



**Arizona's Section 1115 Waiver Demonstration
Annual Report
Federal Fiscal Year 2019
October 1, 2018 – September 30, 2019**

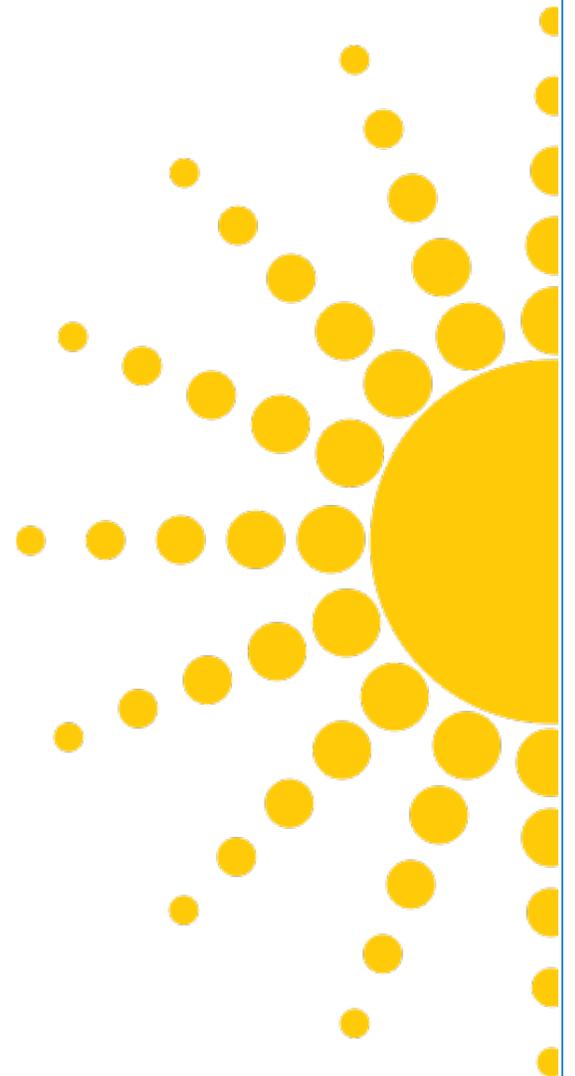


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I. Introduction

Since its inception, the Arizona Health Care Cost Containment System (AHCCCS), Arizona's single state Medicaid agency, has had the unique distinction of operating a statewide managed care program under the Section 1115 Research and Demonstration Waiver. During its 37 years of operation, the program has proven to be an effective model for the delivery of high quality and cost effective health care services to low income populations. With a model based on competition and member choice, AHCCCS has frequently been a pioneer in testing health care policies and financing strategies, continuously seeking to improve health care outcomes while containing costs.

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

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

II. Waiver Demonstration Changes

In its effort to reform and modernize the Medicaid program, AHCCCS continues to work with CMS on various waiver amendment requests. Below is a summary of the waiver amendments that have been approved in fiscal year 2019.

AHCCCS Works Waiver Amendment

On January 18, 2019, CMS approved Arizona's request to amend its Section 1115 Demonstration project, entitled "Arizona Health Care Cost Containment System (AHCCCS)," in accordance with Section 1115(a) of the Social Security Act. The federal approval authorized Arizona's Medicaid Program to implement community engagement requirements for able bodied adult beneficiaries who are 19 to 49 years old and fall within the Group VIII population (individuals with incomes between 0 and 138% of the Federal Poverty Level who are not otherwise eligible for Medicaid in any other category).

Arizona's community engagement program, known as "AHCCCS Works," is designed to encourage qualifying beneficiaries to use existing community services and resources in order to gain and maintain meaningful employment, job training, education, or volunteer service experience. Beneficiaries who are required to comply with AHCCCS Works will participate in at least 80 hours of community engagement activities per month. Beneficiaries may satisfy community engagement requirements through a variety of qualifying activities including:

- Employment (including self-employment)
- Education (less than full-time education)
- Job or life skills training

- Job search activities
- Community service

Upon becoming subject to the community engagement requirements, beneficiaries will receive an initial three-month orientation period to become familiar with the AHCCCS Works program. During this period, the beneficiary will receive information about the community engagement requirements, how to comply, and how to access available community engagement resources. After the three-month orientation period, beneficiaries who do not complete at least 80 hours of community engagement per month will be suspended from AHCCCS coverage for two months, and then be automatically reinstated.

The AHCCCS Works requirements will not apply to individuals who meet any of the following conditions:

- Pregnant women and women up to the end of the month in which the 60th day of post-pregnancy occurs
- Former foster care youth up to age 26
- Beneficiaries who are members of a federally recognized tribe
- Beneficiaries determined to have a serious mental illness (SMI)
- Beneficiaries currently receiving temporary or permanent long-term disability benefits from a private insurer or from the state or federal government, including workers compensation benefits
- Beneficiaries who are medically frail
- Beneficiaries who are in active treatment with respect to a substance use disorder (SUD)
- Full time high school, trade school, college or graduate students
- Victims of domestic violence
- Beneficiaries who are homeless
- Designated caretakers of a child under age 18
- Caregivers who are responsible for the care of an individual with a disability
- Beneficiaries who have an acute medical condition
- Beneficiaries who are receiving Supplemental Nutrition Assistance Program (SNAP), Cash Assistance, or Unemployment Insurance income benefits
- Beneficiaries participating in other AHCCCS approved work programs
- Beneficiaries not mentioned above who have a disability as defined by federal disabilities rights laws (ADA, Section 504, and Section 1557) who are unable to participate in AW Requirements for disability-related reasons

Arizona has decided to postpone implementation of AHCCCS Works until further notice. This decision is informed by the evolving national landscape concerning Medicaid community engagement programs and ongoing litigation regarding this topic.

Prior Quarter Coverage Waiver Amendment

On January 18, 2019, CMS approved Arizona's request to limit retroactive coverage (Prior Quarter Coverage) to the month of application for all Medicaid beneficiaries, except for pregnant women, women who are 60 days or less postpartum, and infants and children under 19 years of age. The goals of

the demonstration are to encourage beneficiaries to obtain and maintain health coverage, even when healthy, or to obtain health coverage as soon as possible after becoming eligible, increase continuity of care by reducing gaps in coverage that occur when members “churn” (individuals moving on and off Medicaid repeatedly), and therefore, improve health outcomes and reduce costs to AHCCCS, ensuring the long term fiscal sustainability of the Arizona Medicaid program. The effective date for the implementation of retroactive coverage changes was July 1, 2019.

