic Plan for SFY 2023[3-5] presents the strategy and direction for AHCCCS, including new programs, initiatives, and past accomplishments. The Strategic Plan identifies AHCCCS' mission, vision, and core values:

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

The Strategic Plan offers three multi-year strategies:

1. Provide equitable access to high quality, whole-person care
   - Increase the amount of funding to direct care workers providing home and community based services
   - Reduce health disparities
   - Increase available housing and supports
   - Improve AHCCCS member connectivity to critical social services

[3-5] AHCCCS Fiscal Year 2023 Strategic Plan 2-pager. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/Plans/FY2023_2-Page_StrategicPlan.pdf. Accessed on: Nov 29, 2022.

2. Implement solutions that ensure optimal member and provider experience
   - Finalize roadmap, detailing the modernization of AHCCCS' Medicaid Enterprise System
   - Improve transparency into delivery system performance
3. Maintain core organizational capacity, infrastructure and workforce planning that effectively serves AHCCCS operations
   - Improve employee engagement
   - Reduce the amount of time that positions remain vacant

Key Initiatives and Accomplishments for AHCCCS

AHCCCS continued to demonstrate innovative and collaborative approaches to managing costs while improving the quality of systems, care, and services. AHCCCS provided the July 2022 enhanced Quality Strategy and Quality Strategy Evaluation, the AHCCCS Strategic Plan State Fiscal Years 2023–2027, and AHCCCS' quarterly quality assurance/monitoring activity reports. These documents provided compelling evidence of AHCCCS' vision and leadership in identifying and proactively pursuing opportunities to improve access to, and the quality and timeliness of care and services, as well as to improve member health outcomes.

AHCCCS has created a webpage to outline current initiatives[3-6] aimed at building a more cohesive and effective healthcare system in Arizona by reducing fragmentation, structuring provider reimbursements to incentivize quality outcomes, leveraging health information technology, and working with private sector partners to further innovation to the greatest extent. This web page highlights ongoing and completed initiatives with links to more detailed information, and is updated as more information becomes available.

Following are key AHCCCS accomplishments related to the AHCCCS SFY 2021 Strategic Plan.

Accessing Behavioral Health Services in School

AHCCCS partners with the Arizona Department of Education and others to ensure students, whether Medicaid-eligible or not, can receive behavioral health services either provided in a school setting or through a referral from a school.

[3-6] AHCCCS Initiatives and Best Practices. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/. Accessed on: Dec 3, 2022.

Jake's Law and The Children's Behavioral Health Services Fund[3-7]

In 2020, the Arizona State Legislature allocated $8 million for behavioral health services in school settings for students who are underinsured or uninsured. This special allocation of one-time state funding, known as the Children's Behavioral Health Services Fund or Jake's Law, allows schools to refer students for behavioral health services for anxiety, depression, social isolation, stress, behavioral issues, or any other mental health concern. Families will not receive a bill for these services; they are covered by tax dollars. Jake's Law requires that schools must develop a policy to refer students for behavioral health services, and to allow families to opt-in or opt-out of the referral process each year. In CYE 2022, behavioral health services under this funding were provided to students by participating healthcare providers contracted with the three RBHAs: Mercy Care (in Central Arizona), Arizona Complete Health Complete Care (in Southern Arizona), and Health Choice Arizona (in Northern Arizona).

Building A Healthcare System: Care Coordination and Integration

AHCCCS has various initiatives[3-8] designed to improve care coordination and communication while reducing fragmentation to create a healthcare system with more effective outcomes. AHCCCS continues to integrate the care delivery systems and align incentives that are designed to transform the structure of the Medicaid program, improve health outcomes, and better manage limited resources.

Improving Behavioral Health and Physical Healthcare Coordination for Individuals with an SMI Designation

On October 1, 2022, AHCCCS updated its contracts[3-9] with MCOs for health insurance coverage for individuals with an SMI designation. Three ACC Contractors now have expanded responsibilities as an ACC-RBHA Contractor[3-10] to include the provision of integrated care addressing physical health and behavioral health for members with an SMI designation and the first 24-hours of Crisis Services. AHCCCS will continue to work collaboratively with the ACC-RBHAs to evaluate methods to reduce program complexity, administrative burden, and unnecessary administrative and medical costs; and to improve care coordination and disease/chronic care management.

[3-7] Accessing Behavioral health in Schools. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/BehavioralHealthServices/ Accessed on: Dec 3, 2022.
[3-8] Building an Integrated Health Care System and Improving Care Coordination. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/ Accessed on Dec 3, 2022.
[3-9] Behavioral Health Contracts. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/behavioralhealth.html. Accessed on: Dec 3, 2022.
[3-10] Effective October 1, 2022, the acronym 'RBHA' changed from Regional Behavioral Health Authority to Regional Behavioral Health Agreement. Services are provided by AHCCCS Complete Care Contractors with Regional Behavioral Health Agreements (ACC-RBHAs).

Medicare and Medicaid Alignment for Dual Eligibles: Alignment Makes a Difference[3-11]

Medicare presents one of the greatest challenges to states serving individuals dually eligible for Medicaid and Medicare. Medicare is its own distinct, complex system of care operated by the federal government with little to no interface with state Medicaid programs. For the over 180,000 Arizonians who are eligible for both Medicare and Medicaid, navigating these two separate systems of care can be overwhelming. Under these circumstances, it is more likely for individuals to fall through the cracks, receive inefficient care, and not achieve optimal health outcomes.

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

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

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

Beginning October 1, 2019, members enrolled with DES/DDD use their assigned DES/DDD plan for all of their non-CRS physical health and behavioral health services. DES/DDD continues to provide long-term care services for these members. Members who qualify for a CRS designation and are not enrolled with DES/DDD have a choice of ACC plans in their service area. The ACC plan manages care for all services[3-12] (including CRS, other non-CRS physical health services, and all covered behavioral health services).

[3-11] Individuals Covered By Both Medicare and Medicaid (Dual Eligible Members). Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/duals.html. Accessed on: Dec 3, 2022.
[3-12] What is Children's Rehabilitative Services (CRS) Designation? Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/CRS.html Accessed on: Dec 3, 2022.

Foster care members receive CRS and non-CRS physical healthcare services from Mercy Care Department of Child Safety Comprehensive Health Plan (Mercy Care DCS CHP) through the Department of Child Safety. American Indian and Alaska Native members with a CRS designation have a choice of an ACC Plan or the American Indian Health Program.

Justice System Transitions

AHCCCS has partnered with state and county governments to improve coordination within the justice system and create the most cost-effective and efficient ways to transition individuals[3-13] leaving the criminal justice system. A significant number of men, women, and children transitioning out of jail and prison into communities are in need of services for behavioral and physical health conditions. Many of these individuals are eligible for Medicaid.

To facilitate the transition, AHCCCS is engaged with the Arizona Department of Corrections Rehabilitation and Reentry (ADCRR), the Arizona Department of Juvenile Corrections (ADJC), and most Arizona counties covering the majority of the State's population, including the two largest—Maricopa and Pima—in a data exchange process that allows AHCCCS to suspend eligibility upon incarceration, rather than terminate coverage. This exchange allows ADCRR, ADJC, and county jails to electronically send discharge dates, which simplifies the process of transitioning directly into care. Through this enrollment suspension process, care can be coordinated by county jails or prisons upon discharge. To support this, AHCCCS Contractors are required to have a justice systems liaison that can ensure a connection to needed behavioral health services following release. In addition, AHCCCS medical management coordinates with counties to facilitate a transition of care into ACC health plans for persons being discharged with serious physical illnesses, such as cancer or other illnesses, that present public health concerns or require immediate attention.

Awards, Studies, and Highlights

Medicaid Innovator Award[3-14]

AHCCCS received a 2022 Medicaid Innovation Award presented by the Robert Wood Johnson Foundation and the National Academy for State Health Policy. The nonpartisan award recognizes states for demonstrating creativity, leadership, and progress in their Medicaid programs despite significant public health challenges in recent years.

AHCCCS received the award for its work on initiatives to address social determinants of health and their impact on whole person care. Specifically, AHCCCS was recognized for developing the Whole Person

[3-13] Support for Individuals Involved in the Justice System. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/justiceinitiatives.html. Accessed on: Dec 3, 2022.
[3-14] States Recognized for Medicaid Program Innovations. Available at: https://www.rwjf.org/en/library/articles-and-news/2022/08/states-recognized-for-medicaid-program-innovations.html?cid=xrs_rss-nr. Accessed on: Dec 3, 2022.

Care Initiative, which offers a range of support services to members, including transitional housing; referrals for and transportation to community-based services such as employment and food assistance, and long-term care services to reduce social isolation.

Office of Individual and Family Affairs[3-15]

The AHCCCS Office of Individual and Family Affairs (OIFA) works to engage the community and ensure that members and their families have a voice in the agency's decisions. OIFA takes pride in helping members and family members in the behavioral public health system. The three core areas to which OIFA dedicates its efforts are:

- Bringing in the member and family member voice
- Helping individuals navigate the behavioral health system
- Ensuring peer support services and family support services are available throughout Arizona

State Efforts to Address Medicaid Home and Community Based Services[3-16]

The Medicaid and CHIP Payment and Access Commission (MACPAC) recognized Arizona's efforts to identify and manage barriers to home- and community-based worker recruitment and retention. by inviting AHCCCS to serve as a panelist for a workforce discussion. Arizona was recognized by CMS in the Direct Service Workforce Learning Collaborative - Summary Report study published in February 2023. This report summarized various innovative programs and approaches undertaken by state Medicaid programs that were designed to build capacity in the direct service workforce.

Two of Arizona's workforce development initiatives were cited in this report.

- The Arizona Department of Education's Home Health Aide/Direct Care Worker Training Program is a partnership with the Career and Technical Education Centers of 20 high schools across the state. The program is designed to create a pipeline of Direct Care Worker (DCW) qualified high school graduates into the DCW workforces. Like all DCW training programs, each high school program must be approved by AHCCCS and operate in accordance with the standards of the AHCCCS Contractor Operations Manual 429 Direct Care Worker Training and Testing Program. Currently the program graduates approximately 800 DCW qualified students annually.
- Mercy Care (AHCCCS MCO) and Solterra (a senior living company) were recognized by CMS for creating an innovative approach to recruiting DCWs. Called Careworks, this program has several aims:
  - Develop new DCW talent pools

[3-15] OIFA 2021 Year in Review. Available at: https://www.azahcccs.gov/shared/Downloads/News/2022/2021_OIFA_YearInReview.pdf. Accessed on: Dec 3, 2022.
[3-16] State Efforts to Address Medicaid Home and Community Based Services. Available at: https://www.azahcccs.gov/shared/Downloads/News/2022/220322_MACPAC-brief-on-HCBS-workforce.pdf. Accessed on: Dec 3, 2022.

- Shift social perceptions of caregiving
- Provide career counseling to middle and high school students about the value of beginning a health career as a DCW
- Develop an apprenticeship program for DCWs that will provide free tuition and hourly compensation for a caregiver certificate as well as a care-giving coach to every applicant

Additional Highlights

- During the COVID-19 PHE, AHCCCS used innovative approaches to expand telehealth utilization and allow providers to accept verbal consent to expedite service referrals supported ongoing delivery of services.
- AHCCCS continued collaborative efforts with Mercy Care through the RBHA in Maricopa County to ensure member access to needed services such as assertive community treatment (ACT). Maricopa County has greater capacity to provide ACT than most comparison communities. It is estimated that 4.3 percent of adults with an SMI need an ACT level of care. Few communities around the country provide ACT to 4.3 percent or more of their adults who have SMI, but 6.2 percent of adults with SMI in Maricopa County received ACT in 2021.[3-17]
- In part because of partnerships with AHCCCS and stakeholders, supportive housing and supported employment services are more available in Maricopa County (especially for Medicaid recipients) than nationwide.[3-15]
- Through ongoing efforts supported by AHCCCS, the supported employment utilization rate is 32 percent and the ongoing supported employment utilization rate is 5 percent, among the highest in a benchmark analysis of comparable service delivery systems nationwide. Utilization rates among adults with SMI in Maricopa County increased from 2.5 percent in 2013 to 7.0 percent in 2021.[3-15]
- AHCCCS continues to partner with Mercy Care and direct care providers to encourage positive health outcomes for members. In 2022, 91 percent of individuals responded that they felt comfortable talking to their doctor about medications and how it made them feel, a continued increase from the 2021 response rate (89 percent). Medication services are identified as one of the most readily available services within 15 days.[3-18]
- As part of continuous quality improvement efforts supported by AHCCCS and stakeholders, 86 percent of sampled member cases reviewed included an Individual Service Plan (ISP) with services based on the member's needs, a continued improvement since the 2020 review (70 percent).[3-16]

[3-17] Mercer Government Human Consulting Services, "Service Capacity Assessment Priority Mental Health Services 2022: Arizona Health Care Cost Containment System," Available at: www.azahcccs.gov/AHCCCS/Downloads/ArnoldVSarn/AnnualReports/2022/2022AnnualServiceCapacityAssessment.pdf. Accessed on: Nov 3, 2022.

[3-18] Mercer Government Human Consulting Services, "Quality Service Review 2022: Arizona Health Care Cost Containment System," Available at: www.azahcccs.gov/AHCCCS/Downloads/ArnoldVSarn/AnnualReports/2022/2022AnnualQSR_Report.pdf. Accessed on: Nov 3, 2022.

- AHCCCS provided ongoing support to direct service providers in the utilization of technical assistance related to ongoing fidelity reviews. All direct service providers reviewed in 2021 met Substance Abuse and Mental Health Services Administration (SAMHSA) fidelity review guidelines for evidence-based practice.[3-19]

2022 AHCCCS Year in Review

In 2022, AHCCCS enhanced healthcare service delivery, increased its use of technology to serve customers, and received national recognition for innovative work to address health-related social needs. During CY 2022[3-20], AHCCCS:

- Obtained 1115 Waiver renewal, sustaining historic innovations like managed care and the provision of home- and community-based services (HCBS) while extending the TI Program to offer incentive funding to providers who meet specific integrated care milestones and implementing the H2O demonstration.
- Received the 2022 Medicaid Innovations Award from the Robert Wood Johnson Foundation and the National Academy for State Health Policy, recognizing AHCCCS' work to advance whole-person care and address social drivers of health and inequitable health outcomes.
- Received CMS approval of the American Rescue Plan Act spending plan to allocate $1.5 billion to improving HCBS programs.
- Implemented the ACC-RBHA LOB serving individuals with an SMI designation and serving all Arizonans during the first 24 hours of crisis services. Efforts also included integrating the national 988 suicide and crisis hotline, and implementing a single, statewide crisis line (1-844-534-4673) and crisis text line (4HOPE).
- Integrated 424 American Indian and Alaska Native individuals with an SMI designation into the American Indian Health Program on October 1, 2022.
- Helped to create the Arizona Perinatal Access Line to provide real-time perinatal psychiatric consultation to primary care practitioners serving pregnant and postpartum members.
- Created a COVID-19 PHE vaccination dashboard and a performance measure data dashboard consistent with AHCCCS' commitment to enhance program performance transparency.
- Launched the AHCCCS Virtual Assistant (AVA) to handle the 25 most-asked eligibility-related questions, resulting in 12 percent fewer calls to the Division of Member and Provider Services member contact unit.

[3-19] WICHE Behavioral Health Program, "FY 2021-2022 (Year 8) Evidence Based Practices Fidelity Project: Arizona Health Care Cost Containment System," Available at: www.azahcccs.gov/AHCCCS/Downloads/ArnoldVSarn/AnnualReports/2022/WICHE_Year_8_EndOfYearReport-FINAL09072022.pdf. Accessed on: Nov 3, 2022.

[3-20] 2022 AHCCCS Year in Review. Available at: https://www.azahcccs.gov/shared/Downloads/News/2023/2022YearInReview_220111.pdf. Accessed on Jan 13, 2023.

- Allocated over $25 million in Substance Abuse Block Grant COVID-19 Supplemental Funds for substance use harm reduction efforts, treatment and recovery services, and primary prevention services and $30 million in Mental Health Block Grant funding to support and expand the spectrum of mental health services available to children and adults, including First Episode Psychosis programs and school-based youth engagement specialists.
- Expanded recovery housing options and funded the first mobile medication-assisted treatment (MAT) unit with State Opioid Relief grant dollars.
- Successfully negotiated revisions to a 20-year-old agreement between the Arizona and Hawaii Medicaid programs, allowing the longstanding partnership that shares a MES to continue. The MES handles functions such as claims payment, provider enrollment, and electronic visit verification.
- Engaged more than 50,000 members, families, and providers in stakeholder events, launched the AHCCCS Explains video series featuring employees, and enhanced social media platforms to increase reach by 71 percent.

AHCCCS' Quality Strategy

In accordance with 42 CFR §438.340 and 42 CFR §457.1240(e), AHCCCS created the AHCCCS Quality Strategy and Quality Strategy Evaluation. During CYE 2021, AHCCCS enhanced its Quality Strategy by reevaluating its structure, content, and data analysis. Part of the approach was to incorporate synchronized reporting processes to ensure alignment across various AHCCCS reports that relate to quality (e.g., Strategic Plan, Quality Strategy, and EQR Reports).

The AHCCCS Quality Strategy is a coordinated, comprehensive, and proactive approach to drive improved health outcomes by utilizing creative initiatives, ongoing assessment and monitoring, and result-based performance improvement. Members, the public, and stakeholders provide input and recommendations regarding the content and direction of the Quality Strategy through public comments and additional feedback obtained following stakeholder presentations.

- The AHCCCS Quality Strategy Evaluation is a companion document to the AHCCCS Quality Strategy for the purpose of evaluating the effectiveness of the AHCCCS Quality Strategy
- AHCCCS' enhanced Quality Strategy and Quality Strategy Evaluation were submitted to CMS in July 2021 and posted to AHCCCS' website

AHCCCS will initiate its efforts to update its Quality Strategy and Quality Strategy Evaluation in July 2023 in preparation for submitting the documents to CMS in July 2024.

Goals and Objectives

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

- 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
- 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

Quality Goal 2: Improve the health of AHCCCS populations

- 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
- Build upon prevention and health maintenance efforts through targeted medical management:
  - Emphasizing disease and chronic care management
  - Improving functionality in activities of daily living
  - Planning patient care for special needs populations
  - Identifying and sharing best practices
  - Expanding provider development of Centers of Excellence (COEs)

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

- Increase analytical capacity to make more informed clinical and policy making decisions
- Develop collaborative strategies and initiatives with state agencies and other external partners, such as:
  - Strategic partnerships to improve access to healthcare services and affordable healthcare coverage
  - Partnerships with sister government agencies, MCOs, and providers to educate Arizonans on health issues
  - Effective medical management for at-risk and vulnerable populations
  - 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

- 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:
  - Collaborate with external stakeholders to facilitate access to supplemental data sources

  - Explore means for collecting and reporting performance measure data utilizing electronic health record (EHR) methodologies
- Drive continuous delivery system performance through advanced data analytics and disparity analyses

Recommendations

- HSAG noted that, with few exceptions, the indicator rates related to the *Preventive Screening* PIP declined during the intervention year when compared to the baseline year (CYE 2019). This decline may be due to the COVID-19 PHE. HSAG recommends that AHCCCS encourage the Contractors to leverage existing member and provider messaging to include education about the COVID-19 PHE and safely receiving these services moving forward. Messaging should consider any specific barriers in local communities to accessing these services and how to effectively manage those barriers in a way that will address members' individual needs within their local community.
- HSAG also recommends that AHCCCS seek Contractor input and proposals when developing value-based payment models.

4. RBHA Program-Level Comparative Results

This section includes comparative results organized by EQR-related activity, strengths, opportunities for improvement, and HSAG's recommendations for program-level performance improvement.

Performance Measure Validation

During CYE 2022, HSAG evaluated each RBHA Program Contractor's data system for processing of each data type used for reporting the Contractor's CY 2021 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. A summary of these findings by RBHA Program Contractor is provided in Table 4-1. Table 4-1 also displays whether each RBHA Program Contractor met the assessed Information Systems (IS) standards, which demonstrates whether the Contractor has effective IS practices and control procedures for data reporting. Additional information about each RBHA Program Contractor's general findings for each data type reviewed can be found in Section 5, RBHA Program Contractor-Specific Results. Additional information regarding the CMS EQR Protocol 2[4-1] audit requirements, including more information about the levels of scoring, can be found in Appendix A—Validation of Performance Measures.

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

Data Type	AzCH-CCP RBHA	HCA RBHA	Mercy Care RBHA
Medical Services Data	*Met*	*Met*	*Met*
Enrollment Data	*Met*	*Met*	*Met*
Provider Data	*Met*	*Met*	*Met*
Medical Record Review Processes	*Met*	*Met*	*Met*
Supplemental Data	*Met*	*Met*	*Met*
Data Preproduction Processing	*Met*	*Met*	*Met*
Data Integration and Reporting	*Met*	*Met*	*Met*

[4-1] The Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: May 4, 2022.

RBHA Program-Level Results

Table 4-2 presents the CY 2021 aggregate performance measure results for the RBHA Integrated SMI Contractors. Performance measure rate cells shaded green indicate that aggregate performance met or exceeded NCQA's Quality Compass national Medicaid HMO mean for HEDIS MY 2021. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the national Medicaid mean are shaded green. Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology. RBHA Program Aggregate rates denoted with a plus sign (+) indicate the measures were reported using a statewide weighted average that blended administrative and hybrid rates, since some RBHA Program Contractors did not report the measure using hybrid methodology.

Table 4-2—CY 2021 Aggregate Performance Measure Results for the RBHA Program Contractors

Measure	AzCH–CCP RBHA	HCA RBHA	Mercy Care RBHA	RBHA Program Aggregate
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	73.5%+	82.9%+	73.7%+	74.8%+
Postpartum Care	59.0%+	61.0%+	55.4%+	57.1%+
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	60.9%	60.6%	53.9%	57.2%
Effective Continuation Phase Treatment	46.2%	42.4%	41.8%	43.3%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	59.6%	54.4%	57.0%	57.6%
Follow-Up After ED Visit for AOD Abuse or Dependence				
7-Day Follow-Up—Total	22.4%	22.7%	17.5%	19.8%
30-Day Follow-Up—Total	30.7%	29.8%	25.3%	27.6%
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total	55.4%	50.0%	54.3%	53.9%
30-Day Follow-Up—Total	71.6%	64.6%	71.0%	70.1%
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total	49.9%	58.4%	69.9%	64.3%
30-Day Follow-Up—Total	73.6%	75.0%	84.5%	81.2%
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total	46.6%	36.4%	43.5%	43.4%
Engagement of AOD Treatment—Total	14.2%	9.8%	12.2%	12.4%

Measure	AzCH–CCP RBHA	HCA RBHA	Mercy Care RBHA	RBHA Program Aggregate
Care of Acute and Chronic Conditions				
Comprehensive Diabetes Care				
*HbA1c Poor Control (>9.0%)**	46.0%+	41.8%+	32.4%+	38.0%+
Controlling High Blood Pressure				
Controlling High Blood Pressure	51.6%+	45.7%+	57.9%+	54.3%+
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	77.5%	80.3%	82.4%	80.8%
Pediatric Health				
Annual Dental Visit				
Annual Dental Visit[1]	42.9%	46.0%	18.0%	24.6%
Preventive Screening				
Breast Cancer Screening				
Breast Cancer Screening	36.2%	35.1%	32.7%	34.3%
Cervical Cancer Screening				
Cervical Cancer Screening	47.7%+	33.8%+	45.3%+	44.4%+
Appropriate Utilization of Services				
Ambulatory Care—Total				
*Ambulatory Care—ED Utilization**	97.6	95.0	103.5	100.6
Plan All-Cause Readmissions				
*O/E Ratio—Total**	1.2643	0.9984	1.3246	1.2764
Use of Opioids at High Dosage				
*Use of Opioids at High Dosage**	11.3%	6.5%	12.0%	10.8%

* A lower rate indicates better performance for this measure.

+ Indicates the measure was reported using hybrid methodology.

[1] The rates included for the *Annual Dental Visit* measure are limited to members 18–20 years of age. Caution should be considered when comparing the rates to the MY 2021 national Medicaid mean.

Cells shaded green indicate that the rate met or exceeded the MY 2021 national Medicaid mean.

Table 4-3 presents the CY 2020 and CY 2021 RBHA Program Aggregate for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and MY 2021. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and/or MY 2021. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 4-3—CY 2020 and CY 2021 Performance Measure Aggregate Results for RBHA Program Contractors

Measure	CY 2020 Performance	CY 2021 Performance	2020-2021 Comparison[2]
Maternal and Perinatal Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	—	74.8%+	—
Postpartum Care	64.2%+	57.1%+	→
Behavioral Health			
Antidepressant Medication Management			
Effective Acute Phase Treatment	53.6%	57.2%	↑
Effective Continuation Phase Treatment	40.3%	43.3%	↑
Adherence to Antipsychotic Medications for Individuals With Schizophrenia			
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	56.9%	57.6%	→
Follow-Up After ED Visit for AOD Abuse or Dependence			
7-Day Follow-Up—Total	20.4%	19.8%	→
30-Day Follow-Up—Total	30.1%	27.6%	→
Follow-Up After ED Visit for Mental Illness			
7-Day Follow-Up—Total	60.3%	53.9%	↓
30-Day Follow-Up—Total	75.2%	70.1%	↓
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up—Total	65.8%	64.3%	↓
30-Day Follow-Up—Total	82.1%	81.2%	→
Initiation and Engagement of AOD Abuse or Dependence Treatment			
Initiation of AOD—Total—Total	41.3%	43.4%	↑
Engagement of AOD—Total—Total	11.4%	12.4%	→
Care of Acute and Chronic Conditions			
Comprehensive Diabetes Care—HbA1c Poor Control (>9%)			
*HbA1c Poor Control (>9.0%)**	45.2%+	38.0%+	↑
Controlling High Blood Pressure			
Controlling High Blood Pressure	—	54.3%+	—
Diabetes Screening For People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	74.1%	80.8%	↑
Heart Failure Admission Rate			
Heart Failure Admission Rate	—	56.3	—

Measure	CY 2020 Performance	CY 2021 Performance	2020-2021 Comparison[2]
Diabetes Short-Term Complications Admission Rate			
Diabetes Short-Term Complications Admission Rate	—	44.7	—
Pediatric Health			
Annual Dental Visit			
Annual Dental Visit[1]	—	24.6%	—
Preventive Screening			
Breast Cancer Screening			
Breast Cancer Screening	37.0%	34.3%	↓
Cervical Cancer Screening			
Cervical Cancer Screening	49.9%+	44.4%+	↓
Appropriate Utilization of Services			
Ambulatory Care—ED Utilization			
*Ambulatory Care—ED Utilization**	—	100.6	—
Plan All-Cause Readmissions			
*O/E Ratio—Total**	—	1.2764	—
Use of Opioids at High Dosage			
*Use of Opioids at High Dosage**	—	10.8%	—

* A lower rate indicates better performance for this measure.
+ Indicates the measure was calculated via mixed methodology in scenarios where one or more Contractors calculated the measure using administrative methodology.
Cells shaded green indicate that the rate met or exceeded the MY 2020 and/or MY 2021 national Medicaid mean.
— Indicates the CY 2020 rate was not presented in the CYE 2021 Annual Technical Report; therefore, a 2020-2021 comparison is not presented in the CYE 2022 Annual Technical Report.
[1] The rates included for the *Annual Dental Visit* measure are limited to members 18–20 years of age. Caution should be considered when comparing the rates to the MY 2020 and/or MY 2021 national Medicaid mean.
[2] Aggregated rates were calculated and compared from MY 2020 to MY 2021, and comparisons were based on a Chi-square test of statistical significance with a p value of <0.01 due to large denominators.
↑ Indicates improvement of measure rates.
↓ Indicates decline of measure rates.
⟶ Indicates stable measure rates.

Table 4-4 highlights the RBHA Program Contractors' performance for the current year by measure group. The table illustrates the Contractors' CY 2021 measure rates and their performance relative to the NCQA national Medicaid Quality Compass HEDIS MY 2021 percentiles, where applicable. The performance level star ratings are defined as follows:

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

Table 4-4—CY 2021 National Percentiles Comparison for the RBHA Program Contractors

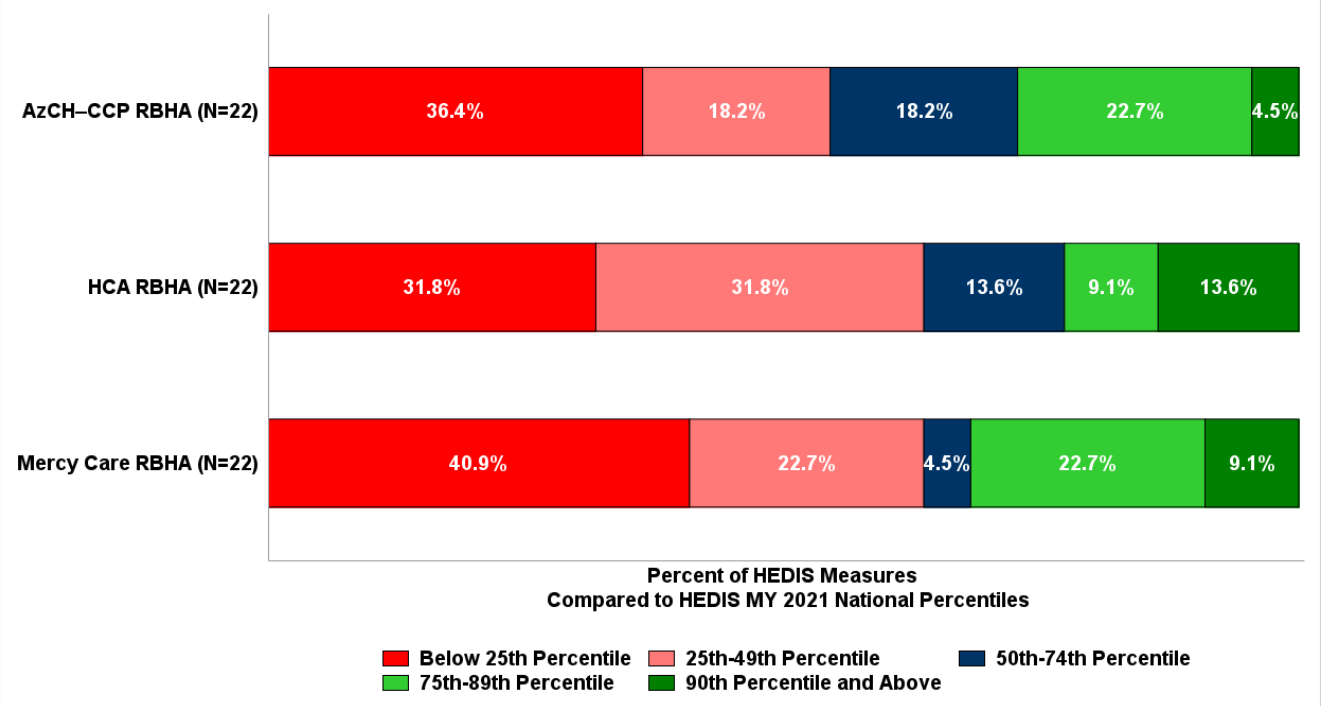
Measure	AzCH–CCP RBHA	HCA RBHA	Mercy Care RBHA	RBHA Program Aggregate
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	★	★★	★	★
Postpartum Care	★	★	★	★
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	★★★	★★★	★	★★
Effective Continuation Phase Treatment	★★★	★★	★★	★★★
Adherence to Antipsychotic Medications for Individuals with Schizophrenia				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	★★	★	★★	★★
Follow-Up After ED Visit for AOD Abuse or Dependence				
7-Day Follow-Up—Total	★★★★★	★★★★★	★★★★	★★★★
30-Day Follow-Up—Total	★★★★	★★★★	★★★	★★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total	★★★★	★★★	★★★★	★★★★
30-Day Follow-Up—Total	★★★★	★★★★	★★★★	★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total	★★★★	★★★★★	★★★★★	★★★★★
30-Day Follow-Up—Total	★★★★	★★★★★	★★★★★	★★★★★
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total	★★★	★	★★	★★
Engagement of AOD Treatment—Total	★★★	★★	★★	★★
Care of Acute and Chronic Conditions				
Comprehensive Diabetes Care				
HbA1c Poor Control (>9.0%)	★★	★★	★★★★	★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	★	★	★★	★
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	★★	★★★	★★★★	★★★
Pediatric Health				
Annual Dental Visit				
Annual Dental Visit[l]	★★	★★	★	★

Measure	AzCH–CCP RBHA	HCA RBHA	Mercy Care RBHA	RBHA Program Aggregate
Preventive Screening				
Breast Cancer Screening				
Breast Cancer Screening	★	★	★	★
Cervical Cancer Screening				
Cervical Cancer Screening	★	★	★	★
Appropriate Utilization of Services				
Ambulatory Care—Total				
Ambulatory Care—ED Utilization	★	★	★	★
Plan All-Cause Readmissions				
O/E Ratio—Total	★	★★	★	★
Use of Opioids at High Dosage				
Use of Opioids at High Dosage	★	★★	★	★

[1] The rates included for the *Annual Dental Visit* measure are limited to members 18–20 years of age. Caution should be considered when comparing the rates to national percentiles.

Figure 4-1 displays the RBHA Program Contractors' HEDIS MY 2021 performance compared to NCQA MY 2021 National Percentiles. HSAG analyzed results from 16 performance measures for HEDIS MY 2021 for a total of 22 measure rates.

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



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

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

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

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health Care measure group: • The *Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure rates for all three RBHA Program Contractors as well as the RBHA Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021. These results may indicate that members enrolled with the three RBHA Program Contractors may be receiving timely follow-up visits for AOD abuse or dependence after an ED visit. Timely follow-up care for individuals with AOD abuse or dependence who were seen in the ED is associated with a reduction in substance use and future ED use and hospital admissions, as well as a decrease in bed days.[4-2] **[Quality, Timeliness, Access]** • The *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure rates for all three RBHA Program Contractors and the RBHA Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021. These results may indicate that members may be receiving timely follow-up visits for mental illness after an ED visit. Research suggests that follow-up care for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function, and increased compliance with follow-up instructions.[4-3] **[Quality, Timeliness, Access]** • The *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure rates for all three RBHA Program Contractors and the RBHA Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021. These results may indicate that members enrolled with the three RBHA Program Contractors may be receiving timely follow-up visits with a mental health provider after inpatient discharge for a diagnosis of mental illness or intentional self-harm. Providing follow-up care to patients after a psychiatric hospitalization can improve patient outcomes and decrease the

[4-2] National Committee for Quality Assurance. Follow-Up After ED Visit for AOD Abuse or Dependence. Available at: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-alcohol-and-other-drug-abuse-or-dependence/. Accessed on: Mar 9, 2023.

[4-3] National Committee for Quality Assurance Follow-Up After ED Visit for Mental Illness. Available at: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/. Accessed on: Mar 9, 2023.

Strengths, Opportunities for Improvement, and Recommendations
likelihood of rehospitalization and the overall cost of outpatient care.[4-4] **[Quality, Timeliness, Access]**
In the Care of Acute and Chronic Conditions measure group: • For the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure rate, the rates for two of the three RBHA Program Contractors and the RBHA Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021. This performance indicates that members receiving antipsychotic medications for schizophrenia who were enrolled with the two high-performing RBHA Program Contractors may be receiving diabetes screenings. Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health, quality of life, and economic outcomes downstream.[4-5] **[Quality, Timeliness, Access]** • The rates for two of three RBHA Program Contractors and the RBHA Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measure rate. Based on evidence-based guidelines, high performance on this measure rate may indicate that members with diabetes may be able to manage their condition through the appropriate use of medications, diet and nutrition, or physical activity. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[4-6] **[Quality]**
Opportunities for Improvement and Recommendations
In the Maternal and Perinatal Care measure group, the rates for all three RBHA Program Contractors and the RBHA Program Aggregate rate for *Prenatal and Postpartum Care—Postpartum Care* did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and fell below the 25th percentile. Additionally, the rates for all three RBHA Program Contractors and the RBHA Program Aggregate rate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021. The rates for two of three RBHA Program Contractors and the RBHA Program Aggregate rate fell below the 25th percentile, indicating that not all women were having timely prenatal and postpartum care visits. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.[4-7] Members may have had difficulties accessing care

[4-4] National Committee for Quality Assurance. Follow-Up After Hospitalization for Mental Illness. Available at https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/. Accessed on: Mar 9, 2023.
[4-5] National Committee for Quality Assurance. Diabetes and Cardiovascular Disease Screening and Monitoring for People With Schizophrenia or Bipolar Disorder. Available at: https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/. Accessed on: Mar 9, 2023.
[4-6] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2023.
[4-7] National Committee for Quality Assurance. Breast Cancer Screening (BCS). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Jan 30, 2023.

Strengths, Opportunities for Improvement, and Recommendations
due to the COVID-19 PHE, as some in-person services were temporarily suspended. **[Quality, Timeliness, Access]** Recommendation: HSAG recommends that the RBHA Program Contractors conduct a root cause analysis or focus study to determine why not all female members were having timely prenatal and postpartum care visits. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, the RBHA Program Contractors should implement appropriate interventions to improve performance related to prenatal and postpartum care.
In the Preventive Screening measure group: • The rates for all three RBHA Program Contractors and the RBHA Program Aggregate rate for *Breast Cancer Screening* did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and fell below the 25th percentile, indicating that not all women were receiving timely screening for breast cancer. Early detection reduces the risk of dying from this type of cancer and can lead to a greater range of treatment options and lower healthcare costs.[4-8] A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person primary care provider (PCP) appointments due to the COVID-19 PHE. **[Quality]** Recommendation: HSAG recommends that the RBHA Program Contractors conduct a root cause analysis or focus study to determine why not all female members were receiving timely screenings for breast cancer. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, the RBHA Program Contractors should implement appropriate interventions to improve performance related to preventive screenings. (Of note, the RBHA Program Contractors are currently conducting the *Preventive Screening* PIP, which includes a root cause analysis and interventions to address this measure.) • The rates for all three RBHA Program Contractors and the RBHA Program Aggregate rate for *Cervical Cancer Screening* did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and fell below the 25th percentile, indicating that not all women were receiving timely screening for cervical cancer. Cervical cancer is one of the most common causes of cancer death for American women; effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate.[4-9] A factor that may have

[4-8] National Committee for Quality Assurance. Breast Cancer Screening (BCS). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Jan 30, 2023.
[4-9] National Committee for Quality Assurance. Cervical Cancer Screening (CCS). Available at: https://www.ncqa.org/hedis/measures/cervical-cancer-screening/. Accessed on: Jan 30, 2023.

Strengths, Opportunities for Improvement, and Recommendations
contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. **[Quality]** Recommendation: HSAG recommends that the RBHA Program Contractors conduct a root cause analysis or focus study to determine why not all female members were receiving timely screenings for cervical cancer. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, the RBHA Program Contractors should implement appropriate interventions to improve performance related to preventive screenings. (Of note, the RBHA Program Contractors are currently conducting the *Preventive Screening* PIP, which includes a root cause analysis and interventions to address this measure.)
In the Appropriate Utilization of Services measure group, the *Plan All-Cause Readmissions—O/E Ratio—Total* measure rate for two RBHA Program Contractors as well as the RBHA Program Aggregate rate did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021, indicating that some members experienced unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay. [**Quality**] Recommendation: HSAG recommends that the RBHA Program Contractors collaborate to identify best practices for reducing unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay, based upon the successes the Contractors have identified in other programs. HSAG also recommends that the RBHA Program Contractors consider conducting a root cause analysis to identify factors contributing to members experiencing unplanned acute readmissions, which should include evaluating that appropriate follow-up care is available to members upon discharge from an acute inpatient admission or observation.
For CY 2022 performance measure reporting, RES will be required based on NCQA HEDIS specifications. Recommendation: HSAG recommends that the RBHA Program Contractors explore data sources for the capture of race/ethnicity data to support future performance measure reporting that may require stratifications related to RES. The RBHA Program Contractors should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race/ethnicity data and explore other methods to augment enrollment data information.

Performance Improvement Projects

Early detection of breast cancer and cervical cancer is important when providing effective interventions. Breast cancer is the most common female cancer in the United States for every major ethnic group, the second most common cause of cancer death in women,[4-10] and accounts for 15 percent of all new cancer diagnoses in the U.S.[4-11] Ensuring that all women receive regular breast cancer screening is critically important in disease prevention, early detection, and treatment. Cervical cancer is a type of cancer that occurs in the cells of the cervix. The risk of developing cervical cancer can be reduced by having screening tests and receiving a vaccine that protects against human papillomavirus (HPV) infection.

Breast cancer and cervical cancer screenings increase the chances of detecting certain cancers early when they might be easier to treat. Prevention offers the most cost-effective long-term strategy for the control of cancer. Policies, programs, and projects should be implemented to raise awareness, to reduce exposure to cancer risk factors, and to ensure that individuals are provided with the information and support needed to participate in preventive screenings.

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Preventive Screening* PIP for the RBHA population. The objective of the *Preventive Screening* PIP is to increase the number and percentage of breast cancer screenings and cervical cancer screenings.

RBHA Program-Level Results

Based on HSAG's PMV for RBHA Program Contractors, HSAG determined that the CY 2021 indicator rates used for the *Preventive Screening* PIP were valid and reliable. Table 4-6 and Table 4-7 present baseline rates for each Contractor during the baseline year and intervention years. For a description of the indicators used for the *Preventive Screening* PIP, see Appendix A. Methodology—Validation of Performance Improvement Projects—Description of Data Obtained.

Table 4-6—RBHA Program Contractor *Preventive Screening* PIP Comparative Rates for Indicator 1

Contractor	PIP Indicator 1: *Breast Cancer Screening*		
	Baseline Year	Intervention Year 1	Intervention Year 2
	CYE 2019*	CY 2020	CY 2021
AzCH-CCP RBHA	38.5%	37.3%	36.2%
HCA RBHA	36.6%	36.7%	35.1%
Mercy Care RBHA	35.8%	36.9%	32.7%

*CYE 2019 indicator rates were calculated by HSAG utilizing AHCCCS data.

[4-10] Jemal A, Siegel R, Ward E, Hao Y, Xu J, Thun MJ. Cancer statistics, 2009. CA Cancer J Clin. 2009 Jul-Aug;59(4):225-49. doi: 10.3322/caac.20006. Epub 2009 May 27. PMID: 19474385.

[4-11] Howlader N, Noone AM, Krapcho M, Miller D, Brest A, Yu M, Ruhl J, Tatalovich Z, Mariotto A, Lewis DR, Chen HS, Feuer EJ, Cronin KA (eds). SEER Cancer Statistics Review, 1975-2016, National Cancer Institute. Bethesda, MD; 2016.

Table 4-7—RBHA Program Contractor *Preventive Screening* PIP Comparative Rates for Indicator 2

Contractor	PIP Indicator 2: *Cervical Cancer Screening*		
	Baseline Year	Intervention Year 1	Intervention Year 2
	CYE 2019*	CY 2020	CY 2021
AzCH-CCP RBHA	43.9%	50.4%	47.7%
HCA RBHA	41.0%	40.1%	33.8%
Mercy Care RBHA	43.5%	53.5%	45.3%

*CYE 2019 indicator rates were calculated by HSAG utilizing AHCCCS data.

RBHA Program-Level Interventions

For the *Preventive Screening* PIP, all Contractors provided lists of interventions that were in place for CY 2022. These lists detailed the identified population, the intervention(s) in place, and whether the intervention(s) will be continued for CY 2023. The most common interventions across the RBHA Program Contractors included targeting members and providers for outreach and education related to breast cancer screenings and cervical cancer screenings. Outreach methods included interactive voice response (IVR), person-to-person, and automated phone calls; text message campaigns; emails; and letters and other mailing materials. These interventions may impact indicator performance, which will be evaluated after validated indicator rates for the first remeasurement year (CY 2022) become available. For further description of each Contractors' interventions, see Section 5. RBHA Program Contractor-Specific Results.

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

Table 4-8 presents program-level strengths, opportunities for improvement, and recommendations for the RBHA Program related to PIPs.

Table 4-8—RBHA Program Strengths, Opportunities for Improvement, and Recommendations Related to PIPs

Strengths, Opportunities for Improvement, and Recommendations
Strengths
RBHA Program Contractors developed and implemented interventions that may lead to improvement in indicator outcomes. **[Quality]** HSAG noted that at the program-level, RBHA Program Contractors showed an increase in the indicator rates from the baseline year to intervention year 1 for indicator 2, with the exception of one RBHA Program Contractor. In intervention year 2, although the indicator rates for indicator 2 showed

Strengths, Opportunities for Improvement, and Recommendations
a decline from intervention year 1, the indicator rates remained above the baseline year indicator rates, with the exception of one RBHA Program Contractor. **[Quality]**
Opportunities for Improvement and Recommendations
Program-level indicator 1 rates demonstrated a decline compared to baseline indicator rates in both intervention years, with some exceptions. For indicator 1, one RBHA Program Contractor showed a decline in the indicator rates between the baseline year and intervention year 1, while the other RBHA Program Contractors showed slight increases in the rates, averaging just under 1 percentage point. However, between intervention year 1 and intervention year 2, indicator rates showed an average of a 2.3 percentage point decline for all RBHA Program Contractors. When compared to the baseline year, the intervention year 2 indicator rates were an average of two percentage points below the baseline year indicator rates. The decline noted in indicator rates may indicate that the COVID-19 PHE had an impact on the rates of compliance with breast cancer screenings. **[Quality]** Recommendation: To support successful progression of the PIPs in the next calendar year, HSAG recommends that the RBHA Program Contractors: • Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary • Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available • Develop and document plans for sustaining the improvement for any demonstrated improvement in indicator rates

Compliance Reviews

AHCCCS includes the following Focus Areas in its compliance review activity. Table 4-9 presents the Focus Areas, including each associated acronym, used by AHCCCS during its compliance review.

Table 4-9—Focus Areas and Associated Acronyms

Focus Area	Acronym
Corporate Compliance	CC
Claims and Information Standards	CIS
Delivery Systems	DS
General Administration	GA
Grievance Systems Focus Area	GS
Adult, EPSDT, and Maternal Child Health	MCH
Medical Management	MM

Focus Area	Acronym
Member Information	MI
Quality Management	QM
Quality Improvement	QI
Division of Grant Administration	DGA
Reinsurance	RI
Third-Party Liability	TPL
Integrated Systems of Care	ISOC

RBHA Program-Level Results

AHCCCS conducts a full compliance review for each Contractor every three years. This current three-year review cycle spans from CYE 2021 to 2023. In CYE 2020, AHCCCS conducted a compliance review for AzCH-CCP RBHA. In CYE 2021, AHCCCS conducted a compliance review for HCA RBHA and Mercy Care RBHA. Table 4-10 presents program-level and comparative results for the RBHA Program for compliance reviews.

Table 4-10—RBHA Program-Level Compliance Review Results

Focus Areas	AzCH-CCP RBHA	HCA RBHA	Mercy Care RBHA	Program-Level Average
Year Reviewed	**CYE 2020**	**CYE 2021**	**CYE 2021**	
CC	90%	100%	100%	97%
CIS	90%	99%	98%	96%
DS	91%	85%	90%	89%
GA	100%	100%	100%	100%
GS	95%	100%	100%	98%
MCH	87%	96%	100%	94%
MM	98%	96%	96%	97%
MI	95%	98%	98%	97%
QM	97%	100%	99%	98%
QI	100%	94%	98%	97%
DGA	90%	96%	94%	93%
RI	100%	100%	100%	100%
TPL	100%	100%	100%	100%
ISOC	NR+	NR+	NR+	NR+

+ NR = "not reviewed." This Focus Area was not reviewed separately during the compliance review cycle; however, elements of this Focus Area were included in other Focus Areas (e.g., ISOC standards included in MM).

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

Table 4-11 presents program-level strengths, opportunities for improvement, and recommendations for the RBHA Program related to compliance.

Table 4-11—RBHA Program Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
The RBHA Program-level average score was at or above 95 percent in the following Focus Areas: • Corporate Compliance (CC) **[Quality, Access]** • Claims and Information Standards (CIS) **[Access]** • General Administration (GA) **[Timeliness, Access]** • Grievance Systems (GS) **[Timeliness, Access]** • Medical Management (MM) **[Timeliness, Access]** • Member Information (MI) **[Quality]** • Quality Management (QM) **[Quality]** • Quality Improvement (QI) **[Quality, Access]** • Reinsurance (RI) **[Quality]** • Third-Party Liability (TPL) **[Quality, Timeliness, Access]** • Integrated Systems of Care (ISOC) **[Quality, Access]**
Opportunities for Improvement and Recommendations
The RBHA Program-level average score was below 95 percent in the following Focus Areas: • Delivery Systems (DS) **[Timeliness, Access]** • Adult, EPSDT, and Maternal Child Health (MCH) **[Quality, Timeliness, Access]** • Division of Grant Administration (DGA) **[Quality]** Recommendation: HSAG recommends that in advance of the forthcoming ACC-RBHA compliance review, the RBHA Contractors conduct a self-assessment of the DS, MCH, and DSA Focus Area requirements.

Network Adequacy Validation

RBHA Program-Level Results

HSAG's biannual validation of the RBHA Program Contractors' results showed minor discrepancies between the Contractors' self-reported AHCCCS Contractors Operations Manual (ACOM) 436 results and HSAG's time/distance calculations for all Contractors in each quarter for which data could be compared. While minor differences (i.e., less than 1 percentage point) between HSAG's time/distance calculation results and each Contractor's time/distance calculation results were common, these findings are most likely attributable to the timing of the input data, software versions used by each Contractor (refer to Table A-12), or due to a small number of members eligible for inclusion in time/distance calculations for the standard and county.

Table 4-12 summarizes HSAG's assessment of each RBHA Program Contractor's compliance with AHCCCS' minimum time/distance network standards. A check mark indicates that the RBHA Program Contractor met the minimum network standard for all assigned counties during the biannual assessment, and an "X" indicates that the RBHA Program Contractor failed to meet one or more minimum network standards in any assigned county or quarter. Section 5. RBHA Program Contractor-Specific Results contains NAV results specific to each Contractor and biannual validation period.

Table 4-12—Summary of CYE 2022 Compliance with Minimum Time/Distance Network Requirements for RBHA Program Contractors

Minimum Network Requirement	AzCH-CCP RBHA	HCA RBHA	Mercy Care RBHA
Behavioral Health Outpatient and Integrated Clinic, Adult	✓	✓	✓
Behavioral Health Residential Facility (only Maricopa and Pima counties)	✓	NA	✓
Cardiologist, Adult	✓	✓	✓
Cardiologist, Pediatric	✓	✓	✓
Crisis Stabilization Facility (only RBHAs)	X	✓	✓
Dentist, Pediatric	✓	X	✓
Hospital	✓	✓	✓
Obstetrics/Gynecology (OB/GYN)	✓	✓	✓
PCP, Adult	✓	✓	✓
PCP, Pediatric	✓	✓	✓
Pharmacy	✓	✓	✓

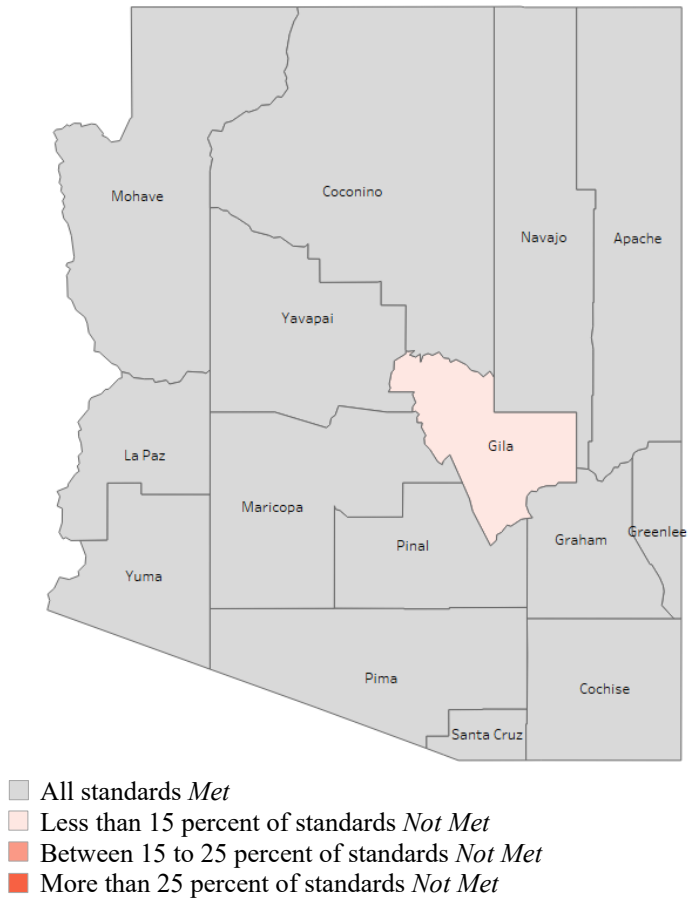
NA indicates the time/distance standard does not apply based on the line of business and county associated with each Contractor.

The RBHA Program Contractors consistently met the Behavioral Health Outpatient and Integrated Clinic, Adult; Behavioral Health Residential Facility; Cardiologist, Adult and Pediatric; Hospital; OB/GYN; Pharmacy; and PCP, Adult and Pediatric standards.

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

Figure 4-2 summarizes how the RBHA Program Contractors performed on meeting the time/distance standards by county as of CYE 2022 Quarter 4 (Q4). Red shading indicates the degree of noncompliance. Specifically, dark red shading indicates more than 25 percent of the standards were *Not Met*, medium red shading indicates between 15 and 25 percent of the standards were *Not Met*, and light red shading indicates less than 15 percent of the standards were *Not Met* in the given county. Gray shading indicates all RBHA Program Contractors met all time/distance standards in the given county.

Figure 4-2—Summary of CYE 2022 Q4 Compliance with Minimum Time/Distance Network Requirements by County for RBHA Program Contractors



Overall, for CYE 2022 Q4, the most recent biannual assessment, all applicable RBHA Program Contractors met all minimum time/distance network requirements for all counties, except for Gila County. Based on the biannual NAV results, Mercy Care RBHA met all requirements for all standards and did not receive saturation analysis results.

Each RBHA Program Contractor should continue to monitor and maintain its existing provider network as of CYE 2022 Q4, with specific attention to ensuring the availability of the following provider types among the applicable RBHA Program Contractors:

- Dentist, Pediatric for HCA RBHA in Gila County

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

Table 4-13 presents program-level strengths, opportunities for improvement, and recommendations for the RBHA Program related to NAV.

Table 4-13—RBHA Program Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
The applicable RBHA Program Contractors met all minimum time/distance network standards in assigned counties for both quarters in CYE 2022, except Gila and La Paz counties.
Opportunities for Improvement and Recommendations
HSAG identified no opportunities for improvement. Recommendation: Although HSAG identified no opportunities for improvement, HSAG recommends that the RBHA Program Contractors: • Seek support from AHCCCS when needed to maintain current compliances • Continue to monitor their processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS

5. RBHA Program Contractor-Specific Results

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

AzCH-CCP RBHA

Validation of Performance Measures

Results for Information Systems Standards Review

HSAG determined that AzCH-CCP RBHA followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

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

Table 5-1—CY 2021 PMV Findings

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

Results for Performance Measures

Table 5-2 presents the CY 2020 and CY 2021 AzCH-CCP RBHA results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and MY 2021. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and/or MY 2021. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 5-2—AzCH-CCP RBHA CY 2020 and CY 2021 Performance Measure Results

Measure	CY 2020 Performance	CY 2021 Performance	2020-2021 Comparison	2021 Performance Level[2]
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	—	73.5%+	—	★
Postpartum Care	69.8%+	59.0%+	→	★
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	51.6%	60.9%	↑	★★★
Effective Continuation Phase Treatment	39.3%	46.2%	↑	★★★
Adherence to Antipsychotic Medications for Individuals with Schizophrenia				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	60.2%	59.6%	→	★★
Follow-Up After ED Visit for AOD Abuse or Dependence				
7-Day Follow-Up—Total	22.0%	22.4%	→	★★★★★
30-Day Follow-Up—Total	30.8%	30.7%	→	★★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total	52.8%	55.4%	→	★★★★
30-Day Follow-Up—Total	70.8%	71.6%	→	★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total	48.5%	49.9%	→	★★★★
30-Day Follow-Up—Total	71.7%	73.6%	→	★★★★
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total	44.3%	46.6%	→	★★★
Engagement of AOD Treatment—Total	14.0%	14.2%	→	★★★
Care of Acute and Chronic Conditions				
Comprehensive Diabetes Care				
*HbA1c Poor Control (>9.0%)**	55.7%+	46.0%+	↑	★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	—	51.6%+	—	★

Measure	CY 2020 Performance	CY 2021 Performance	2020-2021 Comparison	2021 Performance Level[2]
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Med				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	71.4%	77.5%	↑	★★
Heart Failure Admission Rate				
Heart Failure Admission Rate	—	62.3	—	—
Diabetes Short-Term Complication Admission Rate				
Diabetes Short-Term Complications Admission Rate	—	42.0	—	—
Pediatric Health				
Annual Dental Visit				
Annual Dental Visit[1]	—	42.9%	—	★★
Preventive Screening				
Breast Cancer Screening				
Breast Cancer Screening	37.3%	36.2%	→	★
Cervical Cancer Screening				
Cervical Cancer Screening	50.4%+	47.7%+	→	★
Appropriate Utilization of Services				
Ambulatory Care—Total				
*Ambulatory Care—ED Utilization**	—	97.6	—	★
Plan All-Cause Readmissions				
*O/E Ratio—Total**	—	1.2643	—	★
Use of Opioids at High Dosage				
*Use of Opioids at High Dosage**	—	11.3%	—	★

* A lower rate indicates better performance for this measure.