AHCCCS Technical Correction Amendment

On September 13, 2019, CMS approved Arizona’s request for technical amendments to the language in the Special Terms and Conditions to reflect the delivery system changes resulting from the AHCCCS Complete Care managed care contract award. CMS has issued the following technical corrections, in accordance with Arizona's request:

- Simplified language in Waiver Authority #1, Section II Program Overview, and Historical Context and Special terms and conditions (STCs) 26, 29(g), 46 and 72(c).
- Updated STCs 18 and 41 to detail that Arizona Acute Care Program (AACP) beneficiaries receive behavioral and physical health care through a single AHCCCS Complete Care (ACC) Plan.
- Updated STCs 27 and 43 to reflect that Children Rehabilitative Services (CRS) beneficiaries receive behavioral and physical health care through a single ACC Plan.
- Updated STC 42 to reflect how beneficiaries under the Arizona Long Term Care System (ALTCs) receive physical, behavioral, and long term care services.
- Updated STC 61, 68, and 69 Table 8 to reflect accurate measures and targets language for the Targeted investments Program

III. 1115 Waiver Post Award Forum

Pursuant to STC 10 and 42 CFR 431.420(c), within six months of the 1115 waiver demonstration implementation, and annually thereafter, Arizona is required to host a post award public forum in order to give stakeholders the opportunity to provide meaningful comment on the progress of the demonstration.

AHCCCS hosted community meetings across the state to provide the public with information about its 1115 waiver demonstration program. The Agency hosted six public forum meetings in fiscal year 2019; two sessions on March 29, 2019 in Tucson; April 3 and April 15, 2019 in Phoenix; April 5, 2019 in Prescott Valley and April 5, 2019 in Flagstaff. Furthermore, AHCCCS presented the details of its demonstration waiver at the Arizona State Medicaid Advisory Committee (SMAC) on October 17 2018, January 9, 2019, April 11, 2019, July 11, 2019 and October 9, 2019.

In-person tribal consultations were held on October 24, 2018, January 17, 2019, May 24, 2019 and July 11, 2019. Two special tribal consultations were held on February 14, 2019 and April 26, 2019 which were Web conferences only. All the stakeholder meetings had telephonic conference capabilities that ensured statewide accessibility. The presentation slides can be found in **Appendix A**.

Since AHCCCS received Waiver Amendment approval from CMS to implement community engagement requirements and to limit retroactive coverage for some applicants to the beginning of the month in which the Medicaid application is filed, AHCCCS hosted various community meetings and tribal roadshows across the state to provide the public with information on these waiver amendments, to

present on upcoming AHCCCS initiatives, and to gather feedback from stakeholders including members and their families, advocates and providers. A total of six tribal specific roadshows focusing on AHCCCS Works and Prior Quarter Coverage were hosted in Peach Springs, Whiteriver, Window Rock, Yuma, Tucson and Phoenix in May-June 2019.

IV. Outreach and Innovation Activities

AHCCCS conducts numerous outreach activities across Arizona to educate the community about AHCCCS programs, partnerships, and policy changes. Below is a summary of the Agency's outreach activities in FY 2019.

The Division of Community Advocacy and Intergovernmental Relations (DCAIR)

The Division of Community Advocacy and Intergovernmental Relations (DCAIR) at AHCCCS is tasked with supporting members, family members and other stakeholders in navigating the Medicaid delivery system as well as engage federal stakeholders on State plan amendments and 1115 waiver requests. DCAIR has four departments that advocate on behalf of members and oversee federal policy relations:

- ***The Office of Human Rights (OHR)***—Provides advocacy to individuals determined to have a serious mental illness to help them understand, protect and exercise their rights, facilitate self-advocacy through education and obtain access to behavioral health services in the Arizona Medicaid delivery system. OHR's community engagement and advocacy activities include, but are not limited to, special assistance home visits, hospital visits, staffing, provider coordination, grievance and appeal matters, Individual Service Planning (ISP) meetings, jail visits, intakes, general outreach and education. OHR currently provides assistance to the largest number of individuals in the history of this office. Statewide, the OHR maintains a list of 3,229 individuals identified as Special Assistance and provides direct advocacy via assignment to 794 members.
- ***The Office of Individuals and Family Affairs (OIFA)***—Promotes recovery, resiliency, and wellness for individuals with mental health and substance use challenges. OIFA builds partnerships with individuals, families of choice, youth, communities, organizations and collaborates with key leadership and community members in the decision making process at all levels of the behavioral health system. OIFA leverages the strategies below to advocate on behalf of members and families:
 - OIFA works to ensure AHCCCS members and their families have direct and meaningful input into the behavioral health system, policies, programs and practices that affect services. This is accomplished by a variety of methods including supporting community advocacy, ensuring peer and family voice is heard at the policy making level, and reviewing documents that are intended to be shared with the stakeholders;
 - OIFA assists and promotes the Peer and Family Career Academy which provides quality continuing education for peer and family support employees by offering classes that enhance and strengthen their skills and knowledge (e.g. forensic, opioid crisis, self-care, effective advocacy, leadership and supervision);
 - The OIFA Advisory Council meets monthly to allow members, families, and stakeholders to discuss system issues and advocacy opportunities;
 - OIFA holds one-on-one meetings with members to address system barriers and develop strategies that improve access to Medicaid services; and

- OIFA provides one page informational pamphlets to help members and families better understand how to access services.¹
- **Federal Relations and Communications (FRAC)**—The Office of Federal Relations and Communications is responsible for overseeing federal policy relations. The team includes:
 - Federal Relations Administrator
 - State Plan and Health Policy Manager
 - Waiver Manager
 - Tribal Liaison
 - Public Information Officer
 - Graphic Designer

These staff perform various duties including: serving as the liaison and point of contact with the CMS on Title XIX and XXI policy issues; maintaining regular communication with the Office of the Governor and the State’s health policy advisor; coordinating quarterly Tribal Consultation meetings and ad hoc meetings as needed with Arizona tribal communities and Indian Health Services; advising the Director and Governor’s Office on issues related to health care policy.