\+ Indicates the measure was reported using hybrid methodology.

Cells shaded green indicate that the rate met or exceeded the MY 2020 and/or MY 2021 national Medicaid mean.

[1] The rates included for the *Annual Dental Visit* measure are limited to members 18–20 years of age. Caution should be considered when comparing the rates to the MY 2020 and/or MY 2021 national Medicaid mean.

— Indicates the CY 2020 rate was not presented in the CYE 2021 Annual Technical Report; therefore, a 2020-2021 comparison is not presented in the CYE 2022 Annual Technical Report.

↑ Indicates improvement of measure rates.

↓ Indicates decline of measure rates.

→ Indicates stable measure rates.

[2]Performance Levels for CY 2021 were based on comparisons of the HEDIS MY 2021 measure rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks.

Performance Levels for 2021 represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

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

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

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health Care measure group: • Ten of 11 (90.9 percent) of AzCH-CCP RBHA's measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 **[Quality, Timeliness, Access]** • AzCH-CCP RBHA's performance measure rates for *Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*, *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*, *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* were above the 75th percentile, indicating strength in providing follow-up care for behavioral health to members **[Quality, Timeliness, Access]**
Opportunities for Improvement and Recommendations
While AzCH-CCP RBHA was successful in reporting valid rates for all AHCCCS-required performance measures for its RBHA population, the audit identified some considerations and recommendations for future years' reporting. **[Quality]** Recommendation: HSAG recommends that AzCH-CCP RBHA continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. Additionally, HSAG recommends that AzCH-CCP RBHA continue to conduct a formal review of its source code followed by a complete test plan, including live system validation of data, prior to reporting any performance measure data. For CY 2022 performance measure reporting, RES will be required based on NCQA HEDIS specifications. **[Quality]**
Recommendation: HSAG recommends that AzCH-CCP RBHA explore data sources for the capture of race/ethnicity data to support future performance measure reporting that may require stratifications related to RES. AzCH-CCP RBHA should continue working with AHCCCS on

Strengths, Opportunities for Improvement, and Recommendations
collaborative efforts to improve the completion and accuracy of race/ethnicity data and explore other methods to augment enrollment data information.
In the Maternal and Perinatal Care measure group, AzCH-CCP RBHA's performance measure rates for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* fell below the 25th percentile, indicating an opportunity to increase access to timely prenatal and postpartum care. Members may have had difficulties finding access to care due to the COVID-19 PHE, or this weakness may be a result of disparities in the population served. **[Quality, Timeliness, Access]** Recommendation: While AzCH-CCP RBHA conducted a root cause analysis and implemented targeted interventions specific to its CY 2020 *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* rates, its rates remained low in CY 2021. HSAG therefore recommends that AzCH-CCP RBHA continue to implement appropriate interventions to improve performance relative to prenatal and postpartum care. HSAG also recommends that AzCH-CCP RBHA monitor and expand upon interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measures.
In the Care of Acute and Chronic Conditions measure group, AzCH-CCP RBHA's performance measure rate for *Controlling High Blood Pressure* fell below the 25th percentile, indicating that not all members were receiving appropriate screenings and treatment for managing blood pressure. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[5-1] **[Quality]** Recommendation: HSAG recommends that AzCH-CCP RBHA conduct a root cause analysis or focus study to determine why some members were not managing their high blood pressure optimally. Upon identification of a root cause, HSAG recommends that AzCH-CCP RBHA implement appropriate interventions to improve performance related to this chronic condition.
In the Preventive Screening measure group, AzCH-CCP RBHA's performance measure rates for *Breast Cancer Screening* and *Cervical Cancer Screening* fell below the 25th percentile, indicating that not all women were receiving timely screening for breast and cervical cancers. Early detection reduces the risk of dying from these types of cancers and can lead to a greater range of treatment options and lower healthcare costs.[5-2] A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. **[Quality]**

[5-1] National Committee for Quality Assurance. Controlling High Blood Pressure. Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Mar 7, 2023.

[5-2] National Committee for Quality Assurance. Breast Cancer Screening (BCS). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Mar 7, 2023.

Strengths, Opportunities for Improvement, and Recommendations
Recommendation: While AzCH-CCP RBHA conducted a root cause analysis and implemented interventions specific to its CY 2020 *Breast Cancer Screening* and *Cervical Cancer Screening* rates, its rates remained low in CY 2021. HSAG therefore recommends that AzCH-CCP RBHA continue to implement appropriate interventions to improve performance related to preventive screenings. HSAG also recommends that AzCH-CCP RBHA monitor and expand upon interventions currently in place to improve performance related to the *Breast Cancer Screening* and *Cervical Cancer Screening* measures.
In the Appropriate Utilization of Services measure group: • AzCH-CCP RBHA's performance measure rate for *Use of Opioids at High Dosage* fell below the 25th percentile. This result provides an opportunity for AzCH-CCP RBHA to monitor prescribing and utilization data and to implement interventions to improve care and services around opioid prescribing. The Centers for Disease Control and Prevention (CDC) guideline on opioid prescribing for chronic, nonmalignant pain recommends the use of "additional precautions" when prescribing dosages ≥50 morphine equivalent dose (MED) and recommends providers avoid or "carefully justify" increasing dosages ≥90 mg MED.[5-3] **[Quality]** Recommendation: HSAG recommends that AzCH-CCP RBHA conduct a root cause analysis or focus study to determine why there was a higher proportion of members receiving prescriptions for opioids. Upon identification of a root cause, HSAG recommends that AzCH-CCP RBHA implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse. • AzCH-CCP RBHA's performance measure rates for *Plan All-Cause Readmissions O/E Ratio—Total* fell below the 25th percentile **[Quality]** Recommendation: HSAG recommends that AzCH-CCP RBHA identify best practices for reducing unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay. HSAG also recommends that AzCH-CCP RBHA consider conducting a root cause analysis to identify factors contributing to members experiencing unplanned acute readmissions, which should include evaluating that appropriate follow-up care is available to members upon discharge from an acute inpatient admission or observation.

[5-3] National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/. Accessed on: Mar 7, 2023.

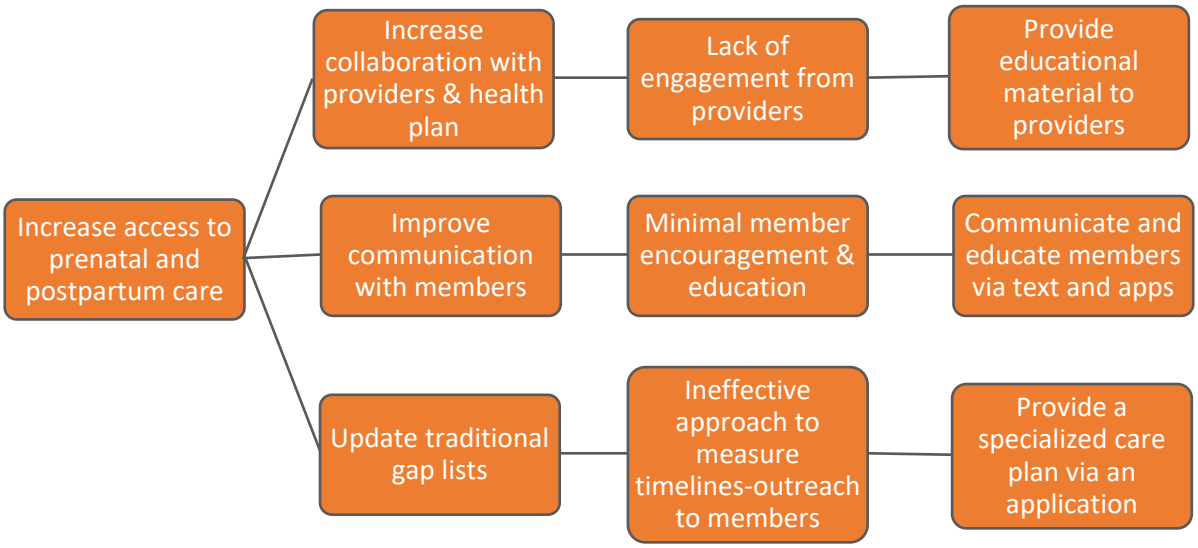
Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Table 5-4 presents performance measure recommendations made to AzCH-CCP RBHA in the CYE 2021 Annual Technical Report[5-4] and AzCH-CCP RBHA's follow-up to the recommendations, as well as an assessment of the degree to which AzCH-CCP RBHA has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

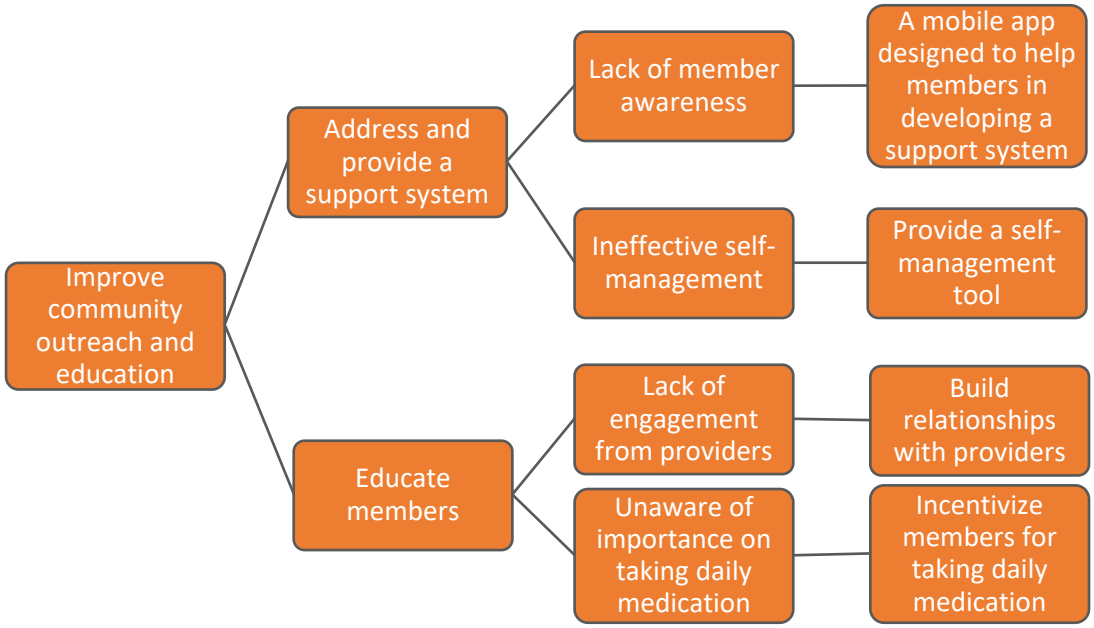
Table 5-4—AzCH-CCP RBHA Follow-Up to CY 2021 Performance Measure Recommendations

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
Recommendation 1:
HSAG recommended that AzCH-CCP RBHA ensure the mapping of provider specialties to HEDIS provider types is compliant with AHCCCS guidance for reporting performance measures where provider specialty type is required.
AzCH-CCP RBHA's Response:
AzCH-CCP RBHA has implemented mapping that is compliant with AHCCCS guidance for reporting performance measures of provider specialties.
HSAG's Assessment:
During CY 2021 PMV, AzCH-CCP RBHA's provider mapping fully aligned with AHCCCS guidance for reporting performance measures where provider specialty type is required. HSAG has therefore determined that AzCH-CCP RBHA has satisfactorily addressed the prior year's recommendation.
Recommendation 2:
HSAG recommended that AzCH-CCP RBHA conduct a formal review of its source code followed by a complete test plan, including live system validation of data, prior to reporting any performance measure data.
AzCH-CCP RBHA's Response:
AzCH-CCP RBHA has implemented standardized processes for formal code reviewal, testing, and verifications to ensure the performance measure data are reported correctly.
HSAG's Assessment:
During CY 2021 PMV, AzCH-CCP RBHA demonstrated implementation of a process to conduct formal source code review, followed by a complete test plan, including live system validation of data, prior to reporting any performance measure data. HSAG has therefore determined that AzCH-CCP RBHA has satisfactorily addressed the prior year's recommendation.

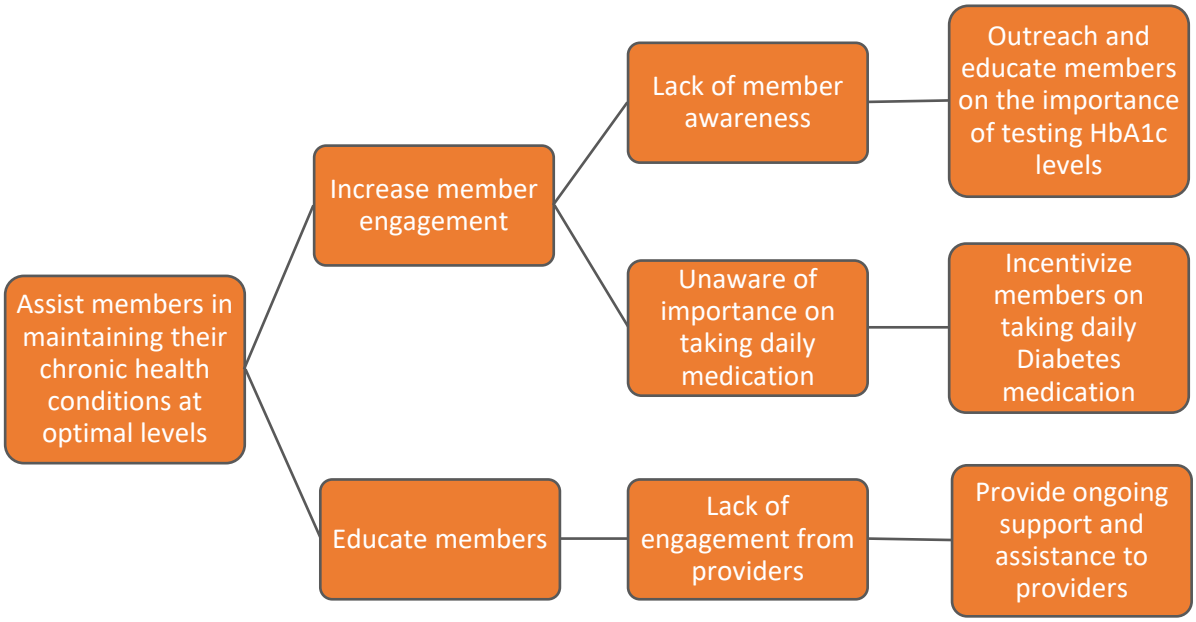
[5-4] Contract Year Ending 2021 External Quality Review Annual Technical Report for Regional Behavioral Health Authorities Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-RBHA.pdf. Accessed on: Dec 29, 2022.

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
Recommendation 3:
HSAG recommended that AzCH-CCP RBHA conduct a root cause analysis to determine why female members were not receiving timely postpartum care. AzCH-CCP RBHA should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of family planning service providers, or the need for improved community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions Additionally, AzCH-CCP RBHA should identify factors related to the COVID-19 public health emergency (PHE) and how access to care was impacted. Upon identification of a root cause, AzCH-CCP RBHA should implement appropriate interventions to improve the performance related to postpartum care.
AzCH-CCP RBHA's Response:
AzCH-CCP RBHA's performance measure rate for Prenatal and Postpartum Care fell below the 25th percentile, indicating an opportunity to increase access to timely postpartum care. The root cause analysis focuses on increasing access to postpartum care by identifying those barriers such as collaboration with providers and the health plan, successful communication with members, and effective gap lists. In response to identified barriers, AzCH-CCP RBHA reported that the following interventions were implemented: • Start Smart for your Baby (SSFB) effectively educates and encourages members via text messaging and emails. The SSFB Text and Email Program added total of 183 members in Q4, rounding out the year with a total of 434 members engaged. • Prenatal and Postpartum Care (PPC) Provider Form supplies providers with educational material and engages providers for education, technical assistance, and performance improvement. • Wellframe mobile application provides a specialized care plan. See the driver diagram below showcasing the root cause analysis. 

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
HSAG's Assessment: AzCH-CCP RBHA identified interventions that were implemented for CY 2021 as a result of conducting a root cause analysis, however the rate remained low in CY 2021. While opportunity remains to improve its rate, HSAG has determined that AzCH-CCP RBHA satisfactorily addressed the prior year's recommendation.
Recommendation 4:
HSAG recommended that AzCH-CCP RBHA conduct a root cause analysis to determine why members taking an antidepressant were not receiving continuous medication treatment. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. AzCH-CCP RBHA should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care or the need for improved community outreach and education), including any factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, AzCH-CCP RBHA should implement appropriate interventions to improve the performance related to these measures.
AzCH-CCP RBHA's Response: AzCH-CCP RBHA's performance measure rates for Antidepressant Medication Management—Effective Acute Phase Treatment and Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications fell below the 25th percentile. The root cause analysis focuses on improving community outreach and education. The barriers identified were need of a support system and lack of education. Interventions in place in response to the barriers are: • A mobile application designed to help members in developing a support system and support members with social determinants of health. At the end of CY 2021, a total of 1,619 members were onboarded and active within the application. • A self-management tool that members can utilize through the AzCH-CCP member portal. Over the course of CY 2021, a total of 62.8% (486) of new users completed a health assessment through the tool, with 33.1% enrolling into one of the self-guided behavioral change programs. • A vendor to build relationships with providers to increase performance and member satisfaction, improve knowledge. • A medication adherence reward program which incentivizes members for taking daily medication. The program had a total of 2,770 members enrolled at the end of CY 2021. See the driver diagram below showcasing the root cause analysis.

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

HSAG's Assessment: AzCH-CCP RBHA identified interventions that were implemented for CY 2021 as a result of conducting a root cause analysis; therefore, HSAG determined that AzCH-CCP RBHA satisfactorily addressed the prior year's recommendation.
Recommendation 5:
HSAG recommended that AzCH-CCP RBHA conduct a root cause analysis or focus study to determine why members were not maintaining their chronic health conditions at optimal levels or why some adult members were experiencing issues with access to care. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, AzCH-CCP RBHA should implement appropriate interventions to improve the performance related to this chronic condition.
AzCH-CCP RBHA's Response: AzCH-CCP RBHA's performance measure rate for Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%) fell below the 25th percentile, indicating that although members with chronic conditions may have had access to care, they were not able to manage their conditions according to evidence-based guidelines through the appropriate use of medications, diet and nutrition, or physical activity. The root cause analysis focuses on assisting members in maintaining their chronic health conditions at optimal levels. The barriers identified were member engagement and collaboration with providers and the health plan. In response to identified barriers the following interventions were implemented: • A medication adherence reward program incentivizes members to take their daily diabetes medication. The program had a total of 2,770 members enrolled at the end of CY 2021.

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
• A vendor to build relationships with providers to increase performance and member satisfaction. • An HbA1c Health Tag Campaign adds health messages attached with the member's prescription to educate and remind the member about the need for HbA1c testing. The campaign ran from May-August with a total of 2,918 members receiving the health tag attached to their prescription. See the driver diagram below showcasing the root cause analysis.



HSAG's Assessment:

AzCH-CCP RBHA identified interventions that were implemented for CY 2021 as a result of conducting a root cause analysis; therefore, HSAG determined that AzCH-CCP RBHA satisfactorily addressed the prior year's recommendation.

Recommendation 6:

HSAG recommended that AzCH-CCP RBHA conduct a root cause analysis or focus study to determine why its female members were not receiving timely screenings for breast and cervical cancers. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, AzCH-CCP RBHA should implement appropriate interventions to improve the performance related to preventive screenings.

AzCH-CCP RBHA's Response:

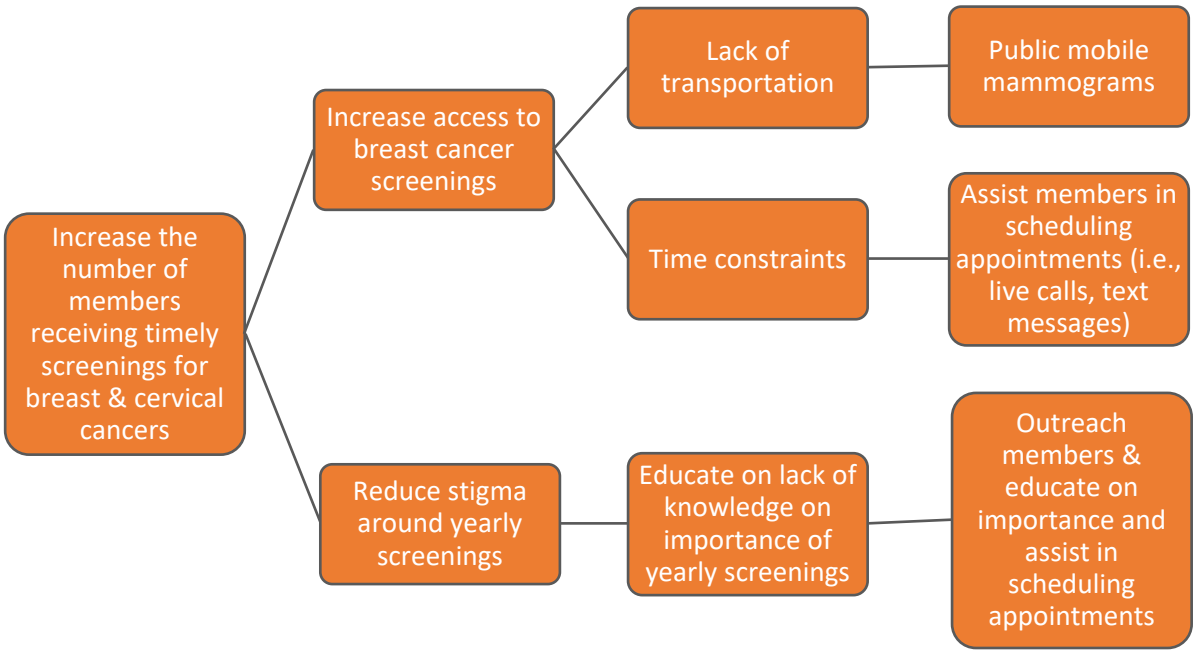
AzCH-CCP RBHA's performance measure rates for Breast Cancer Screening and Cervical Cancer Screening fell below the 25th percentile, indicating that women were not receiving timely screening for breast and cervical cancers. The root cause analysis focuses on increasing the number of members receiving timely screenings and looking at those barriers affecting members, such as access to

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

care/services, scheduling of appointments, and education. Interventions in place in response to the barriers identified were:

- Mobile mammogram events increase access to members as they are open to the public.
- Collaboration with an imaging vendor consisted of direct outreach. With a 6.4% outreach rate from June through September 2021, 6.4% of members successfully contacted scheduled a mammogram appointment.
- A call campaign served as an initiative to educate, encourage, and assist members to schedule necessary appointments; Year to date the blitz call campaign had a successful reach rate of 11%.

See the driver diagram below showcasing the root cause analysis.



HSAG's Assessment:

AzCH-CCP RBHA identified interventions that were implemented for CY 2021 as a result of conducting a root cause analysis. While opportunity remains to improve its *Breast Cancer Screening* and *Cervical Cancer Screening* rates, HSAG has determined that AzCH-CCP RBHA satisfactorily addressed the prior year's recommendation.

Validation of Performance Improvement Projects

In CY 2022, AzCH-CCP RBHA continued the *Preventive Screening* PIP, which was initiated in CYE 2019. As CY 2022 was an intervention year for this PIP, PIP validation activities focus on intervention analysis. AzCH-CCP RBHA submitted interventions implemented during CY 2022 along with the

intervention status, focus, and rationale for changes or possible discontinuation of the intervention for the following year.

AHCCCS will conduct an annual validation of the first remeasurement year reflective of CY 2022 (January 1, 2022, through December 31, 2022) using HSAG-calculated and validated indicator rates. AHCCCS will evaluate AzCH-CCP RBHA's performance based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in Appendix A. Methodology—Validation of Performance Improvement Projects—How Conclusions Were Drawn.

Results

HSAG determined that the PIP has a preliminary validation status of *Met*, based on valid and reliable rate calculation. Validation status based on whether significant or sustained improvement was achieved will be assessed following completion of interventions and final calculation of measures.

Table 5-5 and Table 5-6 provide the *Preventive Screening* PIP baseline and intervention year rates for each indicator for AzCH-CCP RBHA.

Table 5-5—AzCH-CCP RBHA *Preventive Screening* PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: *Breast Cancer Screening*		
	Baseline Year	Intervention Year 1	Intervention Year 2
	CYE 2019*	CY 2020	CY 2021
AzCH-CCP RBHA	38.5%	37.3%	36.2%

*The CYE 2019 indicator rate was calculated by HSAG utilizing AHCCCS data.

Table 5-6—AzCH-CCP RBHA *Preventive Screening* PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: *Cervical Cancer Screening*		
	Baseline Year	Intervention Year 1	Intervention Year 2
	CYE 2019*	CY 2020	CY 2021
AzCH-CCP RBHA	43.9%	50.4%	47.7%

*The CYE 2019 indicator rate was calculated by HSAG utilizing AHCCCS data.

Interventions

Table 5-7 presents PIP interventions that AzCH-CCP RBHA reported for CY 2022. Language in the PIP interventions section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-7—AzCH-CCP RBHA *Preventive Screening* PIP Interventions

Contractor	Intervention
AzCH-CCP RBHA	• Mobile Mammograms events to increase access to breast cancer screenings. Please note these events are open to the public to encourage breast cancer screening, provide education, and reduce stigma. • Collaboration with a vendor to add health messages attached with the member's prescription to educate and remind the member about the need for breast cancer screenings. • Collaboration with a vendor to outreach members to provide education, encouragement, and assistance with scheduling appointments and removing barriers to care. • Utilize internal staff to conduct call campaigns that educate, encourage and assist members to scheduled necessary appointments. • Multi-prong member outreach campaigns consisting of mailers, emails and text messages to educate and encourage members to obtain needed screenings and tests. • Promotoras are community service workers who conduct outreach to members in Yuma and Maricopa who have identified care gaps. They assist in scheduling appointments and manage barriers to completing those appointments. • Collaboration with American Cancer Society to create a motivational interviewing (MI) training for providers with cervical cancer screening as a focus. • Education and promotion of an annual member incentive for members who obtain their cervical cancer screening. • Quality Management (QM) and Care Management (CM) implemented a CM and QM Collaboration Workgroup which meets bi-weekly to coordinate efforts, refine interventions, and identify barriers and opportunities. • QM and CM Partnership, a program of training staff on necessity of cervical and breast cancer screenings. QM provided desktop talking points, vendor resource information, and vendor-based letters to send out to members. CM is inputting touchpoints with members into the vendor HEDIS Structured Notes. • Behavioral Health Residential Facility (BHRF) Outreach where QM staff will be educating BHRF staff on the importance of cervical cancer screening and CHL screenings for members in residence, as well as coordinating with members to obtain such services.

Contractor	Intervention
	• BHRF Outreach where QM staff will be educating & coordinating with members to obtain breast cancer and cervical cancer screenings. • Health Fairs with focuses on completing breast cancer screenings and provide scheduling assistance for cervical cancer screenings. • Breast Cancer Screening and Cervical Cancer Screening have been added to high impact value-based payment (VBP) contracts for greater impact and provider incentivization. • Radiology Partnerships for Rural Communities: Expanding Mobile Mammogram Program to focus specifically on rural & tribal communities.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-8 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP RBHA related to PIPs, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-8—AzCH-CCP RBHA Strengths, Opportunities for Improvement, and Recommendations Related to PIPs

Strengths, Opportunities for Improvement, and Recommendations
Strengths
AzCH-CCP RBHA developed and implemented interventions that may lead to improvement in indicator outcomes. **[Quality]** HSAG noted that for indicator 2, AzCH-CCP RBHA's intervention year 1 indicator rate showed a 6.5 percentage point increase from the baseline year indicator rate. Although the intervention year 2 indicator rate for indicator 2 showed a decline of 2.7 percentage points from the intervention year 1 indicator rate, the intervention year 2 indicator rate remained 3.8 percentage points above the baseline year indicator rate. **[Quality]**
Opportunities for Improvement and Recommendations
For indicator 1, AzCH-CCP RBHA showed a 1.2 percentage point decline in the indicator rate between the baseline year and intervention year 1. Between intervention year 1 and intervention year 2, the indicator rate continued to decline by just over 1 percentage point. When compared to the baseline year indicator rate, the intervention year 2 indicator rate was 2.3 percentage points below the baseline year rate. The decline noted in the indicator 1 rate may indicate that the COVID-19 PHE had an impact on the rates of compliance with the breast cancer screenings for AzCH-CCP RBHA. **[Quality]** Recommendation: As the PIP progresses, HSAG recommends that AzCH-CCP RBHA:

Strengths, Opportunities for Improvement, and Recommendations
• Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary • Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available • Develop and document a plan for sustaining the improvement for any demonstrated improvement in indicator rates

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

Table 5-9 presents PIP recommendations made to AzCH-CCP RBHA in the CYE 2021 Annual Technical Report[5-5] and AzCH-CCP RBHA's follow-up to the recommendations, as well as an assessment of the degree to which AzCH-CCP RBHA has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-9—AzCH-CCP RBHA Follow-Up to CY 2021 PIP Recommendations

Prior Year's Recommendation from the EQR Technical Report for PIPs
While the PIP is in an intervention year and no opportunities for improvement have been identified, HSAG recommended that AzCH-CCP RBHA should continue to implement identified interventions and assess the impact and effectiveness of the interventions after the first remeasurement year.
AzCH-CCP RBHA's Response: While the PIP is in an intervention year and no opportunities for improvement have been identified, AzCH-CCP RBHA will assess the impact and effectiveness of the interventions. AzCH-CCP RBHA monitors the impact and effectiveness of interventions routinely throughout the year.
HSAG's Assessment: HSAG reviewed AzCH-CCP RBHA's PIP intervention submission, which detailed interventions implemented in CY 2022, whether the intervention will be continued, and the rationale for intervention changes or discontinuation. HSAG has determined that AzCH-CCP RBHA has satisfactorily continued to implement interventions, based on activities completed in CY 2022.

[5-5] Contract Year Ending 2021 External Quality Review Annual Technical Report for Regional Behavioral Health Authorities Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-RBHA.pdf. Accessed on: Dec 29, 2022.

Compliance Reviews

AHCCCS conducts a full compliance review for each Contractor every three years. AHCCCS conducted a compliance review of AzCH-CCP RBHA in February 2020. The final report results were published in the *Contract Year Ending 2021 External Quality Review Annual Technical Report for Regional Behavioral Health Authorities*.[5-6] Results of the report as well as corrective action plan (CAP) follow-up details are provided below.

In November 2021, AHCCCS awarded AzCH-CCP a new ACC-RBHA contract, expanding the current RBHA contract. As a result, the Contractor went through an extensive readiness review, which was conducted from April through October 2022.

AHCCCS stated that it recognizes the criticality of member transitions and the readiness of a Contractor to deliver care and services under a new contract award. The readiness review process is paramount to a successful implementation and seamless transition for members. To that end, AHCCCS has implemented an extensive readiness review process for all Contractors awarded new AHCCCS contracts.

AHCCCS stated that it views the readiness review process as an ongoing series of activities to monitor and ensure Contractor progress. AHCCCS initiates the readiness review process roughly six months prior to the contract effective date. These readiness activities are essential to establishing the capacity of the awarded Contractors to function in a number of critical areas, including operations and administration, service delivery, financial management, and systems management. The AzCH-CCP ACC-RBHA contract began October 1, 2022. Future compliance reviews will be for the ACC-RBHA contract/LOB.

Results

AHCCCS conducted a compliance review of AzCH-CCP RBHA from February 18–21, 2020. AHCCCS provided AzCH-CCP RBHA with a draft report for review on April 26, 2021. AzCH-CCP RBHA was given a period of one week in which to file a challenge to any findings it did not feel were accurate based on the evidence available at the time of review. AHCCCS finalized the AzCH-CCP RBHA compliance report on May 24, 2021, and requested that AzCH-CCP RBHA provide a CAP for items that required attention. AzCH-CCP RBHA and AHCCCS worked together to develop a suitable plan for achieving compliance. In a letter dated August 11, 2022, AHCCCS stated that it agreed with all of the proposed steps in AzCH-CCP RBHA's CAP. AHCCCS also provided AzCH-CCP RBHA with a final version of the CAP matrix.

In the CYE 2020 compliance review, AzCH-CCP RBHA scored 95 percent or above in the GA, GS, MM, MI, QM, QI, RI, and TPL Focus Areas. While not at or above 95 percent, AzCH-CCP RBHA

[5-6] Contract Year Ending 2021 External Quality Review Annual Technical Report for Regional Behavioral Health Authorities Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-RBHA.pdf. Accessed on: Jan 7, 2023.

was found to be above the RBHA Program average in the DS Focus Area, with a score of 91 percent. Table 5-10 presents AzCH-CCP RBHA's results from the recent compliance review as well as the program-level average for each Focus Area.

Table 5-10—AzCH-CCP RBHA Compliance Results Compared with RBHA Program-Level Average Results

Focus Areas	AzCH-CCP RBHA	Program-Level Average
Year Reviewed	**CYE 2020**	
CC	90%	97%
CIS	90%	96%
DS	91%	89%
GA	100%	100%
GS	95%	98%
MCH	87%	94%
MM	98%	97%
MI	95%	97%
QM	97%	98%
QI	100%	97%
DGA	90%	93%
RI	100%	100%
TPL	100%	100%
ISOC	NR+	NR+

+ NR = "not reviewed." This Focus Area was not reviewed separately during the compliance review cycle; however, elements of this Focus Area were included in other Focus Areas (e.g., ISOC standards included in MM).

Strengths, Opportunities for Improvement, and Recommendations

Table 5-11 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP RBHA related to compliance, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement. A full analysis including detailed recommendations was provided in the CYE 2021 technical report.[5-7]

[5-7] Contract Year Ending 2021 External Quality Review Annual Technical Report for Regional Behavioral Health Authorities Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-RBHA.pdf. Accessed on: Jan 18, 2023.

Table 5-11—AzCH-CCP RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
AzCH-CCP RBHA scored at or above 95 percent in the following Focus Areas: • General Administration (GA) **[Timeliness, Access]** • Grievance Systems (GS) **[Timeliness, Access]** • Medical Management (MM) **[Timeliness, Access]** • Member Information (MI) **[Quality]** • Quality Management (QM) **[Quality]** • Quality Improvement (QI) **[Quality, Access]** • Reinsurance (RI) **[Quality]** • Third-Party Liability (TPL) **[Quality, Timeliness, Access]**
Opportunities for Improvement and Recommendations
AzCH-CCP RBHA scored below 95 percent in the following Focus Areas: • Corporate Compliance (CC) **[Quality, Access]** • Claims and Information Standards (CIS) **[Access]** • Delivery Systems (DS) **[Timeliness, Access]** • Adult, EPSDT, and Maternal Child Health (MCH) **[Quality, Timeliness, Access]** • Division of Grant Administration (DGA) **[Quality]** Recommendation: HSAG recommends that AzCH-CCP RBHA conduct a self-assessment of the CC, CIS, DS, MCH, and DGA requirements and the recommendations HSAG offered in CYE 2021 (see Table 5-12) to ensure ongoing compliance.

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

Table 5-12 presents compliance recommendations made to AzCH-CCP RBHA in the CYE 2021 Annual Technical Report[5-8] and AzCH-CCP RBHA's follow-up to the recommendations, as well as an assessment of the degree to which AzCH-CCP RBHA has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally

[5-8] Contract Year Ending 2021 External Quality Review Annual Technical Report for Regional Behavioral Health Authorities Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-RBHA.pdf. Accessed on: Dec 29, 2022.

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

Table 5-12—AzCH-CCP RBHA Follow-Up to CY 2021 Compliance Recommendations

Prior Year's Recommendation from the EQR Technical Report for Compliance
HSAG recommended the following to AzCH-CCP RBHA: • Work to ensure that timeliness measures are adhered to through staff training and/or monitoring • Ensure that current policies and documents include adequate details of its processes • Strategize to ensure that its system and provider findings are reviewed to ensure compliance with State and federal requirements • Focus effort on ensuring that special populations, such as EPSDT members and pregnant women, have appropriate access, treatment, monitoring, follow-up, and tracking as required
AzCH-CCP RBHA's Response: In response to the 2020 compliance review, AzCH-CCP RBHA implemented a detailed corrective action plan. This plan included: • Completed trainings covering all aspects of the identified timeliness issues, as well as implementing revisions of monitoring systems to correct the identified gaps. • Completed an in-depth review of all Quality policies and applicable processes to correct any additional deficiencies. AzCH-CCP RBHA has a dedicated Quality staff member whose tasks include reviewing all applicable AHCCCS Medical Policy Manual (AMPM), ACOM, and contract changes that are applicable to Quality and coordinate with the identified subject matter expert to ensure all policies and applicable processes are appropriate, detailed and up to date. • Implemented processes to ensure compliance with State and federal requirements is occurring with the appropriate health plan oversight and monitoring. • Reviewed all EPSDT communications for appropriateness and completed revisions where necessary, internal processes to ensure coordination with appropriate agencies and programs are occurring and completed training with the applicable staff to support special populations with appropriate access to care and on-going monitoring.
HSAG's Assessment: HSAG has determined that AzCH-CCP RBHA has satisfactorily addressed the prior year's recommendation.

Network Adequacy Validation

Results

HSAG evaluated AzCH-CCP RBHA's compliance results with AHCCCS' time/distance standards by geographic service area (GSA) and county. This section presents biannual validation findings specific to the RBHA LOB, with one results table for the following GSA:

- South GSA: Cochise, Graham,[5-9] Greenlee, La Paz, Pima, Pinal, Santa Cruz,[5-10] and Yuma counties

Each region-specific table summarizes biannual validation results containing the percentage of members meeting each time/distance standard by quarter and county, with color coding to identify whether the time/distance standard was *Met* or *Not Met.* The value "NA" is shown for time/distance standards that do not apply to the county or RBHA LOB. The value "NR" is shown for time/distance standards in which no members met the network requirement denominator for the RBHA LOB and county; therefore, HSAG calculated no corresponding time/distance result.

Yellow color coding identifies instances in which HSAG's time/distance results met the minimum network requirement but differed from the ACOM 436 results. Red color coding identifies instances in which HSAG's time/distance results that did not meet the compliance standard, regardless of the ACOM 436 results.

An asterisk (*) indicates that fewer than 10 members were included in the denominator of HSAG's results. A carat (^) indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified Telehealth time/distance standard established by AHCCCS.

Table 5-13—AzCH-CCP RBHA Time/Distance Validation Results for South GSA—Percentage of Members Meeting Minimum Network Requirements

	Cochise		Graham		Greenlee		La Paz		Pima		Pinal		Santa Cruz		Yuma	
Minimum Network Requirement	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100	100^	100	100^	100	100	100	100^	98.1	98.0^	100	100^	100	100^	99.7	99.9^
Behavioral Health Residential Facility (only Maricopa and Pima counties)	NA	NA	NA	NA	NA	NA	NA	NA	95.2	95.1	NA	NA	NA	NA	NA	NA
Cardiologist, Adult	100	100^	100	100^	100	100	100	100^	99.5	99.5^	100	100^	100	100	100	100^

[5-9] Graham County includes the 85542, 85192, and 85550 ZIP codes representing the San Carlos Tribal area; these ZIP codes are physically located in Gila or Pinal County.

[5-10] Santa Cruz County includes the 85645 ZIP code; this ZIP code is physically located in both Pima and Santa Cruz counties.

Minimum Network Requirement	Cochise		Graham		Greenlee		La Paz		Pima		Pinal		Santa Cruz		Yuma	
	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4
Cardiologist, Pediatric	100*	100*^	100*	100*^	NR*	NR*	100*	NR*^	100	99.1^	100	100^	100*	100*	100	100*^
Crisis Stabilization Facility (only RBHAs)	99.8	99.8	99.5	98.9	100	100	89.6	95.2	98.3	98.2	100	100	100	100	99.7	99.9
Dentist, Pediatric	100*	100*	100*	100*	NR*	NR*	100*	NR*	98.1	99.1	100	100	100*	100*	100	100*
Hospital	100	100	100	100	100	100	100	100	99.7	99.7	100	100	100	100	100	100
OB/GYN	100	100	100	100	100*	100*	100	100	99.7	99.8	100	100	100	100	100	100
Pharmacy	99.7	99.6	99.0	98.9	100	100	92.2	96.8	98.4	98.6	100	100	100	100	99.7	99.9
PCP, Adult	99.8	99.8^	98.5	98.9^	100	100^	100	100^	99.9	99.9^	100	100^	100	100^	99.7	99.9^
PCP, Pediatric	100*	100*^	100*	100*^	NR*	NR*^	100*	NR*^	98.1	99.1^	100	100^	100*	100*^	100	100*^

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
represents time/distance standard results that do not meet the compliance standard based on HSAG's results.
represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.

* indicates fewer than 10 members were included in the denominator of HSAG's results.

^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified Telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-14 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP RBHA related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

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

Strengths, Opportunities for Improvement, and Recommendations
Strengths
AzCH-CCP RBHA met all time/distance network standards for all assigned counties in CYE 2022 Q4. **[Access]** Note: AzCH-CCP RBHA provides coverage in the following counties: Cochise, Graham, Greenlee La Paz, Pima, Pinal, Santa Cruz, and Yuma.
Opportunities for Improvement and Recommendations
HSAG identified no opportunities for improvement for AzCH-CCP RBHA. Recommendation: While HSAG identified no opportunities for improvement, HSAG recommends that AzCH-CCP RBHA:

Strengths, Opportunities for Improvement, and Recommendations
• Continue to monitor its processes for creating the PAT files and review the PAT file for accuracy prior to submitting to AHCCCS • Maintain current compliances

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

Table 5-15 presents NAV recommendations made to AzCH-CCP RBHA in the CYE 2021 Annual Technical Report[5-11] and AzCH-CCP RBHA's follow-up to the recommendations, as well as an assessment of the degree to which AzCH-CCP RBHA has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-15—AzCH-CCP RBHA Follow-Up to CY 2021 NAV Recommendations

Prior Year's Recommendation from the EQR Technical Report for NAV
HSAG recommended the following to AzCH-CCP RBHA: • Continue to monitor its processes for creating the PAT files and review the PAT file for accuracy prior to submitting to AHCCCS • AzCH-CCP RBHA should continue to monitor and maintain its existing provider network coverage
AzCH-CCP RBHA's Response: AzCH-CCP RBHA will continue to monitor its processes for creating the PAT files and review the PAT file for accuracy prior to submitting to AHCCCS. Additionally, AzCH-CCP RBHA continues to monitor and maintain its existing provider network coverage with on-going evaluation and outreach to expand where able.
HSAG's Assessment: Based on the CYE 2022 NAV results and the response provided by AzCH-CCP RBHA, HSAG has determined that AzCH-CCP RBHA has satisfactorily addressed the prior year's recommendation.

[5-11] Contract Year Ending 2021 External Quality Review Annual Technical Report for Regional Behavioral Health Authorities Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-RBHA.pdf. Accessed on: Dec 29, 2022.

AzCH-CCP RBHA Best and Emerging Practices

Table 5-16 presents the best and emerging practices provided by AzCH-CCP RBHA for CYE 2022. HSAG made only minor edits to AzCH-CCP RBHA's submission to enhance readability. Best practice responses may be based on Contractor internal data and not EQR validated rates.

Table 5-16—AzCH-CCP RBHA Best and Emerging Practices

AzCH-CCP RBHA Best and Emerging Practices—Medical Report Case Logic Initiative
The Medical Record Chase Logic Initiative was implemented in CYE 2022 Q3 to increase the yield in medical record retrieval for quality gap closure by collaboratively working with internal teams such as the HEDIS team, Quality Analytics, and external provider groups. Rationale: The HEDIS team worked with a vendor to adjust methodologies and derive a new report based on claims logic in an effort to increase the yield in medical record retrieval and subsequently increase quality measure performance. Reports included a focus on open care gaps with the associated provider along with specialty providers who may have seen the member anytime during the measurement year. Goal: To further advance medical record retrieval for the improvement of care gap closure on performance measures that can be impacted through hybrid methodology abstraction. Related Interventions: AzCH-CCP RBHA has multiple interventions focused on improving medical record retrieval and member health outcomes with new reporting based on claims logic. Increased efforts to maximize opportunities around electronic medical record system access (EMR) and supplemental data feeds from contracted provider groups, including: • Targeted outreach to provider groups to educate on the impact of granting access to electronic medical record systems and establishing supplemental data feeds with the health plan • Increased opportunity for information sharing of member outcomes and care gap closure • Reduction in staff and provider burden of manually pulling medical records to supply to the health plan Outcomes: AzCH-CCP RBHA has achieved a significant increase in the number of charts reviewed and care gaps closed during a three-month span in 2022. Through the implementation of new methodologies and collaborations with internal teams, AzCH-CCP RBHA can identify those significant increases in measures like Breast Cancer Screening. Since adopting the new process, measures like BCS have seen a significant increase in the number of charts reviewed and total number of gaps closed in 2022.

BCS	Charts reviewed	Records Found	% Gap Closed
RBHA	150	81	54%

Timespan Sep-Nov 2022

AzCH-CCP RBHA Best and Emerging Practices—Medical Report Case Logic Initiative
AzCH-CCP RBHA had a significant increase in the percentage of positive evidence of completed BCS within three months, with a rate of 54% for RBHA. In comparison, for 2021, AzCH-CCP RBHA had a rate of 16% return for all lines of business. As this new process has shown tremendous success in a short amount of time, AzCH-CCP RBHA anticipates an increase in the contracted performance measures across the board as well as positive member outcomes by the end of the measurement year 2022 HEDIS season.

AzCH-CCP RBHA Best and Emerging Practices—Healthy Equity Committee

The Health Equity Committee has been created to assist in identifying health disparities and developing strategies to ensure health equity for served populations. The committee is responsible for overseeing and managing health equity considerations as they relate to policy, data, health plan oversight and emerging healthcare innovation strategies.

Rationale:
AzCH-CCP RBHA understands that 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 healthcare disparities.

The Agency for Health Care Research and Quality's (AHRQ's) 2022 National Healthcare Quality and Disparities Report determined "Overall, racial and ethnic minority communities have similar outcomes as White communities for just under half of quality-of-care measures. However, when disparities exist, racial and ethnic minority communities exhibit worse outcomes than White communities on a larger number of measures than better outcomes. For example, American Indian and Alaska Native communities have worse quality of care than White communities on 43% of measures and better outcomes on only 12% of measures."

Goal:
This committee strives for the attainment of the highest level of health for all served members by working to understand current initiatives, develop baseline data, make recommendations to decrease health disparities and promote health equity, while avoiding duplication of efforts.

Related Interventions:

- Community health workers (Promotoras) are a direct connection to the community and are instrumental in connecting members with open care gaps to needed services
- Collaboration with a vendor to target members experiencing homelessness who have been discharged from in patient to complete follow-up visits
- Communication, Access, Respect, Education (CARE) Task Force which meets monthly for 90 minutes focusing on specific topics related to member experience and clinical performance measures

Outcomes:
The Health Equity Committee has identified performance measures based on AHCCCS contracted withhold measures and NCQA required health equity measures. The Health Equity Committee is evaluating the disparity data on an ongoing basis and working to effectively reduce disparities

AzCH-CCP RBHA Best and Emerging Practices—Healthy Equity Committee
through a variety of interventions such as the ones listed within the related intervention section above. This committee also strives to increase staff awareness and knowledge of the health disparities affecting AzCH-CCP RBHA populations, so a cross functional approach is ingrained into future analysis.

AzCH-CCP RBHA Best and Emerging Practices—CARE Task Force
CARE is a cross-functional task force focused on promoting agents of change, streamlining processes and resources to improve positive interactions and ease of contact internally and externally. CARE is a collaboration of departmental representatives from across the organization that meet monthly focusing on specific topics related to member experience and clinical performance measures. This group was designed with the intent to encourage discussions on impacting member experience as a department and an organization. Rationale: Increasing consistent and on-going internal cross-functional collaboration expands the capabilities of all staff to approach each member engaged from the best possible position to ensure the best possible health outcome. As AzCH-CCP RBHA works to transform the whole health of each member, building that mindset into company culture is a must to be successful. Goal: CARE Task Force focuses on promoting agents of change, streamlining processes, and providing resources to improve positive interactions and ease of contact both internally and externally. Related Interventions: • Health Equity Committee: This group will share best practices and lessons learned in health equity to be transparent and embrace continuous improvement • CAHPS Champions: mission is to educate on member experience & model positive interactions • Care Management & Quality Improvement Collaboration Workgroup Outcomes: CARE is a collaboration of departmental representatives with attendance ranging from 30 to 40 participants each month from across the organization and designed to encourage discussion on impacting member experience as a department and an organization. Regulatory standards for survey and clinical measures are reviewed, along with the purpose of the measure to provide a whole picture understanding of each measure's impact on the member. Discussion topics for each focus includes current performance, barriers, current interventions, and brainstorming of additional interventions. Participants are asked to share information with their departments and report back to CARE Task Force with any interventions or activities implemented in their department as a result of the discussion. Ideas originating from CARE Task Force are tracked and reviewed for efficacy.

AzCH-CCP RBHA Best and Emerging Practices—References
2022 National Healthcare Quality and Disparities Report. Rockville, MD: Agency for Healthcare Research and Quality; October 2022. AHRQ Pub. No. 22(23)-0030. Accessed at https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2022qdr.pdf.

HCA RBHA

Validation of Performance Measures

Results for Information Systems Standards Review

HSAG determined that HCA RBHA followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-17 displays HSAG's PMV findings for each data type reviewed in alignment with the CMS EQR Protocol 2 audit requirements.

Table 5-17—CY 2021 PMV Findings

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

Results for Performance Measures

Table 5-18 presents the CY 2020 and CY 2021 HCA RBHA performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and MY 2021. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and/or MY 2021. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 5-18—HCA RBHA CY 2020 and CY 2021 Performance Measure Results

Measure	CY 2020 Performance	CY 2021 Performance	2020-2021 Comparison	2021 Performance Level[2]
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	—	82.9%+	—	★★
Postpartum Care	67.9%+	61.0%+	→	★

Measure	CY 2020 Performance	CY 2021 Performance	2020-2021 Comparison	2021 Performance Level[2]
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	58.5%	60.6%	→	★★★
Effective Continuation Phase Treatment	43.2%	42.4%	→	★★
Adherence to Antipsychotic Medications for Individuals with Schizophrenia				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	45.0%	54.4%	↑	★
Follow-Up After ED Visit for AOD Abuse or Dependence				
7-Day Follow-Up—Total	16.9%	22.7%	→	★★★★★
30-Day Follow-Up—Total	28.6%	29.8%	→	★★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total	61.2%	50.0%	↓	★★★
30-Day Follow-Up—Total	75.5%	64.6%	↓	★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total	57.4%	58.4%	→	★★★★★
30-Day Follow-Up—Total	75.2%	75.0%	→	★★★★★
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total	34.0%	36.4%	→	★
Engagement of AOD Treatment—Total	7.8%	9.8%	→	★★
Care of Acute and Chronic Conditions				
Comprehensive Diabetes Care				
*HbA1c Poor Control (>9.0%)**	47.0%+	41.9%+	→	★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	—	45.7%+	—	★

Measure	CY 2020 Performance	CY 2021 Performance	2020-2021 Comparison	2021 Performance Level[2]
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Med				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	74.7%	80.3%	↑	★★★
Heart Failure Admission Rate				
Heart Failure Admission Rate	—	27.3	—	—
Diabetes Short-Term Complication Admission Rate				
Diabetes Short-Term Complications Admission Rate	—	24.5	—	—
Pediatric Health				
Annual Dental Visit				
Annual Dental Visit[1]	—	46.0%	—	★★
Preventive Screening				
Breast Cancer Screening				
Breast Cancer Screening	36.7%	35.1%	→	★
Cervical Cancer Screening				
Cervical Cancer Screening	40.1%+	33.8%+	→	★
Appropriate Utilization of Services				
Ambulatory Care—Total				
*Ambulatory Care—ED Utilization**	—	95.0	—	★
Plan All-Cause Readmissions				
*O/E Ratio—Total**	—	0.9984	—	★★
Use of Opioids at High Dosage				
*Use of Opioids at High Dosage**	—	6.5%	—	★★

* A lower rate indicates better performance for this measure.

+ Indicates the measure was reported using hybrid methodology.

Cells shaded green indicate that the rate met or exceeded the MY 2020 and/or MY 2021 national Medicaid mean.

[1] The rates included for the *Annual Dental Visit* measure are limited to members 18–20 years of age. Caution should be considered when comparing the rates to the MY 2020 and/or MY 2021 national Medicaid mean.

— Indicates the CY 2020 rate was not presented in the CYE 2021 Annual Technical Report; therefore, a 2020-2021 comparison is not presented in the CYE 2022 Annual Technical Report.

↑ Indicates improvement of measure rates.

↓ Indicates decline of measure rates.

→ Indicates stable measure rates.

[2]Performance Levels for CY 2021 were based on comparisons of the HEDIS MY 2021 measure rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks.

Performance Levels for 2021 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 5-19 presents strengths and opportunities for improvement for HCA RBHA for performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement. As of October 1, 2022, the Contractor no longer holds a contract for the RBHA/ACC-RBHA LOB; therefore, the information in this section does not include recommendations.

Table 5-19—HCA RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health Care measure group: • Six of 11 (54.5 percent) of HCA RBHA's measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 **[Quality, Timeliness, Access]** • HCA RBHA's performance measure rates for *Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*, *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total*, as well as *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* were above the 75th percentile, indicating strength in providing follow-up care for behavioral health to members **[Quality, Timeliness, Access]**
Opportunities for Improvement and Recommendations
While HCA RBHA was successful in reporting valid rates for all AHCCCS-required performance measures, the audit identified some considerations and recommendations for future years' reporting. **[Quality]** Recommendation: HSAG continues to recommend that HCA RBHA maintain routine monitoring of its PCP mapping results in comparison to its known Federally Qualified Health Centers (FQHCs) to ensure it identifies appropriate FQHCs as PCPs in final performance measure reporting, which could otherwise result in missed claims for numerator compliance. HCA RBHA indicated that it focused on enhancing PCP mapping for CY 2021, yet measures dependent on PCPs did not demonstrate significant improvements. HSAG also recommends that HCA RBHA prioritize prospectively monitoring its rates throughout the year, since it had multiple rate decreases or lower benchmarking rates, which were not readily identified by HCA RBHA until HSAG conducted rate review. When questioned about reasons for the rate decreases, HCA RBHA required some additional time to research the factors contributing to decreased rates or rates with lower benchmarking. If HCA RBHA monitors its performance routinely

Strengths, Opportunities for Improvement, and Recommendations
throughout the year, it will not only be more likely to identify barriers in real time, but it will also have an opportunity to implement interventions to positively impact rates well before the close of the measurement year. Additionally, HCA RBHA is encouraged to explore the use of other available supplemental data sources, as it indicated the potential for at least one nonstandard supplemental data source, but had not identified a large numerator impact, and therefore elected not to proceed with the source for CY 2021.
In the Maternal and Perinatal Health measure group, HCA RBHA's performance measure rate for *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, indicating an opportunity to increase access to timely postpartum care. Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended, or this weakness may be a result of disparities in the population served. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.[5-12] [Quality, Timeliness, Access]
In the Behavioral Health Care measure group, HCA RBHA's performance measure rates for *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* and *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD—Total* indicators fell below the 25th percentile, indicating opportunities for improvement. Regarding *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*, HCA RBHA's performance indicates medication nonadherence among members with schizophrenia, which may lead to an increase of relapse or hospitalization.[5-13] Regarding *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD—Total*, HCA RBHA's performance indicates that members with a new episode of AOD dependence were not always accessing AOD services or medication-assisted treatment (MAT) within 14 days of diagnosis or within 34 days of the initiation visit. Treatment, including MAT, in conjunction with counseling or other behavioral therapies, has been shown to reduce AOD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.[5-14] Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended. **[Quality, Timeliness, Access]**
Also in the Care of Acute and Chronic Conditions measure group, HCA RBHA's performance measure rate for *Controlling High Blood Pressure* fell below the 25th percentile, indicating that some adult members with hypertension did not have adequately controlled blood pressure. Controlling high blood

[5-12] National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/. Accessed on: Mar 7, 2023.
[5-13] National Committee for Quality Assurance. Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA). Available at: https://www.ncqa.org/hedis/measures/adherence-to-antipsychotic-medications-for-individuals-with-schizophrenia/. Accessed on: Mar 7, 2023.
[5-14] National Committee for Quality Assurance. Initiation and Engagement of AOD Abuse or Dependence Treatment (IET). Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/. Accessed on: Jan 25, 2022.