The team also provides communication and graphic design service for all AHCCCS divisions, including graphics, print and digital needs, press releases, social media posts and internal employee announcements

- **The Community Affairs Liaison**—oversees a number of committees and councils that advise AHCCCS on strategic planning, system operations, and policy changes. These councils and committees include:
 - *ALTCS Advisory Council*— Assist the ALTCS Program to develop and monitor a work plan that addresses opportunities for new service innovations or systemic issues impacting ALTCS Members. The Advisory Council consists of ALTCS members and their family/representatives, MCOs, providers, and advocacy agencies. The ALTCS Advisory Council meetings are held quarterly.
 - *Behavioral Health Planning Council*— Advises AHCCCS in planning and implementing a comprehensive community based system of Behavioral Health and Mental Health Services. The Council reviews plans provided by the State of Arizona and provide suggestions for additions and modifications.²
 - *State Medicaid Advisory Committee (SMAC)*—Reviews and advises the Medicaid agency on the operations, programs, and planning for Arizona's Medicaid program, including issues of concern to the community. SMAC meetings are held quarterly.³
 - *Autism Advisory Committee*— Committee is charged with articulating a series of recommendations to the State for strengthening the health care system’s ability to respond to the needs of AHCCCS members with or at risk for ASD, including those with

¹ <https://www.azahcccs.gov/AHCCCS/HealthcareAdvocacy/OIFA.html>

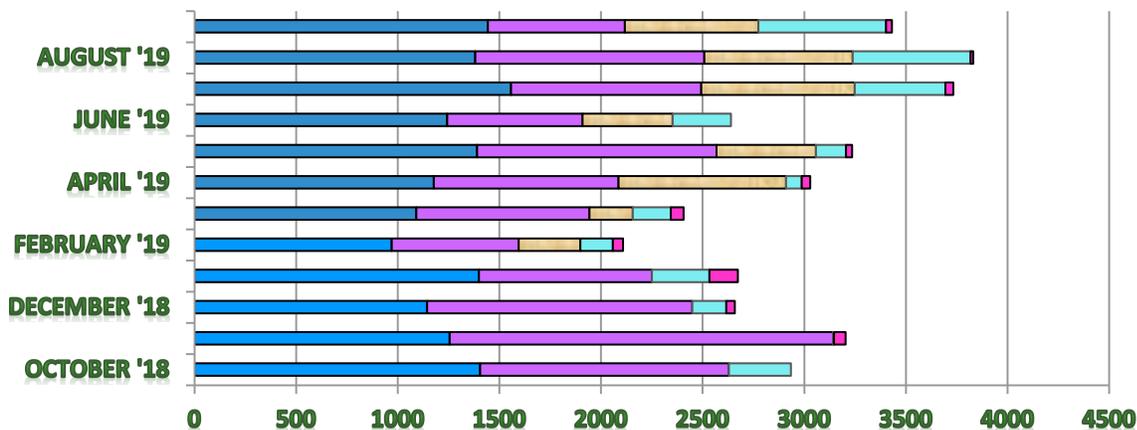
² Behavioral Health Planning Council: <https://www.azahcccs.gov/Resources/Grants/CMHS/>

³ SMAC: <https://www.azahcccs.gov/AHCCCS/HealthcareAdvocacy/smac.html>

comorbid diagnoses. The Committee focuses on individuals with varying levels of needs across the spectrum, including those who are able to live on their own and those who may require institutional levels of care, and addresses both the early identification of ASD and the development of person-centered care plans.⁴

- *Arizona Council of Human Services Providers*— The Council provides a collective voice for members to influence local, state, and federal public policy decisions both legislatively and administratively. Member agencies’ ability to provide high quality, evidence based programs is dependent on ensuring adequate funding is available to those who serve our most vulnerable citizens. Council staff establish and maintain strong relationships with elected officials, their staff, and state department staff (DES, DHS, AOC, etc.), and encourage member program staff to do the same on a local level.
- *The AHCCCS independent Oversight Committees for the Mentally Ill*- These Committees are made up of community volunteers with a range of educational and personal experiences as specified in Arizona Revised Statute 41-3803 and 3804. The Committees review reports, make regular site visits and hold open meetings to provide advocacy to individuals determined to have a serious mental illness. The Committees also make recommendations to the Administration and the Legislature to improve the public behavioral health system.

The charts below delineate the number of individuals who were engaged through DCAIR’s outreach and community engagement activities in FY 2019.



Number of Individuals Engaged through DCAIR’s Outreach and Community Engagement Activities in FY 2019

⁴ Autism Advisory Council: <https://www.azahcccs.gov/shared/asd.html>

	OHR (SMI Specific Community Engagement Activities)	OIFA	FRAC	Committees & Council Liaison	Assistant Director	Total
October '18	1,406	1,224	0	0	305	2,935
November '18	1,256	1,886	0	57	5	3,204
December '18	1,145	1,305	0	42	167	2,659
January '19	1,400	851	0	140	283	2,674
February '19	971	625	303	50	160	2,109
March '19	1,092	852	213	63	187	2,407
April '19	1,178	909	824	42	77	3,030
May '19	1,391	1,178	489	30	148	3,236
June '19	1,244	666	443	0	287	2,640
July '19	1,558	936	755	39	446	3,734
August '19	1,382	1,127	730	13	580	3,832
September '19	1,444	674	657	29	628	3,403
Total	15,467	12,233	4,997	505	3,273	35,863

The Division of Member Services (DMS)

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

- *Quarterly Justice Transition Meetings*—DMS provided an overview of ACC enrollment and discussed partnerships/collaborations between AHCCCS and State/County Justice Community Partners.
- *Juvenile Justice Eligibility and Enrollment Meetings*— DMS discussed efforts to improve partnerships and collaborations between AHCCCS and Juvenile State/County Justice Community Partners.
- *DES/AHCCCS Community Partner Review*—DMS provided information on how stakeholders can become community partners in rural areas.
- *ALTCS Presentations*—numerous meetings were held across the state regarding ALTCS eligibility and enrollment policies.

V. Enrollment Information

Table 1 contains a summary of the number of unduplicated enrollees for FY 2019 (October 1, 2018—September 30, 2019), by population categories. The table also includes the number of voluntarily and involuntarily disenrolled members during this period.

Table 1

Population Groups	Number of Enrollees	Number Voluntarily Disenrolled	Number Involuntarily Disenrolled
Acute AFDC/SOBRA	1,504,278	13,312	878,079
Acute SSI	222,003	1,630	73,394
Prop 204 Restoration	760,362	3552	264,214
Adult Expansion	184,747	1,675	124,635
LTC DD	35,962	196	8,871
LTC EPD	42,373	299	18,025
Non-Waiver	76,169	901	60,747
Total	2,825,894	21,565	1,427,965

Table 2 is a snapshot of the number of current enrollees (as of October 1, 2019) by funding categories as requested by CMS.