Strengths, Opportunities for Improvement, and Recommendations
pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[5-15] **[Quality]**
In the Preventive Screening measure group, HCA RBHA's performance measure rates for *Breast Cancer Screening* and *Cervical Cancer Screening* fell below the 25th percentile, indicating that not all women were receiving timely screening for breast and cervical cancers. Early detection reduces the risk of dying from these types of cancers and can lead to a greater range of treatment options and lower healthcare costs. A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. **[Quality]**

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

Table 5-20 presents performance measure recommendations made to HCA RBHA in the CYE 2021 Annual Technical Report[5-16] and HCA RBHA's follow-up to the recommendations, as well as an assessment of the degree to which HCA RBHA has effectively addressed the recommendations. As of October 1, 2022, the Contractor no longer holds a contract for the RBHA/ACC-RBHA LOB; therefore, information in this section is limited to recommendations that were applicable to the current reporting year. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-20—HCA RBHA Follow-Up to CY 2021 Performance Measure Recommendations

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
Recommendation 1:
While HCA RBHA was able to resolve the identified issues related to the four PQI measures, in order to avoid future performance measure reporting errors, HSAG recommended that HCA RBHA take additional steps to ensure all future performance measure data align with the appropriate technical specifications prior to producing performance measure rates. Additional steps include: • Identifying a second programmer as a peer reviewer to formally review any HCA-created source code • Creating and following a documented test plan to denote the expected and actual results prior to running the code, conducting a live system validation of data to compare raw data to the source system data to ensure alignment with the applicable measure's technical specifications, and maintaining a log of any performance measure programming logic updates so any additional

[5-15] National Committee for Quality Assurance. Controlling High Blood Pressure. Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Mar 7, 2023.

[5-16] Contract Year Ending 2021 External Quality Review Annual Technical Report for Regional Behavioral Health Authorities Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-RBHA.pdf. Accessed on: Dec 29, 2022.

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
measures based on similar supplemental data (e.g., inpatient claims) can be thoroughly evaluated to ensure programmatic errors are not repeated
HCA RBHA's Response:
Since the reporting of CY 2020 data, HCA RBHA has incorporated a process of mapping all providers associated with the AHCCCS participating FQHCs and Rural Health Clinics (RHC) as Primary Care Providers (PCP). HCA RBHA references the AHCCCS website for annual updates of participating FQHCs and RHCs. HCA RBHA has also increased the frequency of the provider mapping refreshes to align with the monthly claims refresh.
HSAG's Assessment:
During CY 2021 PMV, HCA RBHA source code was approved for the measures where HCA RBHA did not use a vendor. Additionally, HCA RBHA demonstrated sufficient monitoring and oversight of HCA-created source code and programmers. HSAG has determined HCA RBHA has satisfactorily addressed the prior year's recommendation.
Recommendation 2:
HSAG recommended that HCA RBHA deploy stronger mechanisms to compare its performance measure extracts provided to its software vendor(s) to its source system data to more readily identify issues associated with data refresh timing.
HCA RBHA's Response:
The issue with incomplete identification of mental health and chemical dependency benefit eligibility was resolved with the reporting of the CY 2020 data. HCA RBHA transitioned to a new HEDIS software vendor. Where the previous vendor did not include this functionality, the new HEDIS software vendor's data build includes a member-level view of benefit flags that was previously not available for member-level review.
HSAG's Assessment:
During CY 2021 PMV, HSAG confirmed that HCA RBHA transitioned to a new HEDIS software vendor, and HCA RBHA demonstrated adequate mechanisms to compare performance measure extracts for reasonability and accuracy. HSAG has determined HCA RBHA has satisfactorily addressed the prior year's recommendation.
Recommendation 3:
HSAG recommended that HCA RBHA conduct a root cause analysis to determine why female members were not receiving timely postpartum care. HCA RBHA should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of family planning service providers, or the need for improved community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, HCA RBHA should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, HCA RBHA should implement appropriate interventions to improve the performance related to postpartum care.

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
HCA RBHA's Response: HCA RBHA has a number of interventions in place to target gaps in prenatal and postpartum care. Interventions include daily calls to all newly identified pregnant members, all unverified pregnant, review of the inpatient and Management and Organizational Practices Survey (MOPS) reports, member prenatal education, a mobile application designed to help members in developing a support system and support members with social determinants of health, timely review and authorization of type of bills (TOB). The Maternal Dashboard includes findings of depression, social isolation, and social determinants of health (SDOH) needs in pregnant members. The maternal team offers to assist with transportation and contacting the provider for scheduling of the postpartum visit. All unsuccessful telephone attempts are followed by additional interventions to reach the members and identify if they sought postpartum care. Interventions to obtain alternate telephone numbers and identify if member accessed postpartum care are standard practice for the maternal team. An unable to contact letter is sent, claims data reviewed, the hospital face sheet reviewed, and providers are called to obtain alternate contact information and identify if postpartum care was received.
HSAG's Assessment: HCA RBHA identified interventions that were implemented for CY 2021 as a result of conducting a root cause analysis, however the rates remained low in CY 2021. While opportunity remains to improve its rates, HSAG has determined that HCA RBHA satisfactorily addressed the prior year's recommendation.
Recommendation 4:
HSAG recommended that HCA RBHA conduct a root cause analysis to determine why members were not adhering to their antipsychotic medications or receiving timely AOD services or MAT. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. HCA RBHA should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). Additionally, HCA RBHA should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, HCA RBHA should implement appropriate interventions to improve the performance related to behavioral health measures.
HCA RBHA's Response: HCA RBHA Care Management teams successfully provided care and disease management to members meeting high risk/high-cost program criteria. HCA RBHA expanded eligibility for our vendor technology platform to our full membership with a focus on Dual Eligible Special Needs Plan (DSNP) members. The vendor application directly reinforces adherence to prescribed antidepressant medications through earned incentives.
HSAG's Assessment: HCA RBHA identified interventions that were implemented for CY 2021, however did not provide evidence of a root cause analysis upon which the interventions were based; therefore, HSAG determined that HCA RBHA partially addressed the prior year's recommendation.

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
Recommendation 5:
HSAG recommended that HCA RBHA conduct a root cause analysis or focus study to determine why members were not maintaining their chronic health conditions at optimal levels or why some adult members were experiencing issues with access to care. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, HCA RBHA should implement appropriate interventions to improve the performance related to this chronic condition.
HCA RBHA's Response:
HCA RBHA expanded eligibility for its technology platform to our full membership with a focus on DSNP members. The vendor application directly reinforces adherence to diabetes care.
HSAG's Assessment:
HCA RBHA identified diabetes care interventions that were implemented for CY 2021 which was appropriate as the recommendation was related to the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measure, however, did not provide evidence of a root cause analysis upon which the interventions were based; therefore, HSAG determined that HCA RBHA partially addressed the prior year's recommendation.

Validation of Performance Improvement Projects

In CY 2022, HCA RBHA continued the *Preventive Screening* PIP, which was initiated in CYE 2019. As this PIP is in an intervention year, PIP validation activities focused on intervention analysis. HCA RBHA submitted interventions implemented during CY 2022 along with the intervention status, focus, and rationale for changes or discontinuation of the intervention for the following year.

AHCCCS will conduct an annual validation of the first remeasurement year reflective of CY 2022 (January 1, 2022, through December 31, 2022) using HSAG-calculated and validated indicator rates. AHCCCS will evaluate HCA RBHA's performance based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in Appendix A. Methodology—Validation of Performance Improvement Projects—How Conclusions Were Drawn.

Results

HSAG determined that the PIP has a preliminary validation status of *Met*, based on valid and reliable rate calculation. Validation status based on whether significant or sustained improvement was achieved will be assessed following completion of interventions and final calculation of measures.

Table 5-21 and Table 5-22 provide the *Preventive Screening* PIP baseline and intervention year rates for each indicator for HCA RBHA.

Table 5-21—HCA RBHA *Preventive Screening* PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: *Breast Cancer Screening*		
	Baseline Year	Intervention Year 1	Intervention Year 2
	CYE 2019*	CY 2020	CY 2021
HCA RBHA	36.6%	36.7%	35.1%

*The CYE 2019 indicator rate was calculated by HSAG utilizing AHCCCS data.

Table 5-22—HCA RBHA *Preventive Screening* PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: *Cervical Cancer Screening*		
	Baseline Year	Intervention Year 1	Intervention Year 2
	CYE 2019*	CY 2020	CY 2021
HCA RBHA	41.0%	40.1%	33.8%

*The CYE 2019 indicator rate was calculated by HSAG utilizing AHCCCS data.

Interventions

Table 5-23 presents PIP interventions for HCA RBHA during CY 2022. Language in the PIP interventions section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-23—HCA RBHA *Preventive Screening* PIP Interventions

Contractor	Intervention
HCA RBHA	Breast Cancer Screening: • Identify members with gaps, outreach to members to coordinate scheduling, possible events • Provide practices with updated mammogram gaps and rosters; Working with providers on orders and follow through • Medical record review to identify potential opportunities to close gaps in care, assist with provider education, review non-compliant records • Teams will track gap closure and assess intervention required to ensure practices are tracking to meet year end gap closure target, vendor alerts, potential for Provider Portal reporting, Provider scorecard • Continue to coordinate activities with vendor partners • Member education and website communication • Member reward and incentive program for completion of visits

Contractor	Intervention
	Cervical Cancer Screening: • Identify members with gaps in care and communicate rosters to practices and Obstetrics/Gynecology (OB/GYN), routine Pap test • Coordinate scheduling through appropriate staff on member care team • Working with Providers on orders and follow through • Reviewing best practices of provider groups scoring well on the cervical cancer screening measure • HCA RBHA calls members who need cervical cancer screening to try to schedule appointments • HCA RBHA also delivers cervical cancer screening gap lists to primary care providers • Implemented an additional text message before or after the phone call to let members know why HCA RBHA is/was calling

Strengths, Opportunities for Improvement, and Recommendations

Table 5-24 presents strengths and opportunities for improvement for HCA RBHA related to PIPs, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement. As of October 1, 2022, the Contractor no longer holds a contract for the RBHA/ACC-RBHA LOB; therefore, the information in this section does not include recommendations.

Table 5-24—HCA RBHA Strengths, Opportunities for Improvement, and Recommendations Related to PIPs

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HCA RBHA developed and implemented interventions that may lead to improvement in indicator outcomes. **[Quality]**
Opportunities for Improvement and Recommendations
For indicator 1, HCA RBHA showed a slight increase in the indicator rate between the baseline year and intervention year 1; however, between intervention year 1 and intervention year 2, there was a 1.6 percentage point decline in the indicator rate. When compared to the baseline year, the intervention year 2 indicator rate was 1.5 percentage points below the baseline year rate. For indicator 2, HCA RBHA showed just under a 1 percentage point decline in the rate between the baseline year and intervention year 1. Between intervention year 1 and intervention year 2, the rate declined an additional 6.3 percentage points. When compared to the baseline year, the intervention year 1 indicator rate was 7.2 percentage points below the baseline year rate. The decline noted in indicator rates may indicate that the COVID-19 PHE had an impact on the rates of compliance with breast cancer and cervical cancer screenings. **[Quality]**

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

Table 5-25 presents PIP recommendations made to HCA RBHA in the CYE 2021 Annual Technical Report[5-17] and HCA RBHA's follow-up to the recommendations, as well as an assessment of the degree to which HCA RBHA has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-25—HCA RBHA Follow-Up to CY 2021 PIP Recommendations

Prior Year's Recommendation from the EQR Technical Report for PIPs
While the PIP is in an intervention year and no opportunities for improvement have yet been identified, HSAG recommended that HCA RBHA should continue to implement identified interventions and assess the impact and effectiveness of the interventions after the first remeasurement year.
HCA RBHA's Response: HCA RBHA worked diligently to improve the measures associated with the *Preventive Screening* PIP. These, as HSAG has noted in the EQR, have been negatively impacted by the COVID-19 PHE.
HSAG's Assessment: HSAG reviewed HCA RBHA's PIP intervention submission, which detailed interventions implemented in CY 2022, whether the intervention will be continued, and the rationale for intervention changes or discontinuation. HSAG has determined that HCA RBHA has satisfactorily continued to implement interventions, based on activities completed in CY 2022.

Compliance Reviews

AHCCCS conducts a full compliance review for each Contractor every three years. AHCCCS conducted a compliance review of HCA RBHA from July 26–29, 2021. AHCCCS provided a draft copy of the compliance report to HCA RBHA on October 25, 2021. HCA RBHA was given a period of one week in which to file a challenge to any findings it did not feel were accurate based on the evidence available at the time of review. AHCCCS finalized the HCA RBHA compliance report on November 24, 2021, and requested that HCA RBHA provide a CAP for items that required attention.

[5-17] Contract Year Ending 2021 External Quality Review Annual Technical Report for Regional Behavioral Health Authorities Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-RBHA.pdf. Accessed on: Dec 29, 2022.

Results

In the CYE 2021 compliance review, HCA RBHA scored 95 percent or above in the CC, CIS, GA, GS, MCH, MM, MI, QM, DGA, RI, and TPL Focus Areas. Table 5-26 presents HCA RBHA's results from the recent compliance review as well as the program-level average for each Focus Area.

Table 5-26—HCA RBHA Compliance Results Compared with RBHA Program-Level Average Results

Focus Areas	HCA RBHA	Program-Level Average
Year Reviewed	**CYE 2021**	
CC	100%	97%
CIS	99%	96%
DS	85%	89%
GA	100%	100%
GS	100%	98%
MCH	96%	94%
MM	96%	97%
MI	98%	97%
QM	100%	98%
QI	94%	97%
DGA	96%	93%
RI	100%	100%
TPL	100%	100%
ISOC	NR+	NR+

+ NR = "not reviewed." This Focus Area was not reviewed separately during the compliance review cycle; however, elements of the Focus Area were included in other Focus Areas (e.g., ISOC standards included in MM).

Strengths, Opportunities for Improvement, and Recommendations

Table 5-27 presents strengths and opportunities for improvement for HCA RBHA related to compliance, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement. As of October 1, 2022, the Contractor no longer holds a contract for the RBHA/ACC-RBHA LOB; therefore, the information in this section does not include recommendations.

Table 5-27—HCA RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HCA RBHA scored at or above 95 percent in the following Focus Areas: • Corporate Compliance (CC) **[Quality, Access]** • Claims and Information Standards (CIS) **[Access]** • General Administration (GA) **[Timeliness, Access]** • Grievance Systems (GS) **[Timeliness, Access]** • Adult, EPSDT, and Maternal Child Health (MCH) **[Quality, Timeliness, Access]** • Medical Management (MM) **[Timeliness, Access]** • Member Information (MI) **[Quality]** • Quality Management (QM) **[Quality]** • Division of Grant Administration (DGA) **[Quality]** • Reinsurance (RI) **[Quality]** • Third-Party Liability (TPL) **[Quality, Timeliness, Access]**
Opportunities for Improvement and Recommendations
HCA RBHA scored below 95 percent in the following Focus Areas: • Delivery Systems (DS) **[Timeliness, Access]** • Quality Improvement (QI) **[Quality, Access]** HSAG recommends that HCA RBHA conduct a self-assessment of the DS and QI Focus Area requirements.

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

Table 5-28 presents compliance recommendations made to HCA RBHA in the CYE 2021 Annual Technical Report[5-18] and HCA RBHA's follow-up to the recommendations, as well as an assessment of the degree to which HCA RBHA has effectively addressed the recommendations. HSAG provided a recommendation; however, the Contractor no longer holds a contract for the RBHA/ACC-RBHA LOB,

[5-18] Contract Year Ending 2021 External Quality Review Annual Technical Report for Regional Behavioral Health Authorities Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-RBHA.pdf. Accessed on: Dec 29, 2022.

so no response or assessment is included. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-28—HCA RBHA Follow-Up to CY 2021 Compliance Recommendations

Prior Year's Recommendation from the EQR Technical Report for Compliance
Although no compliance review findings were provided for CYE 2021, HSAG recommended that the Contractor continue to remedy any findings identified in its CAP to ensure that it remains compliant with the requirements in each of the AHCCCS Focus Areas.
HCA RBHA's Response: HSAG provided a recommendation; however, the Contractor no longer holds a contract for the RBHA/ACC-RBHA LOB so no response is included.
HSAG's Assessment: HSAG provided a recommendation; however, the Contractor no longer holds a contract for the RBHA/ACC-RBHA LOB so no assessment is included.

Network Adequacy Validation

Results

HSAG evaluated HCA RBHA's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents biannual validation findings specific to the RBHA LOB, with one results table for the following GSA:

- North GSA: Apache, Coconino, Gila, Mohave, Navajo, and Yavapai counties

Each region-specific table summarizes biannual validation results containing the percentage of members meeting each time/distance standard by quarter and county, with color coding to identify whether the time/distance standard was *Met* or *Not Met.* The value "NA" is shown for time/distance standards that do not apply to the county or RBHA LOB. The value "NR" is shown for time/distance standards in which no members met the network requirement denominator for the RBHA LOB and county; therefore, HSAG calculated no corresponding time/distance result.

Yellow color coding identifies instances in which HSAG's time/distance results met the minimum network requirement but differed from the Contractor's ACOM 436 results. Red color coding identifies instances in which HSAG's time/distance results that did not meet the compliance standard, regardless of the Contractor's ACOM 436 results.

An asterisk (*) indicates that fewer than 10 members were included in the denominator of HSAG's results. A carat (^) indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified Telehealth time/distance standard established by AHCCCS.

Table 5-29—HCA RBHA Time/Distance Validation Results for North GSA—Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	Apache		Coconino		Gila		Mohave		Navajo		Yavapai	
	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	96.5^	97.6^	99.3^	99.1^	100^	100^	100^	99.9^	99.4^	99.3^	100^	100^
Behavioral Health Residential Facility (only Maricopa and Pima counties)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Cardiologist, Adult	98.2^	99.0^	99.2^	99.2^	100^	100^	100^	99.9^	98.7^	99.0^	100^	100^
Cardiologist, Pediatric	100*^	100*^	100^	100^	100*^	100*^	100^	100^	100*^	100*^	100^	100^
Crisis Stabilization Facility (only RBHAs)	99.6	99.5	99.5	99.5	100	100	99.3	99.3	99.9	99.8	99.4	99.4
Dentist, Pediatric	100*	100*	94.4	100	100*	80.0*	100	100	100*	100*	100	100
Hospital	100	100	100	100	100	100	100	100	100	100	100	100
OB/GYN	100	100	100	100	100	100	100	100	100	100	100	100
Pharmacy	96.5	97.6	98.0	98.1	100	100	99.3	99.3	99.7	99.8	99.3	99.1
PCP, Adult	96.0^	96.6^	99.7^	99.4^	100^	100^	100^	99.9^	99.9^	99.8^	100^	100^
PCP, Pediatric	100*^	100*^	100^	100^	100*^	100*^	100^	100^	100*^	100*^	100^	100^

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
represents time/distance standard results that do not meet the compliance standard based on HSAG's results.
* indicates fewer than 10 members were included in the denominator of HSAG's results.
^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified Telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-30 presents strengths and opportunities for improvement for HCA RBHA related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement. As of October 1, 2022, the Contractor no longer holds a contract for the RBHA/ACC-RBHA LOB; therefore, the information in this section does not include recommendations.

Table 5-30—HCA RBHA Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HCA RBHA met all time/distance network standards in assigned counties for both quarters in CYE 2022, except for Gila County.

Strengths, Opportunities for Improvement, and Recommendations
Note: HCA RBHA provides coverage in the following counties: Apache, Coconino, Gila, Mohave, Navajo, and Yavapai.
Opportunities for Improvement and Recommendations
HCA RBHA failed to meet the time/distance standard for pediatric dentists in Gila County for CYE 2022 Q4.

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

Table 5-31 presents NAV recommendations made to HCA RBHA in the CYE 2021 Annual Technical Report[5-19] and HCA RBHA's follow-up to the recommendations, as well as an assessment of the degree to which HCA RBHA has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-31—HCA RBHA Follow-Up to CY 2021 NAV Recommendations

Prior Year's Recommendation from the EQR Technical Report for NAV
HSAG made the following recommendations to HCA RBHA: • Continue to monitor its processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS • Continue to monitor and maintain its existing provider network coverage
HCA RBHA's Response: HCA RBHA has implemented in 2022 a new provider data management system that serves as the principal source of all provider data. HCA RBHA monitors and validates network adequacy for behavioral health Outpatient (Adult/Pediatric), Pharmacy, Dentist and PCP (Children) by confirming active AHCCCS registration, and directly contacting provider targets to ensure AHCCCS registrations, provider types, and addresses. When there are discrepancies, HCA RBHA requests the providers update their AHCCCS registration for any changes. HCA RBHA continues to recruit in contiguous states Colorado, New Mexico, and Utah to cover any Pharmacy and Pediatric Dental gaps. Apache county is classified as medically underserved for PCPs, Dental and Behavioral Health. The HSAG EQR stated Pharmacy is not met for Apache and Coconino – HCA RBHA identified PAT File matches to the HSAG File recommended pharmacies. Most Provider IDs matched between

[5-19] Contract Year Ending 2021 External Quality Review Annual Technical Report for Regional Behavioral Health Authorities Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-RBHA.pdf. Accessed on: Dec 29, 2022.

Prior Year's Recommendation from the EQR Technical Report for NAV
AHCCCS/HSAG files, but many addresses were incorrect, or the pharmacies were no longer in business; therefore, the HSAG recommendations were non-viable targets.
HSAG's Assessment: Based on the CYE 2022 NAV results and the response provided by HCA RBHA, HSAG has determined that HCA RBHA has satisfactorily addressed the prior year's recommendation.

HCA RBHA Best and Emerging Practices

HCA RBHA best and emerging practices are not included in this report because the Contractor is no longer holding a contract for this LOB as of October 1, 2022.

Mercy Care RBHA

Validation of Performance Measures

Results for Information Systems Standards Review

HSAG determined that Mercy Care RBHA followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-32 displays HSAG's PMV findings for each data type reviewed in alignment with the CMS EQR Protocol 2 audit requirements.

Table 5-32—CY 2021 PMV Findings

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

Results for Performance Measures

Table 5-33 presents the CY 2020 and CY 2021 Mercy Care RBHA performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and MY 2021. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and/or MY 2021. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 5-33—Mercy Care RBHA CY 2020 and CY 2021 Performance Measure Results

Measure	CY 2020 Performance	CY 2021 Performance	2020-2021 Comparison	2021 Performance Level[2]
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	—	73.7%$^{+}$	—	★
Postpartum Care	59.9%$^{+}$	55.4%$^{+}$	→	★

Measure	CY 2020 Performance	CY 2021 Performance	2020-2021 Comparison	2021 Performance Level[2]
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	53.8%	53.9%	→	★
Effective Continuation Phase Treatment	40.3%	41.8%	→	★★
Adherence to Antipsychotic Medications for Individuals with Schizophrenia				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	57.2%	57.0%	→	★★
Follow-Up After ED Visit for AOD Abuse or Dependence				
7-Day Follow-Up—Total	20.7%	17.5%	→	★★★★
30-Day Follow-Up—Total	30.1%	25.3%	→	★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total	64.6%	54.3%	↓	★★★★
30-Day Follow-Up—Total	77.8%	71.0%	↓	★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total	72.9%	69.9%	↓	★★★★★
30-Day Follow-Up—Total	86.5%	84.5%	↓	★★★★★
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total	41.4%	43.5%	→	★★
Engagement of AOD Treatment—Total	10.9%	12.3%	→	★★
Care of Acute and Chronic Conditions				
Comprehensive Diabetes Care				
*HbA1c Poor Control (>9.0%)**	33.6%[+]	32.4%[+]	↑	★★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	—	57.9%[+]	—	★★
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Med				

Measure	CY 2020 Performance	CY 2021 Performance	2020-2021 Comparison	2021 Performance Level[2]
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	75.3%	82.4%	↑	★★★★
Heart Failure Admission Rate				
Heart Failure Admission Rate	—	59.7	—	—
Diabetes Short-Term Complication Admission Rate				
Diabetes Short-Term Complications Admission Rate	—	50.9	—	—
Pediatric Health				
Annual Dental Visit				
Annual Dental Visit[1]	—	18.0%	—	★
Preventive Screening				
Breast Cancer Screening				
Breast Cancer Screening	36.9%	32.7%	↓	★
Cervical Cancer Screening				
Cervical Cancer Screening	53.5%+	45.3%+	↓	★
Appropriate Utilization of Services				
Ambulatory Care—Total				
*Ambulatory Care—ED Utilization**	—	103.5	—	★
Plan All-Cause Readmissions				
*O/E Ratio—Total**	—	1.3246	—	★
Use of Opioids at High Dosage				
*Use of Opioids at High Dosage**	—	12.0%	—	★

* A lower rate indicates better performance for this measure.
+ Indicates the measure was reported using hybrid methodology.
Cells shaded green indicate that the rate met or exceeded the MY 2020 and/or MY 2021 national Medicaid mean.
[1] The rates included for the *Annual Dental Visit* measure are limited to members 18–20 years of age. Caution should be considered when comparing the rates to the MY 2020 and/or MY 2021 national Medicaid mean.
— Indicates the CY 2020 rate was not presented in the CYE 2021 Annual Technical Report; therefore, a 2020-2021 comparison is not presented in the CYE 2022 Annual Technical Report.
↑ Indicates improvement of measure rates.
↓ Indicates decline of measure rates.
→ Indicates stable measure rates.
[2]Performance Levels for CY 2021 were based on comparisons of the HEDIS MY 2021 measure rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks.
Performance Levels for 2021 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 5-34 presents strengths, opportunities for improvement, and recommendations for Mercy Care RBHA related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-34—Mercy Care RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health Care measure group: • Six of 11 (54.5 percent) of Mercy Care RBHA's measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 **[Quality, Timeliness, Access]** • Mercy Care RBHA's performance measure rates for *Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total, Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*, as well as *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* were above the 75th percentile, indicating strength in providing follow-up care for behavioral health to members **[Quality, Timeliness, Access]**
In the Care of Acute and Chronic Conditions measure group: • Mercy Care RBHA's performance measure rate for *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* was above the 75th percentile, indicating that most members with diabetes had controlled HbA1c levels most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[5-20] [**Quality**] • Mercy Care RBHA's performance measure rate for *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication* was above the 75th percentile, indicating that members receiving antipsychotic medications for schizophrenia may be receiving diabetes screenings. Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health, quality of life, and economic outcomes downstream.[5-21] **[Quality, Timeliness, Access]**

[5-20] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2023.

[5-21] National Committee for Quality Assurance. Diabetes and Cardiovascular Disease Screening and Monitoring for People With Schizophrenia or Bipolar Disorder. Available at: https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/. Accessed on: Mar 9, 2023.