Table 2

State Reported Enrollment in the Demonstration (as requested)	Current Enrollees
Title XIX funded State Plan ⁵	1,343,840
Title XXI funded State Plan ⁶	36,050
Title XIX funded Expansion ⁷	409,006
• Prop 204 Restoration (0-100% FPL)	331,438
• Adult Expansion (100% - 133% FPL)	77,568
Enrollment Current as of	10/1/19

VI. Consumer Issues

In support of the annual report to CMS, presented below is a summary of advocacy issues received in the Office of Client Advocacy (OCA) for FY 2019.

Advocacy Issues ⁸	Quarter 1 10/01/18- 12/31/18	Quarter 2 1/1/19- 3/31/19	Quarter 3 4/1/19- 6/30/19	Quarter 4 7/1/19- 9/30/19	Total
Billing Issues	27	26	26	41	120
• Member reimbursements					
• Unpaid bills					

⁵ SSI Cash and Related, 1931 Families and Children, 1931 Related, TMA, SOBRA child and pregnant, ALTCS, FTW, QMB, BCCP, SLMB, QI-1

⁶ KidsCare

⁷ Prop 204 Restoration & Adult Expansion

⁸ Categories of good customer service, bad customer service, documentation, policy, and process are captured under the category it may relate to.

Cost Sharing <ul style="list-style-type: none"> • Co-pays • Share of Cost (ALTCS) • Premiums (Kids Care, Medicare) 	0	6	0	6	12
Covered Services	151	68	41	61	321
ALTCS <ul style="list-style-type: none"> • Resources • Income • Medical 	19	9	23	16	67
DES <ul style="list-style-type: none"> • Income • Incorrect determination • Improper referrals 	74	43	68	23	208
KidsCare <ul style="list-style-type: none"> • Income • Incorrect determination 	5	12	10	10	37
SSI/Medical Assistance Only <ul style="list-style-type: none"> • Income • Not categorically linked 	28	12	19	12	71
Information <ul style="list-style-type: none"> • Status of application • Eligibility Criteria • Community Resources • Notification (Did not receive or didn't understand) 	180	118	223	213	734
Medicare <ul style="list-style-type: none"> • Medicare Coverage • Medicare Savings Program • Medicare Part D 	11	5	9	28	53
Prescriptions <ul style="list-style-type: none"> • Prescription coverage • Prescription denial 	12	14	20	24	70
Fraud-Referred to Office of Inspector General (OIG)	0	1	8	4	13
Quality of Care-Referred to Division of Health Care Management (DHCM)	8	11	25	16	60
Total	515	325	472	454	1,766

Issue Originator⁹	Quarter 1 10/01/18- 12/31/18	Quarter 2 1/1/19- 3/31/19	Quarter 3 4/1/19 - 6/30/19	Quarter 4 7/1/19 - 9/30/19	Total
Applicant, Member or	448	309	417	361	1535

⁹ This data was compiled from the OCA logs by the OCA Client Advocate and the Member Liaison.

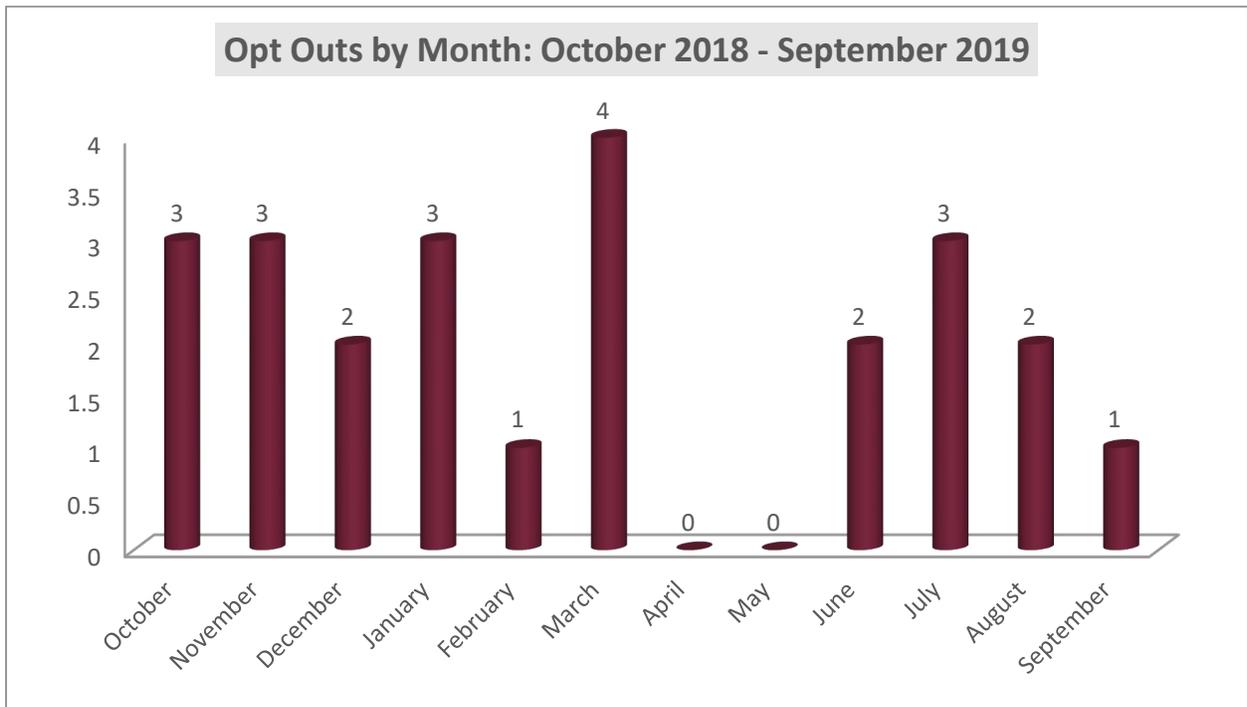
Representative					
CMS	6	14	13	12	45
Governor's Office	29	16	20	15	80
Ombudsmen/Advocates/Other Agencies	20	8	12	9	49
Senate & House	12	21	10	14	57
Total	515	368	472	411	1,766

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

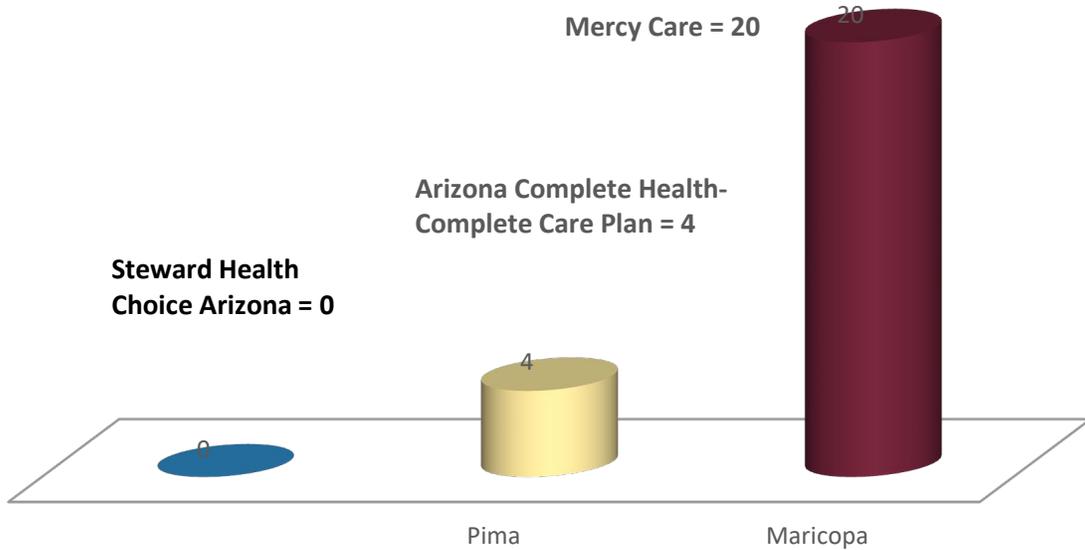
Below is a summary of the opt-out requests filed by individuals determined to have a SMI in Maricopa County and Greater Arizona, broken down by months, health plans, counties, reasons for opt-out requests, opt-out outcome, and post-appeal opt-out outcomes.

Opt Outs for October 2018 – September 2019

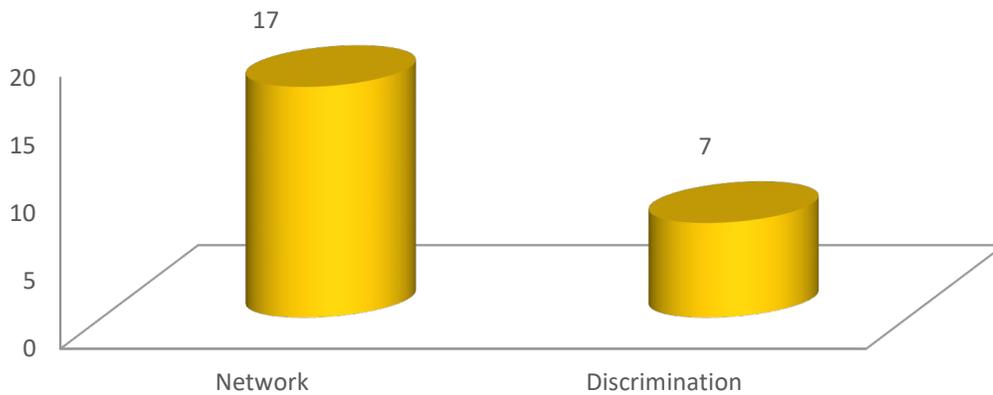
Charts generated by Information Management/Data Analytics Unit (IMDAU)



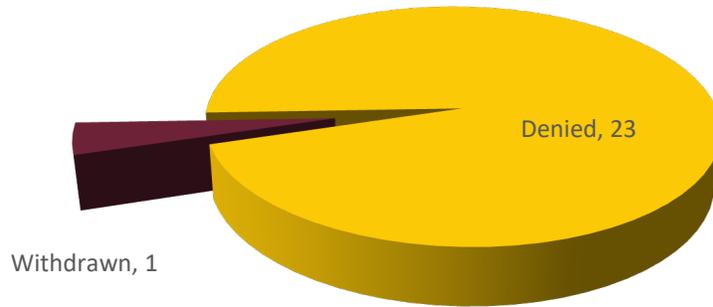
Number of Opt Outs by County/Health Plan (October 2018 - September 2019)



Reason for Opt Out (October 2018 - September 2019)

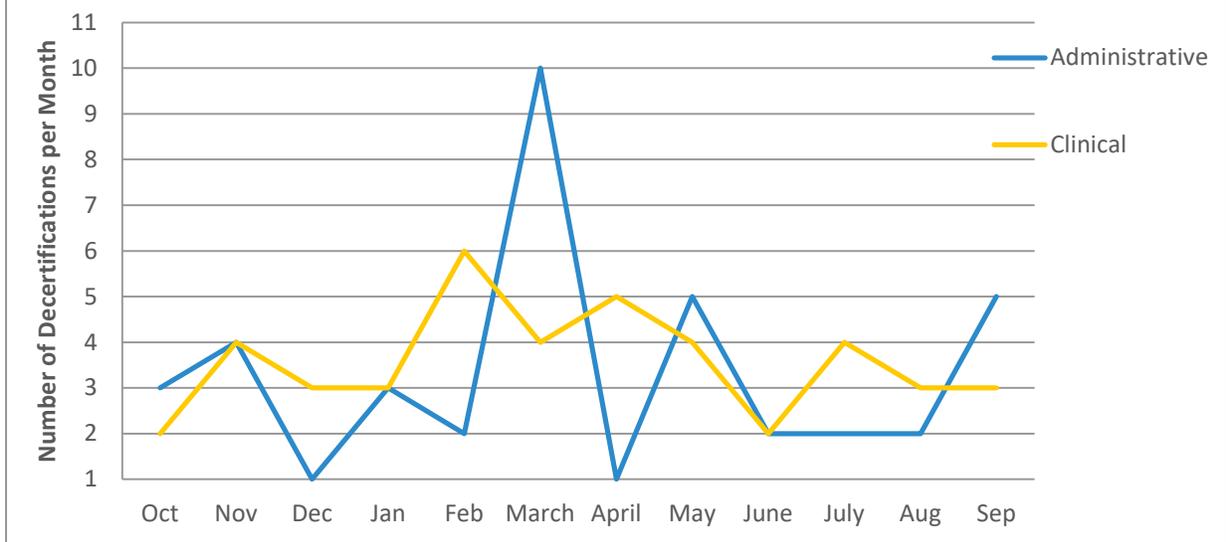


Initial Opt Out Decisions (October 2018 - September 2019)