Strengths, Opportunities for Improvement, and Recommendations
Opportunities for Improvement and Recommendations
While Mercy Care RBHA was successful in reporting valid rates for all AHCCCS-required performance measures, the audit identified some considerations and recommendations for future years' reporting. **[Quality]** Recommendation: HSAG recommends that Mercy Care RBHA continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. Additionally, HSAG recommends that Mercy Care RBHA continue to conduct a formal review of its source code followed by a complete test plan, including live system validation of data, prior to reporting any performance measure data.
For CY 2022 performance measure reporting, RES will be required based on NCQA HEDIS specifications. **[Quality]** Recommendation: HSAG recommends that Mercy Care RBHA explore data sources for the capture of race/ethnicity data to support future performance measure reporting that may require stratification related to RES. Mercy Care RBHA should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race/ethnicity data and explore other methods to augment enrollment data information.
In the Maternal and Perinatal Health measure group, Mercy Care RBHA's performance measure rates for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* fell below the 25th percentile, indicating an opportunity to increase access to timely prenatal and postpartum care. Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended, or this weakness may be a result of disparities in the population served. **[Quality, Timeliness, Access]** Recommendation: While Mercy Care RBHA conducted a root cause analysis and implemented targeted interventions specific to its CY 2020 *Prenatal and Postpartum Care—Postpartum Care* rates, both of its CY 2021 *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* rates were low in CY 2021. HSAG therefore recommends that Mercy Care RBHA continue to implement appropriate interventions to improve performance relative to prenatal and postpartum care. HSAG also recommends that Mercy Care RBHA monitor and expand upon interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measures.
In the Behavioral Health measure group, Mercy Care RBHA's performance measure rate for *Antidepressant Medication Management—Effective Acute Phase Treatment* fell below the 25th percentile, suggesting that barriers exist for some members with a diagnosis of major depression to remain on antidepressant medication. Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment

Strengths, Opportunities for Improvement, and Recommendations
effectiveness, and identifying and managing side effects. Effective medication treatment of major depression can improve a person's daily functioning and well-being, and can reduce the risk of suicide.[5-22] **[Quality]** Recommendation: HSAG recommends that Mercy Care RBHA conduct a root cause analysis or focus study to determine why some members were not managing their antidepressant medication. Upon identification of a root cause, HSAG recommends that Mercy Care RBHA implement appropriate interventions to improve performance and consider the nature and scope of the issues (e.g., whether the issues are related to barriers such as a lack of patient and provider communication or patient education) when implementing interventions.
In the Preventive Screening measure group, Mercy Care RBHA's performance measure rates for *Breast Cancer Screening* and *Cervical Cancer Screening* fell below the 25th percentile, indicating that not all women were receiving timely screening for breast and cervical cancers. Early detection reduces the risk of dying from these types of cancers and can lead to a greater range of treatment options and lower healthcare costs. A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. **[Quality]** Recommendation: While Mercy Care RBHA conducted a root cause analysis and implemented interventions specific to its CY 2020 *Breast Cancer Screening* and *Cervical Cancer Screening* rates, its rates remained low in CY 2021. HSAG therefore recommends that Mercy Care RBHA continue to implement appropriate interventions to improve performance related to preventive screenings. HSAG also recommends that Mercy Care RBHA monitor and expand upon interventions currently in place to improve performance related to the *Breast Cancer Screening* and *Cervical Cancer Screening* measures.
In the Appropriate Utilization of Services measure group: • Mercy Care RBHA's performance measure rate for *Use of Opioids at High Dosage* fell below the 25th percentile. This result provides an opportunity for Mercy Care RBHA to monitor prescribing and utilization data and to implement interventions to improve care and services around opioid prescribing. The CDC guideline on opioid prescribing for chronic, nonmalignant pain recommends the use of "additional precautions" when prescribing dosages ≥50 MED and recommends providers avoid or "carefully justify" increasing dosages ≥90 mg MED.[5-23] **[Quality]** Recommendation: HSAG recommends that Mercy Care RBHA conduct a root cause analysis or focus study to determine why there is a higher proportion of members receiving prescriptions for

[5-22] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Mar 7, 2023.
[5-23] National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/. Accessed on: Mar 7, 2023.

Strengths, Opportunities for Improvement, and Recommendations
opioids. Upon identification of a root cause, HSAG recommends that Mercy Care RBHA implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse. • Mercy Care RBHA's performance measure rates for *Plan All-Cause Readmissions O/E Ratio—Total* fell below the 25th percentile **[Quality]** Recommendation: HSAG recommends that Mercy Care RBHA identify best practices for reducing the unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay. HSAG also recommends that Mercy Care RBHA consider conducting a root cause analysis to identify factors contributing to members experiencing unplanned acute readmissions, which should include evaluating that appropriate follow-up care is available to members upon discharge from an acute inpatient admission or observation.

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

Table 5-35 presents performance measure recommendations made to Mercy Care RBHA in the CYE 2021 Annual Technical Report[5-24] and Mercy Care RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care RBHA has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-35—Mercy Care RBHA Follow-Up to CY 2021 Performance Measure Recommendations

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
Recommendation 1:
HSAG recommended that Mercy Care RBHA conduct a formal review of its source code followed by a complete test plan, including live system validation of data, prior to reporting any performance measure data.
Mercy Care RBHA's Response:
The National Medicaid Quality Team will continue to follow the current plan. Continued progress will include monthly event checks using vendor resources as compared to any technical specifications to ensure that the vendor is accurately capturing the right reporting elements for all core and non-core activities, as well as higher monitoring of internal back-end system integrations to ensure that all data elements are within scope to be captured for reporting.

[5-24] Contract Year Ending 2021 External Quality Review Annual Technical Report for Regional Behavioral Health Authorities Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-RBHA.pdf. Accessed on: Dec 29, 2022.

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
HSAG's Assessment: Considering this recommendation's intention to ensure ongoing oversight of the vendor generating its performance measure rates, which Mercy Care RBHA has explained is conducted through its monthly event checks and monitoring efforts, HSAG has determined Mercy Care RBHA has satisfactorily addressed the prior year's recommendation.
Recommendation 2: HSAG recommended that Mercy Care RBHA conduct a root cause analysis to determine why female members were not receiving timely postpartum care. Mercy Care RBHA should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of family planning service providers, or the need for improved community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, Mercy Care RBHA should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, Mercy Care RBHA should implement appropriate interventions to improve the performance related to postpartum care.
Mercy Care RBHA's Response: As recommended, Mercy Care RBHA conducted a root cause analysis for the postpartum care measure. This included trend review, as well as quantitative and qualitative data analysis. The completed analysis identified the following potential barriers: • Limited health plan resources to conduct member outreach calls post-delivery • Barriers to identifying delivery to initiate timely outreach • Written member outreach process was not sent to members for whom a PCP was not assigned to the member or their newborn • Member utilization of ED or urgent care in the postpartum period without visits to their OB/GYN or PCP • Effects of the PHE, including postponement of many non "essential" health services; clinics reduced hours, number of visitors permitted, and in-person visits during pregnancy limited; social distancing and isolation/quarantine procedures; notable spikes in domestic violence rates • HEDIS audit factors including timely and complete receipt of requested medical records and challenges related to staff resignations Interventions implemented/planned: • Consider leveraging the American College of Obstetricians and Gynecologists (ACOG) data submitted to the perinatal Intensive Care Management (ICM) team for low-risk pregnancy identification, in addition to use by perinatal CM team • Leverage newborn notifications for identification of pregnant members • Implement process to identify pregnant members through positive pregnancy tests in the HIE • Conduct digital outreach throughout the year to capture all postpartum members

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
• Revise outreach process so that the postpartum mailing is sent to member regardless of whether the member's PCP or baby's PCP information is available (revise letter template & process • Expand education to OB/GYNs by MCH Coordinators • Train two staff on the management of this measure to allow for knowledge and early intervention as well as supplying a back-up in the event of staff resignations • Medical Record Vendor challenges—address through work locally at the health plan and nationally in partnership with National Medicaid Quality Management (NMQM)
HSAG's Assessment: Although Mercy Care RBHA's response referred to Mercy Care ACC rates, Mercy Care RBHA demonstrated evidence of conducting a root cause analysis and implementing associated interventions. While opportunity remains to improve its rates, HSAG has determined that Mercy Care RBHA satisfactorily addressed the prior year's recommendation.
Recommendation 3:
HSAG recommended that Mercy Care RBHA conduct a root cause analysis or focus study to determine why its female members were not receiving timely screenings for breast and cervical cancers. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, Mercy Care RBHA should implement appropriate interventions to improve the performance related to preventive screenings.
Mercy Care RBHA's Response: As recommended, Mercy Care RBHA conducted a root cause analysis for the breast and cervical cancer screening measures. This included trend review, quantitative and qualitative data analysis, review and analysis of factors such as demographic data including age and geographic area, as well as enrollment with the health plan and the impact of the PHE, amongst others. Additionally, Mercy Care RBHA conducted disparity analysis for the RBHA SMI population within the breast cancer screening measure, and identified a disparity related to breast cancer screening for Alaskan/American Indian/Native American members. Through these analyses, Mercy Care RBHA identified the following potential barriers: • Member access to mammogram facilities, particularly for those with mobility challenges • Member postponement of many non "essential" health services • This population may have more members that are vulnerable or chronically ill; Members may be unable to tolerate screenings due to physical and mental limitations • More virtual appointments/fewer or no in-person visits (cervical cancer and breast cancer screening cannot be performance through virtual appointments) Interventions implemented/planned: • Additional outreach and education to providers in underutilized areas

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
• Partner with mobile mammography provider to complete mammograms for members with a gap in care • Partner with Arizona Diagnostics Radiology to outreach members specifically assigned to these providers • Addition of *Breast Cancer Screening* measure to Value-Based programs • Develop content that is specific to this measure and identified disparities to be included in the Mercy Care Provider Conference • Increase member education utilizing educational videos on the Mercy Care member website Goal achievement status: Mercy Care RBHA has not yet achieved the goal of meeting the NCQA HEDIS® Medicaid Mean for either measure. Mercy Care RBHA's analysis of the CY 2020 and CY 2021 rates demonstrates that the PHE had a significant impact on the rates of compliance with preventive health services, such as mammograms to screen for breast cancer and PAP tests to screen for cervical cancer. The CY 2020 and CY 2021 rates demonstrated a decline as compared to the baseline (CYE 2019) rate.
HSAG's Assessment: Mercy Care RBHA identified interventions that were implemented for CY 2021 as a result of conducting a root cause analysis. While opportunity remains to improve its *Breast Cancer Screening* and *Cervical Cancer Screening* rates, HSAG has determined that Mercy Care RBHA satisfactorily addressed the prior year's recommendation.

Validation of Performance Improvement Projects

In CY 2022, Mercy Care RBHA continued the *Preventive Screening* PIP, which was initiated in CYE 2019. As this PIP is in an intervention year, PIP validation activities focused on intervention analysis. Mercy Care RBHA submitted interventions implemented during CY 2022 along with the intervention status, focus, and rationale for changes or discontinuation of the intervention for the following year.

AHCCCS will conduct an annual validation of the first remeasurement year reflective of CY 2022 (January 1, 2022, through December 31, 2022) using HSAG-calculated and validated indicator rates. AHCCCS will evaluate Mercy Care RBHA's performance based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in Appendix A. Methodology—Validation of Performance Improvement Projects—How Conclusions Were Drawn.

Results

HSAG determined that the PIP has a preliminary validation status of *Met*, based on valid and reliable rate calculation. Validation status based on whether significant or improvement was achieved will be assessed following completion of interventions and final calculation of measures.

Table 5-36 and Table 5-37 provide the *Preventive Screening* PIP baseline and intervention year rates for each indicator for Mercy Care RBHA.

Table 5-36—Mercy Care RBHA *Preventive Screening* PIP Rates for PIP Indicator 1

Contractor	PIP Indicator 1: *Breast Cancer Screening*		
	Baseline Year	Intervention Year 1	Intervention Year 2
	CYE 2019*	CY 2020	CY 2021
Mercy Care RBHA	35.8%	36.9%	32.7%

*The CYE 2019 indicator rate was calculated by HSAG utilizing AHCCCS data.

Table 5-37—Mercy Care RBHA *Preventive Screening* PIP Rates for PIP Indicator 2

Contractor	PIP Indicator 2: *Cervical Cancer Screening*		
	Baseline Year	Intervention Year 1	Intervention Year 2
	CYE 2019*	CY 2020	CY 2021
Mercy Care RBHA	43.5%	53.5%	45.3%

*The CYE 2019 indicator rate was calculated by HSAG utilizing AHCCCS data.

Interventions

Table 5-38 presents PIP interventions for Mercy Care RBHA during the Intervention Year 2. Language in the PIP interventions section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-38—Mercy Care RBHA *Preventive Screening* PIP Interventions

Contractor	Intervention
Mercy Care RBHA	• Educational outreach to female members aged 40-74 to encourage well-woman exams and mammograms (Breast Cancer Screening). • Female members aged 40-74 receive the Breast Cancer Screening or Breast Cancer Screening/Cervical Cancer Screening self-mailer. • Members aged 50-74 receive breast cancer trifold education piece. • Members aged 50-74 receive partner organization notification—partner organization will be contacting those members who have not had a mammogram in the past year and assist with scheduling an appointment for mammogram. • Partner organization contacts members on list which the health plan has provided of members in need of mammogram.

Contractor	Intervention
	• Providers are notified via mail of members who are due for a mammogram. Members are given an order form to sign and return to the health plan. We then contact the member and assist with scheduling mammogram and submitting order form. • Outreach staff contact members who still have not had a mammogram to assist with scheduling appointments. • Incentive letters are mailed annually to members who still need a mammogram, once the member completes a mammogram, and Mercy Care receives/verifies the claim from the provider, the incentive is sent to the member. • Maternal Child Health (MCH) Coordinators conduct provider site visits including education on breast cancer screening guidelines and providing a list of members in need of mammogram. • Multi-channel member outreach campaign provides information on covered service and the importance of breast cancer screenings. • Twice annually, partner with Arizona Diagnostic Radiology to conduct outreach calls to members in need of a mammogram, to offer scheduling assistance. • Additional provider education for those areas mentioned that are underutilized. • Partner with Arizona Diagnostics Radiology to outreach members specifically assigned to providers in underutilized areas. • Develop and implement a written or multi-channel outreach (text/IVR/email) intervention for newly enrolled female members ages 50-74, as well as members ages 52-59. • Addition of *Breast Cancer Screening* measure to value-based programs. • Consideration of partnership with mobile mammography provider in targeted zip codes. • Develop content that is specific to this disparity to be included in provider newsletters and the Mercy Care Provider Conference. • Provider "Gaps-in-Care" well-woman mailing includes a list of members who need a cervical cancer screening. • Outreach staff contact members who need Pap test and assist with scheduling appointments. • Send out cervical cancer screening mailer biannually. • Make it priority for MCH representative to meet with Medical Doctor (MD) and office staff, specifically in areas that are in need (Phoenix), at a minimum of once per year to review provider outreach manual.

Contractor	Intervention
	• Leverage Tribal liaisons to engage members who might be difficult to engage or find, provide health information, offer referral, assist with navigation, etc. to assist in addressing health disparities. • Meet with Native Health and the Phoenix Indian Medical Center to determine if partnership opportunities exist.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-39 presents strengths, opportunities for improvement, and recommendations for Mercy Care RBHA related to PIPs, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-39—Mercy Care RBHA Strengths, Opportunities for Improvement, and Recommendations Related to PIPs

Strengths, Opportunities for Improvement, and Recommendations
Strengths
Mercy Care RBHA developed and implemented interventions that may lead to improvement in indicator outcomes. **[Quality]** HSAG noted that Mercy Care RBHA's intervention year 1 rate showed a 10 percentage point increase from the baseline year for indicator 2. Although the intervention year 2 indicator rate for indicator 2 showed a decline from the intervention year 1 indicator rate, the intervention year 2 indicator rate remained 1.8 percentage points above the baseline year rate. **[Quality]**
Opportunities for Improvement and Recommendations
For indicator 1, Mercy Care RBHA showed just over a 1 percentage point increase in the indicator rate between the baseline year and intervention year 1; however, between intervention year 1 and intervention year 2, the rate showed a decline of 4.2 percentage points. When compared to the baseline year, the intervention year 2 indicator rate was 3.1 percentage points below the baseline year rate. The decline noted in the indicator 1 rate may indicate that the COVID-19 PHE had an impact on the rates of compliance with breast cancer screenings for Mercy Care RBHA. **[Quality]** Recommendation: As the PIP progresses, HSAG recommends that Mercy Care RBHA: • Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary • Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available • Develop and document a plan for sustaining the improvement for any demonstrated improvement in indicator rates

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

Table 5-40 presents PIP recommendations made to Mercy Care RBHA in the CYE 2021 Annual Technical Report[5-25] and Mercy Care RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care RBHA has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-40—Mercy Care RBHA Follow-Up to CY 2021 PIP Recommendations

Prior Year's Recommendation from the EQR Technical Report for PIPs
While the PIP is in an intervention year and no opportunities for improvement have yet been identified, HSAG recommended that Mercy Care RBHA should continue to implement identified interventions and assess the impact and effectiveness of the interventions after the first remeasurement year.
Mercy Care RBHA's Response: Intervention progress: Mercy Care RBHA interventions to improve rates of compliance with breast and cervical cancer screening continue. Goal achievement status: The PIP goal is to demonstrate a statistically significant increase in the number and percentage of 1) breast cancer screenings and 2) cervical cancer screenings, followed by sustained improvement for one consecutive year. Mercy Care RBHA's analysis of the MY 2020 and MY 2021 rates demonstrates that the PHE had a significant impact on the rates of compliance with preventive health services, such as mammograms to screen for breast cancer and PAP tests to screen for cervical cancer. The MY 2020 and MY 2021 rates demonstrated a decline as compared to the baseline (CYE 2019) rate.
HSAG's Assessment: HSAG reviewed Mercy Care RBHA's PIP intervention submission, which detailed interventions implemented in CY 2022, whether the intervention will be continued, and the rationale for intervention changes or discontinuation. HSAG has determined that Mercy Care RBHA has satisfactorily continued to implement interventions, based on activities completed in CY 2022.

[5-25] Contract Year Ending 2021 External Quality Review Annual Technical Report for Regional Behavioral Health Authorities Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-RBHA.pdf. Accessed on: Dec 29, 2022.

Compliance Reviews

AHCCCS conducts a full compliance review for each Contractor every three years. AHCCCS conducted a compliance review of Mercy Care RBHA from June 21–24, 2021. A draft copy of the report was provided to Mercy Care RBHA on October 12, 2021. Mercy Care RBHA was given a period of one week in which to file a challenge to any findings it did not feel were accurate based on the evidence available at the time of review. AHCCCS finalized the Mercy Care RBHA compliance report on November 10, 2021, and requested that Mercy Care RBHA provide a CAP for items that required attention. In a letter dated February 8, 2022, AHCCCS informed Mercy Care RBHA that its proposed CAP submitted on January 12, 2022, had been accepted and Mercy Care RBHA had until August 8, 2022, to provide AHCCCS with an update of any CAPs.

In November 2021, AHCCCS awarded Mercy Care a new ACC-RBHA contract, expanding the current RBHA contract. As a result, the Contractor went through an extensive readiness review, which was conducted from April through October 2022.

AHCCCS stated that it recognizes the criticality of member transitions and the readiness of a Contractor to deliver care and services under a new contract award. The readiness review process is paramount to a successful implementation and seamless transition for members. To that end, AHCCCS has implemented an extensive readiness review process for all Contractors awarded new AHCCCS contracts.

AHCCCS stated that it views the readiness review process as an ongoing series of activities to monitor and ensure Contractor progress. AHCCCS initiates the readiness review process roughly six months prior to the contract effective date. These readiness activities are essential to establishing the capacity of the awarded Contractors to function in a number of critical areas, including operations and administration, service delivery, financial management, and systems management. The Mercy Care ACC-RBHA contract began October 1, 2022. Future compliance reviews will be for the ACC-RBHA contract/LOB.

Results

In the CYE 2021 compliance review, Mercy Care RBHA scored 95 percent or above in the CC, CIS GA, GS, MCH, MM, MI, QM, QI, RI, and TPL Focus Areas. While not at or above 95 percent, Mercy Care RBHA was found to be above the RBHA Program average in the DS and DGA Focus Areas. Table 5-41 presents Mercy Care RBHA's results from the recent compliance review as well as the program-level average for each Focus Area.

Table 5-41—Mercy Care RBHA Compliance Results Compared with RBHA Program-Level Average Results

Focus Areas	Mercy Care RBHA	Program-Level Average
Year Reviewed	**CYE 2020**	
CC	100%	97%

Focus Areas	Mercy Care RBHA	Program-Level Average
CIS	98%	96%
DS	90%	89%
GA	100%	100%
GS	100%	98%
MCH	100%	94%
MM	96%	97%
MI	98%	97%
QM	99%	98%
QI	98%	97%
DGA	94%	93%
RI	100%	100%
TPL	100%	100%
ISOC	NR+	NR+

+ NR = "not reviewed." This Focus Area was not reviewed separately during the compliance review cycle; however, the Focus Area was included in other Focus Areas (e.g., ISOC standards included in MM).

Strengths, Opportunities for Improvement, and Recommendations

Table 5-42 presents strengths, opportunities for improvement, and recommendations for Mercy Care RBHA related to compliance, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-42—Mercy Care RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
Mercy Care RBHA scored at or above 95 percent in the following Focus Areas: • Corporate Compliance (CC) **[Quality, Access]** • Claims and Information Standards (CIS) **[Access]** • General Administration (GA) **[Timeliness, Access]** • Grievance Systems (GS) **[Timeliness, Access]** • Adult, EPSDT, and Maternal Child Health (MCH) **[Quality, Timeliness, Access]** • Medical Management (MM) **[Timeliness, Access]** • Member Information (MI) **[Quality]**

Strengths, Opportunities for Improvement, and Recommendations
• Quality Management (QM) **[Quality]** • Quality Improvement (QI) **[Quality, Access]** • Reinsurance (RI) **[Quality]** • Third-Party Liability (TPL) **[Quality, Timeliness, Access]**
Opportunities for Improvement and Recommendations
Mercy Care RBHA scored below 95 percent in the following Focus Areas: • Delivery Systems (DS) **[Timeliness, Access]** • Division of Grant Administration (DGA) **[Quality]** Recommendation: HSAG recommends that Mercy Care RBHA conduct a self-assessment of the DS and DGA Focus Area requirements.

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

Table 5-43 presents compliance recommendations made to Mercy Care RBHA in the CYE 2021 Annual Technical Report[5-26] and Mercy Care RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care RBHA has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-43—Mercy Care RBHA Follow-Up to CY 2021 Compliance Recommendations

Prior Year's Recommendation from the EQR Technical Report for Compliance
Although no OR findings were provided for CYE 2021, HSAG recommended that the Contractor continue to remedy any findings identified in its CAP to ensure that it remains compliant with the requirements in each of the AHCCCS Focus Areas.
Mercy Care RBHA's Response: Mercy Care RBHA reported that in response to the HSAG compliance recommendation, annual and ad hoc reviews have been ongoing.
HSAG's Assessment: Based on the results of the CYE 2022 compliance review and the response provided by Mercy Care RBHA, HSAG determined that Mercy Care RBHA has satisfactorily addressed the prior year's recommendation.

[5-26] Contract Year Ending 2021 External Quality Review Annual Technical Report for Regional Behavioral Health Authorities Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-RBHA.pdf. Accessed on: Dec 29, 2022.

Network Adequacy Validation

Results

HSAG evaluated Mercy Care RBHA's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents biannual validation findings specific to the RBHA LOB, with one results table for the following GSA:

- Central GSA: Maricopa[5-27] County

Each region-specific table summarizes biannual validation results containing the percentage of members meeting each time/distance standard by quarter and county, with color coding to identify whether the time/distance standard was *Met* or *Not Met.* The value "NA" is shown for time/distance standards that do not apply to the county or RBHA LOB. The value "NR" is shown for time/distance standards in which no members met the network requirement denominator for the RBHA LOB and county; therefore, HSAG calculated no corresponding time/distance result.

Yellow color coding identifies instances in which HSAG's time/distance results met the minimum network requirement but differed from the Contractor's ACOM 436 results. Red color coding identifies instances in which HSAG's time/distance results that did not meet the compliance standard, regardless of the Contractor's ACOM 436 results.

An asterisk (*) indicates that fewer than 10 members were included in the denominator of HSAG's results. A carat (^) indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified Telehealth time/distance standard established by AHCCCS.

Table 5-44—Mercy Care RBHA Time/Distance Validation Results for Central GSA—Percentage of Members Meeting Minimum Network Requirements

	Maricopa	
Minimum Network Requirement	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	99.1^	99.1^
Behavioral Health Residential Facility (only Maricopa and Pima counties)	99.5	99.5
Cardiologist, Adult	99.9^	100^
Cardiologist, Pediatric	100^	100^
Crisis Stabilization Facility (only RBHAs)	99.5	99.5
Dentist, Pediatric	96.5	98.1

[5-27] Maricopa County includes the 85342, 85358, and 85390 ZIP codes; these ZIP codes are physically located in both Maricopa and Yavapai counties.

Minimum Network Requirement	Maricopa	
	Q2	Q4
Hospital	99.9	100
OB/GYN	100	100
Pharmacy	99.5	99.4
PCP, Adult	99.7^	99.7^
PCP, Pediatric	100^	100^

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

^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified Telehealth time/distance standard established by AHCCCS.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-45 presents strengths, opportunities for improvement, and recommendations for Mercy Care RBHA related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

Table 5-45—Mercy Care RBHA Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
Mercy Care RBHA met all time/distance network standards for both quarters in CYE 2022 for all assigned counties. **[Access]** Note: Mercy Care RBHA provides coverage in Maricopa County.
Opportunities for Improvement and Recommendations
HSAG identified no opportunities for improvement. Recommendation: While HSAG identified no opportunities for improvement, HSAG recommends that Mercy Care RBHA: • Continue to monitor its processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS • Maintain current compliances but continue to address network gaps as applicable

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

Table 5-46 presents NAV recommendations made to Mercy Care RBHA in the CYE 2021 Annual Technical Report[5-28] and Mercy Care RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care RBHA has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-46—Mercy Care RBHA Follow-Up to CY 2021 NAV Recommendations

Prior Year's Recommendation from the EQR Technical Report for NAV
HSAG made the following recommendations to Mercy Care RBHA: • Continue to monitor its processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS • Continue to monitor and maintain its existing provider network coverage
Mercy Care RBHA's Response: Mercy Care RBHA continues to review the data provided in these reports to AHCCCS and find trends that can be corrected, keeping the error ratios as low as possible. Mercy Care RBHA will continue this process, as outlined in detail in its annual Network Plans. During FY22, Mercy Care RBHA added over 200 new providers, with various specialties, to its network, which is evidentiary of its oversight and management in ensuring the most robust network of providers for its membership.
HSAG's Assessment: Based on the CYE 2022 NAV findings and Mercy Care RBHA's response to recommendations, HSAG has determined that Mercy Care RBHA has satisfactorily addressed the prior year's recommendation.

Mercy Care RBHA Best and Emerging Practices

Table 5-47 presents the best and emerging practices provided by Mercy Care RBHA for CYE 2022. HSAG made only minor edits to Mercy Care RBHA's submission to enhance readability. Best practice responses may be based on Contractor internal data and not EQR validated rates.

[5-28] Contract Year Ending 2021 External Quality Review Annual Technical Report for Regional Behavioral Health Authorities Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-RBHA.pdf. Accessed on: Dec 29, 2022.

Table 5-47—Mercy Care RBHA Best and Emerging Practices

Mercy Care RBHA Best and Emerging Practices—Assertive Community Treatment
Assertive Community Treatment (ACT) is the highest level of outpatient services available in the RBHA SMI Network. Mercy Care RBHA follows the Substance Abuse and Mental Health Services Administration (SAMHSA) ACT criteria, inclusive of twenty-eight fidelity metrics. Utilization of ACT services demonstrates the applicability and meaningfulness of delivering ACT services in Maricopa County. ACT team capacity throughout 2021 has been ranged between 91%-94%. The 2020 Mercer reports that the population with an SMI receiving ACT services, exceeds the national best estimates. Mercy Care RBHA's ACT network consists of twenty-four ACT teams. Twenty-one ACT Teams have PCP Partnerships, and the network includes one Medical ACT Team (MACT) making twenty-two ACT teams integrated. In addition, there are three Forensic ACT Teams (FACT) which are also PCP Partnerships (inclusive of the twenty-one ACT with PCP). The MACT team has an enhanced admission criterion; in addition to ACT criteria MACT members must also have a chronic health condition that has not been managed. Similarly, the FACT team must meet ACT criteria in addition to demonstrating a high risk of recidivism using the Risk to Recidivate Score, Offender Screening Tool, Offender Re-Screening Tool and/or being released from Department of Corrections, after a minimum two years of incarceration. Mercy Care RBHA has also established reporting to help better identify members for ACT/FACT teams that will be used in conjunction with training delivered to providers. ACT Teams have the highest penetration rate (31%) for integrated services across other integrated programs targeting members determined to be SMI. The goal of ACT is to provide a comprehensive array of services, including addressing the social determinants of health for each member receiving ACT services. Each ACT team is maximized at 100 members receiving services from a team of thirteen staff including (but not limited to): psychiatrists, nurses, housing specialists, employment specialists, rehabilitation specialists, peer support, substance abuse specialists, independent living specialist, ACT specialist, program assistant and a clinical coordinator, among other staff. It is an expectation that most, if not all, services provided to the members are delivered by the ACT team. Having a robust team provides the opportunity for a higher intensity of services for the most vulnerable members. ACT teams provide coverage 24/7 and are available to respond to crises after hours. ACT teams are also able to provide routine services during nights and weekends. Mercy Care RBHA is shifting to a claims-based approach for reporting ED visits, hospital admissions (behavioral health and physical health), jail bookings as well as other demographic and social determinant of health information. Data are reviewed monthly with Mercy Care RBHA Medical Directors. Claims-based reporting is reviewed with providers and coupled with provider data for validation.