Appeal Outcomes (October 2018 - September 2019)			
Approved	Withdrawn	Denied	Pending
0	0	3	0

Decertification by Type per Month: October 2018 - September 2019



October 2018 – September 2019 Opt Out Request													
	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Total
Admin	3	4	1	3	2	10	1	5	2	2	2	5	40
Clinical	2	4	3	3	6	4	5	4	2	4	3	3	43

Note:

There are two established mechanisms for changing an individual’s designation and service eligibility as SMI as follows:

- Clinical decertification. Eligibility for SMI services is based upon a clinical determination involving whether a person meets a designated set of qualifying diagnostic and functional criteria. Clinical decertification involves a review of the criteria to establish whether or not an individual continues to meet SMI criteria. If a clinical review finds that a person no longer meets the established criteria, the person’s SMI eligibility is removed. In this case the person will be eligible for behavioral health services under the general mental health (GMH) program category. These determinations are made by AHCCCS’ contracted vendor, Crisis Response Network.
- Administrative decertification. This process is an administrative option that allows for an individual to elect changing their behavioral health category from SMI to GMH. This process is available to individuals who have a designation of SMI in the system but have not received behavioral health services for two or more years. This process is facilitated by AHCCCS.

VIII. Demonstration Operations and Policies

Legal Update

The Office of Administrative Legal Services (OALS) provides legal counsel to the AHCCCS Administration, is responsible for the Agency rulemaking process, and oversees the Grievance and Appeals System for the AHCCCS Program. Major components of the Grievance and Appeals System include: scheduling State Fair Hearings for disputed matters, the informal adjudication of member appeals and provider claim disputes, and the issuance of AHCCCS Hearing Decisions (also referred to as Director's Decisions). AHCCCS Hearing Decisions represent the Agency's final administrative decisions and are issued subsequent to review of the Recommended Decisions made by Administrative Law Judges employed by the State Office of Administrative Hearings. AHCCCS General Counsel (also referred to as Assistant Director of OALS) additionally serves as the Agency's Chief Privacy Officer with oversight authority over HIPAA and Part II compliance issues.

During the time period of 10/1/18 through 9/30/19, OALS received 20,828 matters which included member appeals, provider claim disputes, ALTCS trust reviews, and eligibility appeals. Of the 20,828 total cases received, 454 were member appeals, 18,323 were provider claim disputes, 421 were ALTCS trust reviews, and 1,630 were eligibility appeals. OALS issued 834 Director's Decisions after State Fair hearings were held. In addition, OALS issued 16,474 informal dispositions of disputes filed with the AHCCCS Administration. In excess of 97% of these disputes were resolved at the informal level, thus obviating the need for State Fair Hearings in these cases.

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

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

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

The AHCCCS Administration was not a named defendant. However, because the injunctive and declaratory relief, including imposition of a court monitor, would impair the ability of the AHCCCS Administration to manage the Title XIX program and, in particular, the provision of EPSDT services, AHCCCS filed a Motion to Intervene on May 7, 2015 to add AHCCCS then-Director Betlach as a defendant on the EPSDT claims. Also on May 7th, Defendants DCS and ADHS jointly moved to dismiss the case on abstention grounds arguing that the federal suit would interfere with state juvenile court proceedings. Plaintiffs filed their Response to Defendants' Motion to Abstain on June 11, 2015, and on

June 29th, Defendants filed their Joint Reply. The Court denied Defendants' Motion to Abstain on September 29, 2015. On May 19, 2015, the Plaintiffs responded by not opposing AHCCCS' Motion to Intervene, stating they would amend their complaint to add Director Betlach once the Court grants the motion. The Court granted the Motion to Intervene on June 3, 2015.

Plaintiffs then filed a Second Amended Complaint on June 8, 2015 which includes allegations specific to the AHCCCS Program and the Medicaid subclass. In the Second Amended Complaint, Plaintiffs particularly allege that they have suffered physical and emotional harm and remain at risk of ongoing harm, as a result of Defendants' longstanding failures: (1) to provide adequate health care services to children in state foster care; (2) to conduct timely investigations into reports that children have been abused or neglected while in state care; (3) to provide a minimally adequate number and array of foster homes for children not placed with kin; and (4) to take minimally adequate steps to keep families together after removing children from their homes. A scheduling order was entered on December 21, 2015, and discovery began.

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

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

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

On October 16, 2017, Defendants filed a Petition to the Ninth Circuit Court of Appeals challenging the ruling on an immediate interlocutory basis. Plaintiffs filed a Response to the Petitions on October 25,

2017, and the Ninth Circuit granted the Petitions on December 19, 2017. Defendants filed a Motion to Stay the case pending the outcome of the appeal which was denied by the District Court Judge on February 13, 2018. Shortly thereafter, Defendants filed a Motion to Stay with the Ninth Circuit which was granted on February 27, 2018. Events in the district court will not stop while the Ninth Circuit decides the class certification issue. Defendants filed their Joint Opening Brief on April 30th, and on June 29th, Plaintiffs filed their Answering Brief opposing Defendants' appeal of the class certification Order. Meanwhile, Defendants filed a Motion with the Ninth Circuit on June 26, 2018 requesting en banc review of the class certification issue rather than review by the 3 judge panel in light of the importance of the issue. The Court of Appeals denied the Motion without comment.

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

Darjee and Sanchez Haro v Betlach (Lawsuit Alleging Violation of the Medicaid reasonable promptness requirement at 42 U.S.C. Section 1396a(a)(8), the Medicaid notice requirements at 42 U.S.C. Section 1396a(a)(3), and the due process clause of the Fourteenth Amendment to the U.S. Constitution. Persons Transitioned from Full AHCCCS Coverage to Federal Emergency Services Coverage)

On July 22, 2016, the Morris Institute and the National Health Law Program filed a purported class action in federal district court, naming two AHCCCS recipients, seeking declaratory and injunctive relief pursuant to 42. U.S.C. Section 1983. The Complaint alleged violations of the Medicaid reasonable promptness requirement at 42 U.S.C. Section 1396a(a)(8), the Medicaid notice requirements at 42 U.S.C. Section 1396a(a)(3), and the due process clause of the Fourteenth Amendment to the U.S. Constitution. The Complaint was filed on behalf of two individuals and a statewide class of persons who were alleged to have been improperly transitioned from full AHCCCS coverage to federal emergency services only coverage. The Motion for Class Certification was filed on July 22, 2016. Plaintiffs subsequently filed a Motion for Preliminary Injunction on July 27, 2016, and Defendant Betlach filed a Motion for Extension of Time to Respond to Motion for Preliminary Injunction and Class Certification. On August 24, 2016, the District Court granted Defendant's Motion to extend time for Defendant to respond to the Complaint and the Motions. However, the Court denied Defendant's Motion to conduct discovery prior to responding to Plaintiffs' Motion for Preliminary Injunction and Motion for Class Certification. On August 29, 2016, Defendant Betlach filed its Motion to Dismiss the Complaint for lack of jurisdiction and failure to state a claim. Plaintiff filed its Response on September 9, 2016. Defendant Betlach filed its Reply on September 19, 2016. On this date, Plaintiffs filed a Reply in Further Support of

Motion for Class Certification. Oral argument on all three motions was heard on October 4, 2016. On October 25, 2016, the Magistrate Judge filed his Report and Recommendation that the case be dismissed with prejudice and that the Plaintiffs' other motions all be denied as moot. The Plaintiffs filed an Objection to these recommendations on November 7, 2016. Defendant Betlach filed its Response to Plaintiffs' Objections to the Magistrate's Report and Recommendations. The Plaintiffs were granted leave to file a Reply, which they did on December 19, 2016. Oral argument had been requested but has not yet been scheduled.

The District Court Judge entered two Orders on March 31, 2017: Plaintiffs' Motions for Class Certification and Preliminary Injunction were denied, and Defendant Betlach's Motion to Dismiss was denied. Plaintiffs did not appeal. A Settlement Conference was held on June 19 2017 which was not successful. Plaintiffs' filed a Renewed Motion for Class Certification on September 16, 2017, and Defendant Betlach filed a Response to Motion for Class Certification on September 30, 2017. Plaintiffs filed their Reply on October 12, 2017. Argument was heard on December 14th, and further briefing was completed on January 5, 2018. On November 8, 2017, Plaintiffs also filed a Motion to Compel Defendant's Discovery Responses, and Defendant filed its Response to the Motion on November 11, 2017.

The Magistrate Judge, on February 9, 2018, issued a Report and Recommendation, denying Plaintiffs' Renewed Motion for Class Certification on several independent grounds and denying most of Plaintiffs' Motion to Compel further discovery responses. On February 26, 2018, the Plaintiffs filed an Expedited Motion to Stay all discovery pending an appeal of the Magistrate Judge's Recommendation to the District Court Judge. On March 1, 2018, the Magistrate Judge denied Plaintiffs' Expedited Motion to Stay discovery. On March 3, Plaintiffs filed Objections to the Magistrate Judge's Recommendation regarding the Renewed Motion for Class Certification. AHCCCS filed its Response on March 23rd. Meanwhile, on June 1, 2018, AHCCCS filed a Motion for Summary Judgment against the two Plaintiffs. The Plaintiffs then filed a Cross-Motion for Partial Summary Judgment on the notice issues on July 13, 2018, and AHCCCS filed a combined Reply and Response to the Cross-Motion on August 6, 2018. On August 30, 2018, the Plaintiffs filed a Reply regarding the notice issue. Oral argument has not been scheduled. On September 5, 2018, the District Court Judge denied Plaintiffs' Renewed Motion for Class Certification, agreeing with the Magistrate that class certification is not appropriate. In her ruling, the District Court Judge also denied Plaintiffs' request for discovery but ordered AHCCCS to respond to one interrogatory. The District Court Judge ruled that: the Magistrate Judge's Report and Recommendation is accepted and adopted in full; Plaintiffs' Renewed Motion for Class Certification is denied; Plaintiffs' Alternative Motion for Class Discovery is denied, Plaintiffs' Objections to the Magistrate Judge's Denial of Plaintiffs' Motion to Compel is sustained with respect to Plaintiffs' objection to Plaintiffs' Interrogatory 7 and overruled as to Plaintiffs' Interrogatory Numbers 2, 4, 8-13 and Request for Production Numbers 2-4, 10, 11, 12 and 13. Plaintiffs did not file an interlocutory appeal.

With respect to the AHCCCS Motion for Summary Judgment and Plaintiffs' Cross Motion for Summary Judgment filed in June 2018 and July 2018, respectively, the Magistrate Judge recommended that the District Judge grant AHCCCS' Motion and deny Plaintiffs' Cross Motion on February 7, 2019. In light of the ruling, Plaintiffs agreed to dismiss the case in exchange for payment of \$10,000 and the opportunity to discuss with DES notice and policy issues pertaining to persons who are reduced from full coverage to emergency services only coverage. To the extent that Plaintiffs' counsel and DES tentatively agree to propose changes in these areas, approval from AHCCCS must be obtained for any modification to be

implemented. On March 12, 2019, this case was dismissed with prejudice. The Release and Settlement Agreement was entered on March 13, 2019

CMS Disallowance of Medicaid School-Based Administrative Claims

On October 20, 2016, CMS issued its final disallowance of school-based administrative claims that AHCCCS submitted for the period of January 1, 2004-September 30, 2008. CMS disallowed \$5,421,711 for failure of the AHCCCS contractor, Maximus, Inc., to retain documentation to support claims in two fiscal quarters and disallowed an additional \$6,295,139 because Maximus and AHCCCS used a sampling methodology that was disapproved by CMS. On December 14, 2016, AHCCCS sent a Request for Reconsideration to the Secretary of HHS. By letter dated February 14, 2017, but received by AHCCCS on March 6, 2017, CMS denied AHCCCS' Request for Reconsideration. AHCCCS filed a Notice of Appeal to the Departmental Appeals Board (DAB) on April 3, 2017, and AHCCCS' Opening Brief was filed on May 5, 2017. CMS filed its Response on June 5, 2017^h, and AHCCCS filed its Reply on June 20, 2017. On October 2, 2017, the DAB denied AHCCCS' appeal. AHCCCS filed a Complaint in the U.S. District Court in Phoenix on December 1, 2017, appealing the DAB ruling. On February 8, 2018, the Federal Government filed its Answer. The administrative record was filed on March 30, 2018. AHCCCS filed its Opening Brief on May 11, 2018. The Federal Government filed its Response June 18, 2018, and AHCCCS filed its Reply on July 9, 2018. The District Court has not issued a decision.