Mercy Care RBHA Best and Emerging Practices—Substance Use Disorder Cognitive Behavior Therapy
Mercy Care RBHA will be partnering with the Beck Institute for Cognitive Behavior Therapy to deliver Substance Use Disorder Cognitive Behavior Therapy (SUD CBT) focused on increasing awareness of substance use disorders and evidence-based cognitive behavioral methods for helping individuals recover from substance use/opioid use disorders. This training was selected for licensed staff with clinical expertise with substance use and/or looking to expand specialties services for members across the state of Arizona. Goal for Initiative: Mercy Care RBHA recognizes the importance of timely access to services for members diagnosed with a substance use disorder diagnosis and responding to the national opioid crisis. Mercy Care RBHA has continued to focus efforts on expanding evidence-based practices specifically designed for members seeking a diagnosis, and/or diagnosed with SUD that would benefit from a model geared towards reframing perception, addressing challenges with sobriety and healing past or current trauma that have a role in managing sobriety. Training Objectives: • Conceptualize clients' dysfunctional substance use via the cognitive model • Identify, evaluate, and moderate patients' dysfunctional substance use-related beliefs (including "permission-giving" beliefs) • Apply a range of cognitive-behavioral techniques to help patients choose not to use substances, even when they experience cravings or otherwise wish to self-medicate • Address "resistance" by integrating motivational interviewing strategies into CBT • Integrate cognitive-behavioral principles with mutual help groups (e.g., 12-step) ideas and values • Understand medication treatment options and how CBT can support patients receiving medication treatment for their opioid use Outcomes Resulting in Significant Improvement: Mercy Care RBHA will increase expertise in SUD CBT practices within the provider network focused on recovery and treatment for individuals diagnosed with SUD. Mercy Care RBHA will provide results from the training evaluations per training date upon request.

Mercy Care RBHA Best and Emerging Practices— Trauma Informed Care for Child Welfare-Involved Children, Youth and Families
Mercy Care RBHA developed two workshops geared towards enhancing Trauma Informed Care for Child Welfare-Involved Children, Youth and Families focused on understanding trauma and identify strategies for well-being and emotion-focused communication skills for those caring for individuals involved in child welfare. This training was selected for paraprofessionals including case managers, direct support workers, family support staff as well as individuals from tribal regions across Arizona. Mercy Care RBHA strives to ensure providers and community partners understand trauma exposure and prevalence of trauma in children and adolescents across all lines of business.

Mercy Care RBHA Best and Emerging Practices— Trauma Informed Care for Child Welfare-Involved Children, Youth and Families
Goal for Initiative: Mercy Care RBHA continues to focus its efforts on expanding trauma services within the provider network to ensure providers and members understand how trauma impacts a child's life. Mercy Care RBHA focused primarily in 2022 on expanding the trauma training to paraprofessionals statewide to promote a culture of safety, common language and practice when serving children and adolescents. Training Objectives: • Trauma (what is it, prevalence, impact) • Signs of post-traumatic stress or other trauma-related reactions that might require treatment • Evidence-based mental health treatments that can help families and individuals involved with child welfare dealing with post-traumatic stress (what are they, questions to ask when seeking services or making referrals) • Resilience (what is it, how can we cultivate it); Emphasis on the protective power of safe, stable and nurturing relationships • Overview of specific strategies for caregivers/adults who care for individuals involved in child welfare to build: – Skills for self-care, emotional self-awareness and regulation (parents/caregivers/providers) – Skills for understanding and responding to child/youth/adult emotional needs: o Communicating about challenging topics (e.g. trauma, stressful events or family transition) o Addressing behavioral challenges Outcomes Resulting in Significant Improvement: With the roll-out of two Trauma Informed Care workshops, Mercy Care RBHA saw an extensive amount of interest from the provider network for these trainings. Given the demand, we were able to create 5 training dates for paraprofessionals both in-person and virtual to capture statewide providers particularly in rural and tribal regions. Currently, Mercy Care RBHA has 315 individuals registered to attend the trauma informed care workshops. These trainings will result in an increase of trauma informed care, and how to incorporate both organizational and clinical practice to improve awareness on trauma. Mercy Care RBHA will provide results from the training evaluations per training date upon request.
Mercy Care RBHA Best and Emerging Practices—Transition to Independence
Mercy Care RBHA focused this year on expanding Transition to Independence (TIP) process, which is a youth-driven, strength-based, evidence-supported framework that was developed for working with youth and young adults (14-29 years old) with emotional/behavioral difficulties (EBD) to improve their real-life outcomes across Transition Domains such as Education, Employment, Career Housing and Community Life Functioning. This training was selected based

Mercy Care RBHA Best and Emerging Practices—Transition to Independence
on the growing need for a transitional program focused on supporting youth and young adults with their progress and outcomes across transition domains and navigating the complex system of healthcare. Goal for Initiative: Mercy Care RBHA recognizes the importance of specialty services for youth and young adults with a primary focus on assessment of needs and goals that allow young people the opportunity to achieve greater self-sufficiency and confidence. Mercy Care RBHA will be completing Train the Trainer for the TIP Program to ensure sustainability within the existing provider network. Mercy Care RBHA staff will participate in the following fidelity and implementation areas and will monitor domains within the provider network. Training for High-Fidelity TIP Model Implementation: To achieve Full TIP Implementation, trainees will also receive training and consultation in the following areas: • Implementation Science • Coaching for Continuous Competency Enhancement • On-Going Consultation and Technical Assistance • TIP Model Fidelity Assessment Tool • Development of Certified TIP Site-Based Trainer Development • Development of Certified Regional TIP Fidelity Assessors Outcomes Resulting in Significant Improvement: With the additional focus on TIP expansion, Mercy Care RBHA will be able to monitor effectiveness and fidelity of treatment, train and increase provider expertise with the TIP Model Transition Domains and support the unique needs of youth and young adults within the child welfare system and developmental disability community. TIP Program is available for all lines of business but recognizes the needs of specialty populations. Mercy Care RBHA will provide results from the training evaluations per training date upon request.

Mercy Care RBHA Best and Emerging Practices—References
Beck Institute. https://beckinstitute.org/blog/treating-substance-misuse-disorders-with-cbt/ Stars Training Academy. https://www.starstrainingacademy.com/transition-to-independence-process-tip-model/

Appendix A. Methodology

Appendix A—Methodology presents, for each EQR activity:

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

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

Validation of Performance Measures

Objectives

The primary objectives of the PMV process were to:

- Evaluate the accuracy of performance measure data collected by the Contractors
- Determine the extent to which the specific performance measures calculated by the Contractors (or on behalf of the Contractors) followed the specifications established for each performance measure
- Identify overall strengths and areas for improvement in the performance measure calculation process

Technical Methods of Data Collection

The CMS PMV protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the types of data collected and how HSAG analyzed these data:

- **Information Systems Capabilities Assessment Tool (ISCAT):** Contractors completed and submitted an ISCAT to address data collection and reporting specifics of their performance measures. HSAG used the responses from the ISCAT to complete the pre-on-site assessment of information systems.
- **Source code (programming language) for performance measures:** Contractors calculated, or contracted with vendors to calculate, the non-HEDIS performance measures using source code and were required to submit the source code used to generate non-HEDIS performance measures being validated. HSAG completed a line-by-line review of the supplied source code to ensure compliance

with the measure specifications required by AHCCCS. If NCQA Certified Measures[SM, A-1] vendors were used, HSAG reviewed a copy of the certified measures reports to confirm each measure's certification status. HSAG identified any areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any).

- **Medical record documentation:** Contractors submitted the following documentation for review: medical record hybrid tools and instructions, training materials for medical record review (MRR) staff, and policies and procedures outlining the processes for monitoring the accuracy of the reviews performed by the review staff.
- **Supporting documentation:** HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

Pre-Review Activities:

In alignment with CMS Protocol 2, several steps and actions were involved in preparing both the EQRO and each Contractor to implement and conduct the PMV activity, including:

- **Define the scope of the validation:** HSAG worked with AHCCCS to identify the performance measures to be validated for each Contractor and to confirm all standardized measure specifications (e.g., sampling guidelines, eligible population criteria, and numerator and denominator identification). HSAG submitted final validated performance measure results in an agreed-upon AHCCCS-approved Microsoft (MS) Excel workbook format. HSAG provided AHCCCS with each Contractor's LOB-specific rate reporting template and provided AHCCCS with a consolidated view of the final validated rates as well. HSAG used Contractor-to-Contractor comparisons; comparisons to CY 2020 rates, where applicable; as well as comparisons to national Medicaid benchmarks, as reasonability checks.
  - A rate was considered materially biased and received a Do Not Report (DNR) designation if any identified error or errors impacted the performance measure rate by more than 5 percentage points.
  - For hybrid measure reporting, each Contractor's sampling and oversampling methodology was required to align with the measure steward's hybrid reporting specifications. If the Contractor used an oversampling rate larger than 20 percent, HSAG required the Contractor to provide evidence of NCQA approval. HSAG did not accept an oversampling rate larger than the established NCQA standard without the Contractor providing its evidence of NCQA approval.
  - HSAG followed CMS Protocol 2 in reviewing hybrid measures by conducting MRR of 30 records for at least two performance measures, across lines of business as applicable per Contractor, as selected by each Contractor's lead auditor.

[A-1] NCQA Measure Certification[SM] is a service mark of the National Committee for Quality Assurance (NCQA).

- **Audit preparation:** HSAG confirmed the final scope of the audit with AHCCCS to ensure all written communication to the Contractors contained accurate information on the measures being reported. Upon obtaining AHCCCS' approval of the document request packet templates, HSAG prepared customized document request packets for each Contractor. The memo accompanying the packet provided details of the audit process and requirements, including:
  - The audit timeline
  - Information about virtual review scheduling
  - A list of all measures under the scope of the audit
  - The ISCAT to complete and reference to appropriate use of the HEDIS MY 2021 Record of Administration, Data Management, and Processes (Roadmap)
  - Information on source code review, as well as medical record review validation and supplemental database review, as applicable
  - Information on where and how to submit performance measure rates and required documentation
  - Next steps and whom to contact for additional information
- **Assess the integrity of the Contractor's information systems (IS):** As part of the ISCAT, HSAG received detailed information regarding all data systems that feed into the collecting and reporting of performance measures, including patient data, provider data, claims/encounter data, survey data, and data integration processes.

HSAG used the completed ISCATs to evaluate Contractors' IS and environments, identify any existing potential barriers to data collection and reporting, verify the use and oversight of contracted vendors, and review the medical record abstraction process. Upon completing its review of the ISCAT, HSAG prepared preliminary follow-up actions and items that needed clarification in an IS Tracking Grid. HSAG used the grid throughout the audit process to communicate with the Contractors about items that needed follow-up and to document resolution of each item.

If a Contractor had a recent (i.e., July 2021 or sooner) comprehensive, independent assessment of its information systems as conducted during an NCQA HEDIS Compliance Audit™, HSAG reviewed and assessed the Contractor's responses to NCQA's Roadmap and its associated attachments. Additionally, if the Contractor had not yet received its NCQA Medicaid Health Plan Accreditation but was working through a certified HEDIS Compliance Auditor specific to its Arizona Medicaid rates, HSAG accepted and reviewed the HEDIS Roadmap responses as applicable to the Contractor's Medicaid product.

- **Conduct detailed review of measures:** HSAG obtained from each Contractor the detailed source code and programming logic used to calculate each measure when NCQA Certified Measures vendors were not used. HSAG programmers, assigned according to familiarity and expertise with the programming language each Contractor used, conducted a detailed review of each line of code to ensure strict compliance with measure specifications, identifying and estimating any potential bias, and identifying any necessary corrections. As part of this step, HSAG provided each Contractor with feedback on each measure selected for source code review. HSAG's source code reviewers conducted a line-by-line review to meet the following three objectives:

1. Ensure strict compliance with current technical specifications, regardless of source (e.g., HEDIS or CMS) and the accuracy of programming logic. The reviewer documented any noted deviation from the specifications and provided detailed feedback to the Contractor's programmer.
2. Identify and estimate the potential for bias that each deviation can introduce to the measure calculation.
3. Flag issues requiring corrections to code, further investigation, or fixes to the sample. The reviewer documented each issue clearly and initiated discussion with the Contractor to determine action steps for resolving the identified issues.

HSAG made every attempt to identify all issues requiring action before the virtual audit so it could discuss specific strategies with the Contractor during the virtual review. After HSAG verified all corrections to code, it provided the Contractor with a final, written summary of the programming review findings and implications for measure designations. If NCQA Certified Measure vendors were used, HSAG requested the Contractors to provide a copy of the certified measures reports to confirm each measure's certification status.

- **Medical Record Review and Validation (MRRV)**: HSAG provided the Contractors with guidance through each step of the medical record review to ensure all obstacles that potentially impact hybrid reported rates were identified and corrected early in the audit process. HSAG's medical record review team participated in each Contractor's kick-off call to discuss the medical record review process and answer any questions the Contractor had. HSAG did not request a convenience sample but conducted an over-read of approximately 30 records from two hybrid measures to ensure the accuracy of the medical record data abstracted by each Contractor. HSAG followed NCQA's guidelines to validate the integrity of the MRRV processes used by each Contractor and used the MRRV results to determine if the findings impacted the audit results for each performance measure rate. As part of the medical record review and validation, the medical record review team:
  - Reviewed and clarified all ISCAT responses (inclusive of the Roadmap, when applicable) pertaining to the Contractor's medical record review process, including reviewer training and quality assurance, the medical record procurement approach, data integration with administrative data, and medical record vendor oversight.
  - Conducted a thorough review of the Contractor's selected data abstraction tools, functionality, and reviewer instructions.
  - Conducted a final over-read review of a sample of 30 records from two hybrid measures and all medical record exclusions, inclusive of cases across the Contractors' applicable lines of business (when applicable), to ensure the accuracy of the medical record data abstracted.
  - Identified errors and determined if they were critical or noncritical based on the following definitions:
    - **Critical error**: Any finding that changed the compliance of a measure from numerator positive to numerator negative impacting the overall rate.
    - **Non-critical error**: Any finding that did not change the overall compliance of the member and resulted in zero change to the overall rate (i.e., data entry errors, lab result date collected versus read by MD). If errors were identified, a Contractor could be required to provide additional records for review, based upon the auditor's request. Samples with errors

exceeding 10 percent were determined to be materially biased, and HSAG reported the results to AHCCCS to consider adjusting the Contractor's reporting from hybrid to administrative in such instances (although none occurred during the CY 2021 PMV). Error rates less than 10 percent were evaluated for overall rate impact and hybrid data collection would be allowed if the rate was not materially biased, based upon an impact analysis.

- **Prepare for the contractor virtual audit:** HSAG worked with each Contractor to identify a date for the virtual audit that allowed for all appropriate Contractor staff to be present. Once the audit schedule was finalized, HSAG sent it to AHCCCS and coordinated for AHCCCS staff to observe audits based upon AHCCCS' request. HSAG produced a detailed agenda for the virtual audit and worked with each Contractor to ensure the agenda timeline included appropriate staff in the sessions for which they are responsible. Before the date of the virtual audit, HSAG sent the agenda to the Contractor and to AHCCCS, if applicable. Before the virtual audit, HSAG scheduled and facilitated a kick-off call with each Contractor to:
  - Discuss the audit logistics, including virtual review hosting preferences (i.e., Contractor or HSAG), key Contractor attendees, and potential vendor and/or subcontractor attendance if applicable
  - Review the draft agenda
  - Discuss any changes in the Contractor's processes or systems since the previous year's PMV audit
  - Discuss the medical record review process and timeline
  - Discuss the timelines for ISCAT submission, use of the HEDIS Roadmap, identification of supplemental data, administrative rate review, preliminary rate review, and performance measure rate submission
  - Remind the Contractor of the scope of the audit, including measures and primary source verification (PSV) processes
  - Discuss supplemental databases
  - Confirm the Contractor's vendor for certified measures, if applicable
  - Address any Contractor questions or concerns

Virtual Site Review Activities:

HSAG conducted a virtual on-site visit with each Contractor. HSAG collected information using several methods, including interviews, system demonstration, review of data output files, PSV, observation of data processing, and review of data reports. The virtual on-site visit activities are described as follows:

- **Opening meeting:** The opening meeting included an introduction of the validation team and key Contractor staff involved in the PMV activities. The review purpose, the required documentation, basic meeting logistics, and queries to be performed were discussed.
- **Review of ISCAT and Roadmap (if applicable) documentation:** This session was designed to be interactive with key Contractor staff so that the validation team could obtain a complete picture of all steps taken to generate responses to the ISCAT and evaluate the degree of compliance with written documentation. Additionally, to reduce the administrative burden on the Contractors, HSAG allowed

for submission of the same Roadmap used for the NCQA HEDIS Compliance Audit conducted by the Contractors' NCQA-licensed organizations, where appropriate and applicable as part of their ISCAT submissions. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and ascertained that written policies and procedures were used and followed in daily practice.

- **Evaluation of enrollment, eligibility, and claims systems and processes:** This evaluation included a review of the information systems focusing on the processing of claims, processing of enrollment and disenrollment data, and tracking of changes. The evaluation also encompassed a review of the Contractor's claims processing steps through its encounter data submissions to AHCCCS, reviewing for a general reconciliation. Throughout the evaluation HSAG conducted interviews with key staff familiar with the processing, monitoring, reporting, and calculating of the performance measures. Key Contractor staff included executive leadership, enrollment specialists, claims processors, business analysts, customer operations staff, data analytics staff, and other front-line staff familiar with the processing, monitoring, and generating of the enrollment, eligibility, and claims performance measure data.
- **Overview of data integration and control procedures:** The overview included discussion and observation of source code logic, a review of how all data sources were combined, and a review of how the analytic file was produced for the reporting of selected performance measure data. HSAG performed PSV to further validate the output files and reviewed backup documentation on data integration. HSAG also addressed data control and security procedures during this session.
- **Primary source verification:** HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Each Contractor provided a listing of the data that it had reported to HSAG from which HSAG selected a sample. These data included numerator positive records for HEDIS and Core Set measures. HSAG selected a random sample from the submitted data and requested that the Contractor provide proof of service documents or system screenshots that allowed for validation against the source data in the system. These data were also reviewed live in the Contractor's systems during the virtual on-site review for verification, which provided the Contractor with an opportunity to explain its processes as needed for any exception processing or unique, case-specific nuances that may not impact final measure reporting. There may be instances in which a sample case is acceptable based on virtual on-site clarification and follow-up documentation provided by the Contractor.

  Using this technique, HSAG assessed the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across measures to verify that the Contractor had system documentation which supported that it appropriately included records for measure reporting. This technique did not rely on a specific number of cases for review to determine compliance; rather, it was used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected could result in the selection of additional cases to better examine the extent of the issue and its impact on reporting.

- **Closing conference:** The closing conference included a summation of preliminary findings based on the review of the ISCAT and virtual on-site visit, and revisited the documentation requirements for any post-virtual on-site activities.

Description of Data Obtained

As identified in the CMS EQR Protocol, HSAG obtained and reviewed the following key types of data for CY 2021 as part of the PMV:

1. **ISCAT:** This was received from each Contractor. The completed ISCAT provided HSAG with background information on the Contractor's IS, policies, processes, and data in preparation for the virtual validation activities.
2. **Source code (programming language) for performance measures:** This was obtained from each Contractor and was used to determine compliance with the performance measure definitions. If NCQA Certified Measures vendors were used, HSAG requested the Contractors to provide a copy of the certified measure reports to confirm each measure's certification status.
3. **Supporting documentation:** This provided additional information needed by HSAG reviewers to complete the validation process, including performance measure definitions, file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.
4. **Current performance measure results:** HSAG obtained the results from the measures each Contractor reported and calculated.
5. **Virtual interviews and demonstrations:** HSAG obtained information through interaction, discussion, and formal interviews with key Contractor staff as well as through system demonstrations.

How Data Were Aggregated and Analyzed

HSAG also performed a performance validation audit of each Contractor for AHCCCS' selected measures. HSAG evaluated each Contractor's eligibility and enrollment data systems, medical services data systems, and data integration process through an ISCAT, source code review, virtual review of the Contractor, and PSV of a selected sample of measure data.

HSAG analyzed the quantitative results obtained from the above PMV activity to identify strengths and opportunities for improvement in each domain of Quality, Timeliness, and Access to services furnished by each Contractor. HSAG then identified common themes and the salient patterns that emerged across Contractors related to the PMV activity conducted.

How Conclusions Were Drawn

Information Systems Standards Review

Contractors were required to demonstrate compliance with IS standards. Contractors' compliance with IS standards is linked to the validity and reliability of reported performance measure data. HSAG reviewed and evaluated all data sources to determine Contractor compliance with *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*.[A-2] The IS standards are as follows:

- Medical Services Data (Claims/Encounters): Sound Coding Methods and Data Capture, Transfer, and Entry
- Enrollment Data: Data Capture, Transfer, and Entry
- Practitioner Data: Data Capture, Transfer, and Entry
- Medical Record Review Processes: Training, Sampling, Abstraction, and Oversight
- Supplemental Data: Capture, Transfer, and Entry
- Data Preproduction Processing: Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity
- Data Integration: Accurate Reporting, Control Procedures That Support Measure Reporting Integrity

HSAG used the following standardized rating methodology for PMV, as outlined in the current CMS Protocol 2:

- Reportable I: The measure was compliant with the applicable technical specifications
- DNR: The Contractor rate was materially biased and should not be reported
- Not Applicable (NA): The Contractor was not required to report the measure due to a small denominator

Based on all validation activities, HSAG determined results for each performance measure. According to the CMS EQR PMV protocol, the validation designation for each performance measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be noncompliant based on the review findings. Consequently, an error for a single audit element may result in a designation of "DNR" because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, leading to a designation of "R."

Any suggested corrective action that was closely related to accurate rate reporting that could not be implemented in time to produce validated results, rendered a particular measure as "DNR."

[A-2] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington D.C.

Performance Measure Results

Each Contractor's performance measure results for CY 2021 were compared to program-level aggregate rates, prior year Contractor-specific performance, and NCQA's Quality Compass national Medicaid Health Management Organization (HMO) mean for CY 2021, where applicable.

To draw conclusions about the quality and timeliness of, and access to care and services provided by the Contractors, HSAG assigned each of the performance measures to one or more of the three domains of care (i.e., Quality, Timeliness, and Access). This assignment to domains of care is depicted in Table A-1. The measure marked NA indicates the measure is related to utilization of services and, therefore, is not assigned to a domain.

Table A-1—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains

Performance Measure	Quality	Timeliness	Access
Maternal and Perinatal Care			
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Behavioral Health			
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	✓		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	✓		✓
Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	✓	✓	✓
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	✓	✓	✓
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total and *Total Engagement of AOD Treatment—Total—Total*	✓	✓	✓
Care of Acute and Chronic Conditions			
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)	✓		
Controlling High Blood Pressure	✓		

Performance Measure	Quality	Timeliness	Access
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓	✓	✓
Heart Failure Admission Rate	✓		
Diabetes Short-Term Complications Admission Rate	✓		
Pediatric Health			
Annual Dental Visit			✓
Preventive Screening			
Breast Cancer Screening—Total	✓		
Cervical Cancer Screening	✓		
Access to Care			
Annual Dental Visit			✓
Appropriate Utilization of Services			
*Ambulatory Care—ED Visits**	NA	NA	NA
Plan All-Cause Readmissions—Observed Readmissions and *O/E Ratio*	✓		
Use of Opioids at High Dosage	✓		

*Not assigned to a domain as a lower or higher rate does not indicate better or worse performance.

Validation of Performance Improvement Projects

Objectives

The purpose of PIPs is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in both clinical and nonclinical areas. For the projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, the PIPs must be designed, conducted, and reported using sound methodology and must be completed in a reasonable time. This structured method of assessing and improving health plan processes is expected to have a favorable effect on health outcomes and member satisfaction.

The primary objective of PIP validation is to determine the validity and reliability of a PIP through assessing a health plan's compliance with the requirements of 42 CFR §438.330(d)(2) including:

- Measurement of performance using objective quality indicators
- Implementation of systematic interventions to achieve improvement in quality
- Evaluation of the effectiveness of the interventions
- Planning and initiation of activities for increasing or sustaining improvement

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Preventive Screening* PIP for the RBHA population. The objective of the *Preventive Screening* PIP is to increase the number and percentage of breast cancer screenings and cervical cancer screenings. The goal is to demonstrate a statistically significant increase in the number and percentage of breast cancer screenings and cervical cancer screenings, followed by sustained improvement for one consecutive year.

Technical Methods of Data Collection

AHCCCS established a process for selection and validation of clinical and nonclinical focused PIP topics that is based on *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019.[A-3] Table A-2 describes the nine protocol activities and the specific tasks that AHCCCS performed to complete each activity.

[A-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Oct 27, 2022.

Table A-2—Protocol Activities Performed for Validation of PIPs

For this protocol activity,	AHCCCS completed the following activities:
Activity 1:	**Select the Topic**
	PIP topics shall be selected to improve clinical and/or nonclinical services. Selected topics shall reflect the characteristics of AHCCCS members in terms of demographics, prevalence of disease, and potential consequences of the disease. Project topics and performance indicators used to assess each project are identified through data collection and analysis of member needs, care, and services. The selection of PIP topics shall consider: • Performance on standardized performance measures established by CMS, NCQA, Substance Abuse and Mental Health Services Administration (SAMHSA), etc. • Feedback from members or providers • Care of special populations or high priority services, including BH, children with special healthcare needs, Long-Term Services and Supports (LTSS), preventive care, continuity or coordination of care, etc. • Alignment with priority areas identified by CMS
Activity 2:	**Define the Aim statement**
	The PIP aim statement shall identify the focus of the PIP as well as establish the framework for data collection and analysis. The aim statement shall also be answerable and measurable. The aim statement shall clearly and concisely outline: • The improvement strategy • Population • Time period
Activity 3:	**Identify the Population**
	The PIP may be inclusive of the Contractor's entire enrolled population (based on the LOB) or a subset of the population. The included population shall be clearly defined by the following (as applicable): • Age • Length of enrollment • Diagnoses • Procedures • Other characteristics
Activity 4:	**Use Sound Sampling Methods**
	For PIPs which require a sampling methodology, appropriate sampling methods are required to ensure the collection of information produces valid and reliable results.

For this protocol activity,	AHCCCS completed the following activities:
	PIP indicators which align with standardized performance measures shall adhere to the sampling methodology outlined within the measure's associated technical specifications. The sampling methodology shall: • Outline the sampling frame that contains a complete, recent, and accurate list of the target population • Consider and specify the true or estimated frequency of the event, the confidence interval utilized, and the acceptable margin of error • Contain a sufficient number of members • Assess the representativeness of the sample according to subgroups (e.g., age, geographic location, health status) • Include valid sampling techniques utilized to protect against bias
Activity 5:	**Select the Indicators**
	The selected PIP indicator(s) shall: • Be objective, clearly defined, and time-specific • Reliably measure/answer the PIP aim statement • Be available to measure performance and track improvement over time For PIP indicators that are based on standardized performance measures, the indicators shall: • Assess an important aspect of care that will have meaningful impact on members' health or functional status • Be appropriate based on the availability of data and resources to collect the data • Be based on current clinical knowledge or health services research • Monitor performance at a point in time • Track performance over time • Compare performance over time • Inform the selection and evaluation of quality improvement activities The following shall also be considered when selecting PIP indicator(s) based on standardized performance measures: • The measure addresses accepted clinical guidelines relevant to the PIP question • The measure addresses an important aspect of care or operations that was meaningful to members • The available data sources allow for the reliable and accurate calculation of the measure • The criteria utilized in the measure were defined clearly • The measure captures changes in member satisfaction or experience of care

For this protocol activity,	AHCCCS completed the following activities:
Activity 6:	**Collect Valid and Reliable Data**
	Data collection procedures shall ensure that the data utilized to measure performance are valid and reliable. To ensure the validity and reliability of the PIP data collected, the data collection procedures shall specify: • The systematic method for collecting valid and reliable data that represents the population • The frequency of data collection • The data sources • The data elements to be collected The data collection plan shall link to the data analysis plan to ensure that appropriate data are available for the PIP. Additionally, the data collection instruments shall allow for consistent and accurate data collection over the studied time periods. For PIP indicators which utilize qualitative data collection methods, the methods shall be well-defined and designed to collect meaningful and useful information from respondents.
Activity 7:	**Analyze Data and Interpret Results**
	PIP data analysis includes measurements at multiple points in time and tests for statistical significance. Interpretation of the PIP results shall involve an assessment of performance. The PIP methodology shall ensure the analysis: • Is conducted in accordance with the data analysis plan • Includes baseline and repeated measurements of project outcomes • Assesses the statistical significance of any differences between the initial and repeat measurements • Accounts for factors that may influence the comparability of initial and repeat measurements • Accounts for factors that may threaten the internal or external validity of the findings • Compares the results across multiple entities (e.g., MCOs, member subgroups/subpopulations, provider sites, etc.), as applicable PIP results and findings shall be presented in a concise and easily understood manner. To promote continuous quality improvement, the analysis and interpretation of PIP data shall include lessons learned and opportunities for improvement.
Activity 8:	**Review Improvement Strategies**
	Based on the data analysis and interpretation of PIP results, the improvement strategies implemented as part of the PIP shall be reviewed. The selected improvement strategies shall be:

For this protocol activity,	AHCCCS completed the following activities:
	• Evidence-based (i.e., based on existing evidence that the test of change would be likely to lead to the desired improvement in processes or outcomes) • Designed to address root causes or barriers identified through data analysis and quality improvement processes • Culturally and linguistically appropriate Plan-Do-Study-Act (PDSA) cycles shall be utilized to test the selected improvement strategy. In addition, the implementation of the improvement strategy shall be designed to account or adjust for any major variables that could have an obvious impact on the PIP outcomes. Based on the findings from data analysis and interpretation of results, the PIP shall assess the extent to which the improvement strategy was successful and include potential follow-up activities.
Activity 9:	**Assess Whether Significant and Sustained Improvement Occurred**
	A PIP is intended to result in significant and sustained improvement in healthcare delivery processes and outcomes, rather than a short-term or random change. The PIP results shall be assessed to determine if the PIP resulted in statistically significant changes over time that could reasonably be attributed to the improvement strategy implemented as part of the PIP. In order to assess if significant and sustained improvement occurred, repeated measurements that utilize the same methodology as the baseline measurement are required. Tests of statistical significance are also required to assess if statistically significant improvement is demonstrated. The assessment shall consider: • The quantitative evidence of improvement in processes or outcomes of care • If the reported improvement is likely to be a result of the selected intervention • Statistical evidence/significance tests that the observed improvement is a result of the intervention • If sustained improvement was demonstrated through repeated measurements over time

Description of Data Obtained

Typically, PIPs include one intervention year; however, to account for the impact of the COVID-19 PHE, the *Preventive Screening* PIP includes two intervention years within its design in which each Contractor will implement strategies and interventions to improve performance, with CYE 2019 serving as the baseline year, unless otherwise indicated. AHCCCS will then conduct annual measurements to evaluate Contractor performance, with remeasurement years aligning with calendar years: the first remeasurement

year reflective of CY 2022 (January 1, 2022, through December 31, 2022) and the second remeasurement year reflective of CY 2023 (January 1, 2023, through December 31, 2023).

In CY 2022, each Contractor submitted the PIP Intervention Year Attachment form to AHCCCS. The form described each intervention the Contractor implemented during the intervention year, along with the intervention status, focus, and rationale for changes or discontinuation of the intervention for the following year. Specific intervention information for each Contractor can be found in Section 5. RBHA Program Contractor-Specific Results.

Table A-3 and Table A-4 show the indicators, numerators, and denominators that will be used to measure the baseline of this PIP.

Table A-3—*Preventive Screening* PIP Indicator 1

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

Table A-4—*Preventive Screening* PIP Indicator 2

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

Evaluation of Contractor performance on the selected PIP indicators is based on systematic, ongoing collection and analysis of accurate, valid, and reliable data, as collected and reported by AHCCCS or as validated by the AHCCCS' EQRO. For Contractor self-selected PIPs that are not based on standardized

performance measures, the Contractor shall ensure collected data are accurate, valid, and reliable through internal processes.

How Data Were Aggregated and Analyzed

AHCCCS-mandated PIPs typically begin on a date that corresponds with a calendar year. Table A-5 presents the timeline for the *Preventive Screening* PIP.

Table A-5—RBHA Program Timeline for *Preventive Screening* PIPs

PIP—*Preventive Screening*				
CYE 2019	**CY 2020**	**CY 2021**	**CY 2022**	**CY 2023**
Baseline Measurement	Intervention Year 1	Intervention Year 2	Remeasurement Year 1	Remeasurement Year 2

Baseline data are collected and analyzed at the beginning of the PIP. During the Intervention Year[A-4], AHCCCS requires the Contractors to implement interventions to improve performance based on an evaluation of barriers to care/use of services and evidence-based approaches to improving performance. An intervention may consider any unique factors, such as a Contractor's membership, provider network, or geographic area(s) served.

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

Annual measurements (Remeasurement Year 1, Remeasurement Year 2, as well as any subsequent Remeasurement Years necessary for the Contractor to meet the required criteria for PIP closure) are utilized to evaluate Contractor performance. AHCCCS may require interim measurements, depending on the resources required, to collect and analyze data. Annual measurements (rates and results) are used as the basis for quantitative and qualitative analysis, and the selection/modification of interventions.

Contractors are required to submit a formal PIP report to AHCCCS in accordance with the contract. AHCCCS reviews and validates each Contractor PIP Report submission to ensure alignment with AHCCCS PIP policy and checklist requirements are met. Following this review, each AHCCCS Contractor is provided formal feedback and may be required to resubmit its PIP report if such requirements are not met.

[A-4] To account for the impact of the COVID-19 PHE, the *Preventive Screening* PIP, which began in CYE 2019, includes two intervention years within its design.

AHCCCS reviews Contractors' submissions to verify adequate participation in the PIP until Contractors demonstration of significant and sustained improvement is shown, as outlined below.

How Conclusions Were Drawn

AHCCCS ensures the validity and reliability of data submissions through verifying:

- Measurement of performance using objective quality indicators
- Evaluation of the effectiveness of the interventions based on indicators collected as part of the PIP
- AHCCCS determines a Contractor has demonstrated sustained improvement when the Contractor achieves both of the following conditions:
- Establishes how the significant improvement can be reasonably attributable to interventions implemented by the Contractor (i.e., improvement occurred due to the project and its interventions, not another unrelated reason)
- Maintains, or increases, the improvements in performance for at least one year after the significant improvement in performance was first achieved

To draw conclusions about the quality and timeliness of, and access to care and services provided by the Contractors, HSAG assigned each of the components reviewed for PIP validation to one or more of the three domains (i.e., Quality, Timeliness, and/or Access). While the focus of a Contractor's PIP may have been to improve performance related to healthcare Quality, Timeliness, or Access, PIP validation activities were designed to evaluate the validity and quality of the Contractor's process for conducting valid PIPs. Therefore, HSAG assigns all PIPs to the Quality domain. In addition, PIP topics are also assigned to other domains as appropriate. This assignment to domains is shown in Table A-6.

Table A-6—Assignment of PIPs to the Quality, Timeliness, and Access Domains

Performance Improvement Project	Quality	Timeliness	Access
Preventive Screening PIP	✓		

Compliance Review

Objectives

AHCCCS' objectives for conducting compliance reviews are as follows:

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

Technical Methods of Data Collection

To assess for the Contractors' compliance with regulations, AHCCCS conducted the five activities described in CMS' EQR *Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity,* October 2019.[A-5] Table A-7 describes the five protocol activities and the specific tasks that AHCCCS performed to complete each activity.

Table A-7—Protocol Activities Performed for Assessment of Compliance with Regulations

For this protocol activity,	AHCCCS completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	• AHCCCS determined the timing and scope of the reviews, as well as scoring strategies.

[A-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Aug 10, 2021.

For this protocol activity,	AHCCCS completed the following activities:
	• AHCCCS developed monitoring tools and templates, agendas, and set review dates. • AHCCCS conducted training for all reviewers to ensure consistency in scoring across the Contractors.
Activity 2:	**Perform Preliminary Review**
	• AHCCCS notified the Contractors in writing of the request for desk review documents via email delivery of the compliance monitoring tool and an agenda. The desk review request included instructions for organizing and preparing the documents to be submitted. • Prior to the review, the Contractors provided data files from which AHCCCS chose samples to be reviewed, including grievances, appeals, and denials. AHCCCS provided the final samples to the Contractors via AHCCCS' secure file transfer protocol (FTP) site. Prior to the scheduled review, the Contractors provided documentation for the desk review, as requested. • Examples of documents submitted for the desk review and compliance review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The AHCCCS review team reviewed all documentation submitted prior to the scheduled webinar and prepared a request for further documentation, as needed, and an interview guide to use during the webinar.
Activity 3:	**Conduct the Review**
	• During the review, AHCCCS met with groups of the Contractors' key staff to obtain a complete picture of the Contractors' compliance with Medicaid and CHIP managed care regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the Contractors' performance. • AHCCCS requested, collected, and reviewed additional documents, as needed. • At the close of the review, AHCCCS may provide the Contractors' staff with a high level overview of how the overall review process went.
Activity 4:	**Compile and Analyze Findings**
	• AHCCCS used a compliance report template to compile the findings and incorporate information from the compliance review activities. • AHCCCS analyzed the findings and calculated scores based on pre-determined scoring strategies.

For this protocol activity,	AHCCCS completed the following activities:
	• AHCCCS determined opportunities for improvement, recommendations, and corrective actions required based on the review findings.
Activity 5:	**Report Results**
	• AHCCCS populated the report template. • AHCCCS submitted the draft report to the Contractors for review and comment. • AHCCCS considered the Contractor's requests for reconsideration, as applicable, and finalized the report. • AHCCCS included a CAP template with the final report for all requirements determined to be out of compliance with managed care regulations (i.e., received a score less than 95%). • AHCCCS distributed the final report, scores, and CAP template to the Contractor.

Description of Data Obtained

The following are examples of documents reviewed and sources of the data obtained:

- Committee meeting agendas, minutes, and reports
- Policies and procedures
- Management/monitoring reports
- Quarterly reports
- Provider manual and directory
- Member handbook and informational materials
- Staff training materials and documentation of training attendance
- Applicable correspondence or template communications
- Records or files related to administrative tasks (grievances and appeals)
- Interviews with the Contractors' key staff
- How Data Were Aggregated and Analyzed

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

Focus Areas include standards articulated at 42 CFR Part 438 as well as additional contractual requirements. In addition, there may be Focus Areas based solely on contract requirements.

AHCCCS included the following Focus Areas in its compliance review. Table A-8 includes a list of each Focus Area cross-walked with the related federal requirements found in 42 CFR Part 438.

Table A-8—Crosswalk of AHCCCS Focus Areas, Standards, and Federal Requirements

Focus Areas	Federal Requirements Included
CC	438.242, 438.608, 438.610, 455.1, 455.17, 455.100-106, 455.436
CIS	433.135, 434.6, 438.242, 438.600
DS	438.12, 438.102, 438.206, 438.207, 438.214, 438.242
GA	164.530, 438.3, 438.224
GS	438.10, 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.420, 438.424
MCH	441.56, 441.58
MM	438.62, 438.114, 438.136, 438.208, 438.210, 438.228, 438.230, 438.236, 438.240, 438.330, 438.404, 456.125-133
MI	438.10, 438.100, 438.206, 438.207, 438.208, 438.406
QM	438.3, 438.66, 438.206, 438.214, 438.228, 438.230, 438.402, 438.406, 438.408, 438.416, 438.330, 479.98, 476.160
QI	438.330, 438.240, 438.242
DGA	This Focus Area reflects the Contractor's fulfillment of State requirements or regulations outside of CFR §438.
RI	This Focus Area reflects the Contractor's fulfillment of State requirements or regulations outside of CFR §438.
TPL	This Focus Area reflects the Contractor's fulfillment of State requirements or regulations outside of CFR §438.
ISOC	This Focus Area reflects the Contractor's fulfillment of State requirements or regulations outside of CFR §438.

AHCCCS conducts a review of Contractor information systems as part of its PMV process; therefore, there is not an IS component in the compliance review. In addition to the compliance review process, AHCCCS evaluates the Contractors' information systems through ongoing monthly deliverables, encounter editing process, and data validation processes. Further, as of CY 2020, AHCCCS transitioned to using Contractor-calculated performance measure rates that are validated by the Arizona EQRO. The EQRO PMV activities (detailed in Section 5. RBHA Program Contractor-Specific Results) included a review of the Contractors' information systems.

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

HSAG analyzed the quantitative results obtained from the above compliance activity to identify strengths and opportunities for improvement in each domain of Quality, Timeliness, and Access to services furnished by each Contractor. HSAG then identified common themes and the salient patterns that emerged across Contractors related to the compliance activity conducted.

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

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

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to care and services, AHCCCS assigned each of the components reviewed for assessment of compliance with regulations to one or more of the three domains (i.e., Quality, Timeliness, and/or Access). Each standard may involve assessment of more than one domain of care due to the combination of individual requirements within each standard. HSAG then analyzed, to draw conclusions and make recommendations, the individual requirements within each standard that assessed the quality and timeliness of, or access to care and services provided by the Contractors.

Table A-9 depicts assignment of the standards to the domains of care for the RBHA Program.

Table A-9—RBHA Program Assignment of Focus Areas to the Quality, Timeliness, and Access Domains

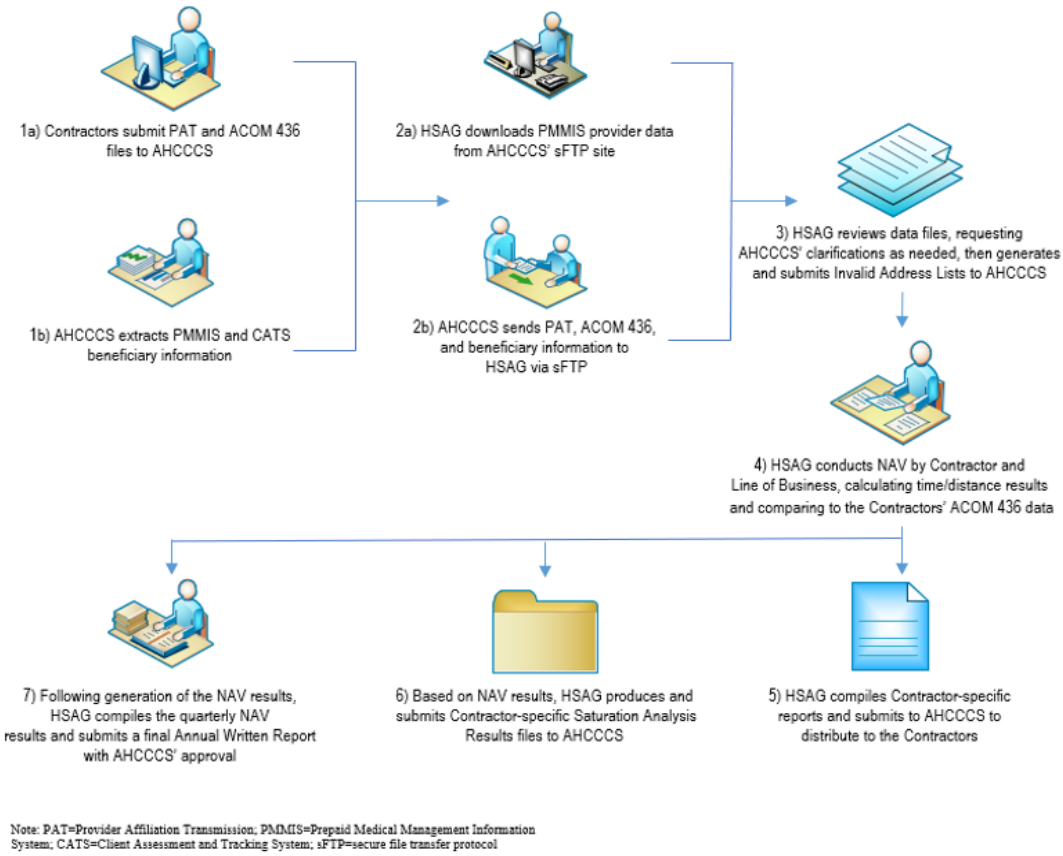
Focus Areas	Quality	Timeliness	Access
CC	✓		✓
CIS			✓
DS		✓	✓
GA		✓	✓
GS	✓	✓	✓
MCH		✓	✓

Focus Areas	Quality	Timeliness	Access
MM	✓	✓	✓
MI	✓		
QM	✓		
QI	✓		✓
DGA	✓		
RI	✓		
TPL	✓	✓	✓
ISOC	✓		✓

Network Adequacy Validation

CYE 2022 is the fourth year in which AHCCCS contracted with HSAG to support biannual analysis and validation of healthcare provider networks subcontracted to AHCCCS' RBHA Program Contractors [A-6]. HSAG's biannual NAV considered each RBHA Program Contractor's compliance with 12 AHCCCS-established time/distance standards during the CYE 2022 measurement period.[A-7] Figure A-1 summarizes the biannual network adequacy data process and reporting products.

Figure A-1—CYE 2022 Biannual Network Adequacy Validation Process



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

[A-6] Validation of network adequacy is a mandatory EQR activity, and states must begin conducting this activity, described in CMS rule §438.358(b)(1)(iv), no later than one year from the issuance of the associated EQR protocol. While the protocol was not released during this study, HSAG's analysis of the Contractor's time/distance results aligns with current federal regulations.

[A-7] The AHCCCS Contractors Operations Manual (ACOM), Section 436—Network Standards defines time/distance standards, as well as provider identification and members' county assignment criteria. The ACOM is available at: https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/436_Network_Standards.pdf.

HSAG conducted biannual validation between the RBHA Program Contractors' self-reported ACOM 436 results and HSAG's time/distance calculations for all Contractors in each quarter that data could be compared.

Objectives

The NAV activities, in anticipation and release of the CMS protocol, were designed to help AHCCCS meet the NAV requirements once the EQR protocol is released. HSAG used data supplied by AHCCCS to calculate the number and percentage of RBHA members within a defined time or distance from up to 11 types of AHCCCS-defined providers. As Table A-10 describes, these time/distance standards vary by provider type and county, and some standards may not apply to every Contractor.

Table A-10—Time/Distance Network Standards for AHCCCS Contractors by Provider Type and Geography

Provider Type	Member Population	Network Standard Maricopa and Pima Counties	Network Standard All Other Arizona Counties
Behavioral Health Outpatient and Integrated Clinic, Adult[3]	Members aged 18 years and older	90 percent of members within 15 minutes or 10 miles	90 percent of members within 60 miles
Behavioral Health Residential Facility[1]	All members	90 percent of members within 15 minutes or 10 miles	Not Applicable
Cardiologist, Adult[3]	Members aged 21 years and older	90 percent of members within 30 minutes or 20 miles	90 percent of members within 75 minutes or 60 miles
Cardiologist, Pediatric[3]	Members younger than 21 years	90 percent of members within 60 minutes or 45 miles	90 percent of members within 110 minutes or 100 miles
Crisis Stabilization Facility[2]	All members	90 percent of members within 15 minutes or 10 miles	90 percent of members within 15 minutes or 45 miles
Dentist, Pediatric	Members younger than 21 years	90 percent of members within 15 minutes or 10 miles	90 percent of members within 40 minutes or 30 miles
Hospital	All members	90 percent of members within 45 minutes or 30 miles	90 percent of members within 95 minutes or 85 miles
OB/GYN	Female members aged 15 to 45 years	90 percent of members within 45 minutes or 30 miles	90 percent of members within 90 minutes or 75 miles

Provider Type	Member Population	Network Standard Maricopa and Pima Counties	Network Standard All Other Arizona Counties
Pharmacy	All members	90 percent of members within 12 minutes or 8 miles	90 percent of members within 40 minutes or 30 miles
PCP, Adult[3]	Members aged 21 years and older	90 percent of members within 15 minutes or 10 miles	90 percent of members within 40 minutes or 30 miles
PCP, Pediatric[3]	Members younger than 21 years	90 percent of members within 15 minutes or 10 miles	90 percent of members within 40 minutes or 30 miles

1. Applies only to Maricopa and Pima counties.
2. Applies only to RBHA Program Contractors.
3. Services identified as eligible for a telehealth standard modification only require 80 percent of a county's membership to meet the time and distance standards where telehealth services are available for that provider category

Technical Methods of Data Collection

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

1. **Time/Distance Calculation**: HSAG's calculation of results for all applicable AHCCCS-established time/distance standards by Contractor, LOB, and county, using member and PAT data.
   - Study indicators show the percentage of members assigned by AHCCCS to the specified county, with access to any provider location serving the LOB within the time/distance standard
2. **Time/Distance Validation**: Validation of each Contractor's compliance with the time/distance standards, based on HSAG's time/distance calculation results from #1 above.
   - Study indicators validate each Contractor's reported compliance with each time/distance standard applicable to the LOB and county. Scoring is as follows:
     - A score of *Met* indicates that HSAG's time/distance results show a percentage of members at or above the time/distance standard
     - A score of *Not Met* indicates that HSAG's time/distance results show a percentage of members below the time/distance standard
     - An asterisk (*) identifies standards with fewer than 10 members included in HSAG's time/distance calculation results
     - The value "NA" identifies standards not applicable to the LOB and/or geography
     - The value "NR" identifies standards for which no members met the network requirement denominator for the LOB and geography; therefore, HSAG calculated no corresponding time/distance result

- Study indicators also consider the degree to which HSAG's time/distance results align with the time/distance values reported in each Contractor's ACOM 436 submission
  - Shaded cells in the Findings tables identify notable differences between each Contractor's ACOM 436 time/distance calculation results and HSAG's results

3. **Provider Saturation Analysis**: HSAG's assessment of the degree to which each Contractor's provider network reflects available AHCCCS-contracted providers.
   - Study indicators include the number of AHCCCS-contracted provider locations not reflected in each Contractor's biannual PAT file for each applicable time/distance standard scored as *Not Met*

Description of Data Obtained

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

- Prepaid Medical Management Information System (PMMIS) provider data—Data files maintained by AHCCCS that list all AHCCCS-contracted providers and their corresponding addresses.
- AHCCCS member data—A data file compiled by AHCCCS from the PMMIS and Client Assessment and Tracking System (CATS) data. PMMIS data elements include the addresses and other necessary demographic information on AHCCCS members. Specific data elements from CATS identify all AHCCCS members who live in their own homes for calculation of the Nursing Facility time/distance standard.
- Contractor PAT files—An aggregated data file listing each Contractor's network providers, as identified to AHCCCS by each Contractor.
- Contractor-specific ACOM 436 submissions—One MS Excel workbook for each Contractor and LOB with a tab listing the Contractor's results for compliance with county-level time/distance standards.

Table A-11 shows the effective dates for the data files supplied to HSAG in each measurement period.

Table A-11—Effective Dates for AHCCCS-Supplied Network Adequacy Data by Quarter and Data Type

Data Source	CYE 2022 Q2	CYE 2022 Q4
Measurement Period	April 2022	October 2022
PMMIS Providers	April 2022	October 2022
AHCCCS Members	April 2022	October 2022
Contractor-Specific PAT Providers	April 2022	October 2022
Contractor-Specific ACOM 436 Submissions	April 2022	October 2022

How Data Were Aggregated and Analyzed

HSAG used the Quest Analytics Suite software, version 2022.1 (Quest) to geocode the PAT and PMMIS addresses for members and providers, assigning each address to an exact geographic location (i.e., latitude and longitude). To facilitate geocoding, HSAG standardized member and provider address data to align with the United States Postal Service Coding Accuracy Support System (USPS CASS) to ensure consistent address formatting across data files.

HSAG assembled the geocoded member (PMMIS) and provider (PAT) addresses into datasets that were used with Quest to calculate the percentage of members meeting the time/distance standards described in Table A-12. Biannual county-specific time/distance calculations were conducted separately for each LOB and excluded less than 1 percent of members and providers with addresses that could not be geocoded or were geocoded to non-neighboring states. HSAG's time/distance calculations considered the driving time/distance between a member and the nearest provider location (i.e., the time or distance for the member to reach the provider using established roadways). Driving time calculations assumed 30 miles per hour (MPH) for Maricopa and Pima counties and 55 MPH for all other counties.

How Conclusions Were Drawn

To assess the validity of each Contractor's biannual ACOM 436 submission, HSAG compared the time/distance results calculated from the PMMIS and PAT data against the biannual ACOM 436 time/distance results submitted to AHCCCS by each Contractor.

Biannual analyses reflect the following measurement periods, which is a change from the previous quarterly measurement periods:

- CYE 2022 Q2: January 1–March 31, 2022
- CYE 2022 Q4: July 1–September 30, 2022

Additionally, detailed time/distance results were presented to AHCCCS and the Contractors each quarter as interactive Tableau dashboards containing the following information:

- Network Adequacy Assessment Comparison—Time and Distance: A dashboard assessing the differences between Contractors' network adequacy results and HSAG's results calculated for the time distance standards
- Network Adequacy Assessment Trending—Time and Distance: A dashboard comparing Contractor and HSAG Network Adequacy Assessment results across reporting periods by county, urbanicity, and provider category
- Time and Distance Standards Assessment: A dashboard assessing Contractors' compliance with time and distance standards by county, urbanicity, and provider category

HSAG deemed that all NAV activities were related to both the Access and Timeliness domains of care.

Analytic Considerations

AHCCCS does not define the software or process by which each RBHA Program Contractor calculates the biannual ACOM 436 time/distance results. HSAG uses Quest to calculate time/distance results based on driving distances, and additional discrepancies may result if Contractors use different versions of Quest during each of the different data network validations.[A-8] Table A-12 describes each RBHA Program Contractor's self-reported methods for calculating the ACOM 436 results, as of September 2022.

Table A-12—RBHA Program Contractors' ACOM 436 Calculation Methods, as of September 2022

Contractor	ACOM 436 Calculation Method
AzCH-CCP RBHA	Calculates time/distance results based on driving distances using Quest version 2021.4
HCA RBHA	Calculates time/distance results based on driving distances using Quest version 2022.1
Mercy Care RBHA	Calculates time/distance results based on driving distances using Quest version 2022.2

AHCCCS members may seek care from network providers practicing outside of the member's county of residence. As such, HSAG considered all applicable provider locations within a LOB when calculating time/distance results. This section presents, by LOB, the biannual validation results for Contractors' county-specific time/distance network standards. However, HSAG's time/ distance calculations included all available provider locations noted in Contractors' PAT data files, without considering potential barriers to new patient acceptance or appointment availability at individual provider locations.

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

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

[A-8] AHCCCS' member address data may not always reflect a member's place of residence (e.g., use of post office boxes), or be identifiable with mapping software (e.g., addresses reflecting local place designations, rather than street addresses). While mapping software may assign members to geographic coordinates, these coordinates may not align with the member's exact residential location for records that do not use a standard street address.

Aggregating and Analyzing Program-Level Data

HSAG follows a four-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the Quality, Timeliness, and Access to care furnished by each MCO, as well as the program overall. To produce AHCCCS' Annual Technical Reports, HSAG performed the following steps to analyze the data obtained and draw program-level conclusions about the Quality, Timeliness, and Access to care and services provided by the Contractors:

Step 1: HSAG analyzed the quantitative results obtained from each EQR activity for each Contractor to identify strengths and opportunities for improvement in each domain of Quality, Timeliness, and Access to services furnished by the Contractor for the EQR activity.

Step 2: From the information collected, HSAG identified common themes and the salient patterns that emerged across EQR activities for each domain and drew conclusions about overall Quality, Timeliness, and Access to care and services furnished by the Contractor.

Step 3: From the information collected, HSAG identified common themes and the salient patterns that emerged across all EQR activities related to strengths and opportunities for improvement in one or more of the domains of, Quality, Timeliness, and Access to care and services furnished by the Contractor.

Step 4: HSAG identified any patterns and commonalities that exist across the program to draw conclusions about the Quality, Timeliness, and Access to care for the program.

Appendix B. Acknowledgments and Copyrights

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