Legislative Update

The legislature passed a number of bills in the 2019 Legislative session that have impacts on the Agency including:

- **SB 1244** (caregivers; assisted living; training) was an agency supported bill which aligns the training and testing requirements for direct care workers with the training and testing requirements of assisted living caregivers. This alignment allows for easier transitions for workers between in-home care and caregiving in an assisted living facility.
- **SB 1246** (behavioral health; foster children) allows for the integration of physical and behavioral health under a single plan (the Comprehensive Medical and Dental Program) for foster children across the state.
- **SB 1535** (AHCCCS; opioid treatment programs; requirements) requires opioid treatment programs to submit a series of reports to ensure community engagement and adherence to best practices in order to qualify for AHCCCS reimbursement. SB 1535 also creates a new process for the establishment of criteria regarding Opioid Treatment Program centers of excellence and creates the Opioid Use Disorder Review Council.
- **HB 2754/HB 2747** (budget bills) contain appropriations for state agencies and programs. Specific to the AHCCCS Administration, the budget included the following items:
 1. Eliminates a mandatory enrollment freeze on the KidsCare program due to declining Federal funding participation and fully funds the program
 2. Creates a licensure type for Secure Behavioral Health residential facilities
 3. Provides additional state funds for Graduate Medical Education

4. Provides additional funding for long term care providers

The Arizona Legislature adjourned Sine Die on May 28th, 2019; the general effective date for legislation is August 27, 2019

Program Integrity Update

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

The Agency continues to increase its commitment of resources, and the development of programs to implement internal controls throughout the Medicaid System to detect, prevent, and investigate cases of suspected fraud, waste, and abuse.

The OIG is comprised of five sections that accomplish different but interrelated functions as follows:

Provider Enrollment Section (PES) - The providers must be affiliated with managed care organizations (MCOs) in order to provide services; as such, the state requires all Medicaid providers to be enrolled through AHCCCS' PES;

Provider Compliance Section (PCS) - Conducts investigations of external referrals and internally detected cases using data mining (Program Integrity Audits) activities. This section also makes independent referrals to the State Medicaid Fraud Control Unit (MFCU) and other city, state, and federal law enforcement authorities;

Member Compliance Section (MCS) - This section is divided in two subsections: (1) the Member Criminal Investigations Unit (MCIU); and (2) the Fraud Prevention Unit (FPU). Each section has a distinctive role leading to accomplishments in their investigations regarding post and pre enrollment of potential fraud cases involving beneficiaries;

Program Integrity Team (PIT) – The section's main function is data mining and data audits of post payments. This section also conducts periodic utilization reviews of target providers to identify trends and determine potential fraudulent billing practices; and

Performance Improvement and Audits Section (PIAS) – This section oversees the Corporate Compliance Program as required by Federal law and as established in the AHCCCS contract with Managed Care Organizations including behavioral health. The section has two major goals: to conduct performance improvement projects; and to conduct independent provider audits.

In State Fiscal Year (SFY) 2019, the total OIG savings and recoveries for all programs was \$52,603,551. OIG continued with projects, initiatives, cases, and joint efforts to proactively combat fraud, waste, and abuse within the AHCCCS program.

Provider Enrollment Section (PES)

- 6,961 providers were added to the State Medicaid Program in SFY 2019.

- 87,279 total providers are active in AHCCCS.
- The provider registration call center handled 37,690 telephone calls in SFY 2019.
- The PRS processed 78,946 documents related to provider applications.
- 190 site visits were completed in SFY 2019.

Provider Compliance Section (PCS)

The OIG has continually sought to increase its footprint among Federal, State, and Local Law Enforcement, and to support this effort the PCS has developed several new partnerships at the county level in our bid to combat fraud, waste and abuse. Unbeknownst to AHCCCS-OIG and MFCU, several county prosecutors were successful in the prosecution of cases involving Health Care theft, fraudulent schemes and/or elder abuse prosecutions. AHCCCS Providers submitted police reports that ultimately led to the subjects accepting plea deals, being convicted, and sentenced. However, the individuals convicted were not reported to the United States Department of Health and Human Services (HHS), OIG, for potential exclusions. PCS staff members worked to introduce themselves to the county prosecutors in hopes of achieving future joint initiatives between our agencies. Additionally, AHCCCS OIG submitted the county prosecutions into HHS OIG for review of potential exclusions.

Pharmacy Fraud Investigative Team (PFIT), a unit within PCS, has successfully partnered with Los Angeles District Attorney John Niedermann regarding a joint case on an overprescribing provider. Mr. Neidermann was the first prosecutor to successfully convict a doctor of murder. This is an ongoing and active case joint with the Federal Bureau of Investigation (FBI) and the United States Attorney's Office (USAO). AHCCCS OIG collaborated with Mr. Neidermann to present this case for joint law enforcement investigation, after it was declined by the MFCU.

PCS instituted a partial suspension process for new patient admissions on an entity that was unable to produce complete records and also ensure patient safety. Additional providers involved in the oversight of the facility were also suspended. These suspensions are current and ongoing.

The OIG Self Disclosure Program continues to be a success for AHCCCS OIG. Providers take advantage of their ability to reimburse overpayments directly to OIG while ensuring access to service for members and maintaining a cost effective program for Arizona's taxpayers.

The OIG obtained statistical accomplishments, as follows:

- Received 32 self-disclosures referrals;
- Achieved \$305,013.38 in total recoveries; and
- Accomplished \$141,722.90 in program savings.

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

- Unlicensed therapists utilizing a contracted therapist to bill services under to the tune of \$38,526.27 in recoveries
- Uncontracted facility billing under a different contracted location/facility equivalent to \$30,284.16. AHCCCS OIG caught this fairly quickly and was able to mitigate continued losses
- Excluded provider billed under the facility ID for services rendered which resulted in \$176,448.26 recovered.

PCS incorporates coding algorithms and flags with data to identify cases. Recoveries include: \$88,000 recovered from NCCI edit violations and presumed hours at an emergency department; \$908,422 recovered and \$991,005.81 in program savings for podiatry codes billed by a Tribal Nation during a period they were not covered services, resulting in \$37,360 in recoveries; \$56,040 in program savings and two separate convictions for high utilization levels. This specific case was for personal care services rendered in the home and involved five separate individuals, two of which were convicted for their parts in the overbilling. One individual was sentenced to four months with an additional five years of probation. The second individual also received a four month sentence, three years of probation and 100 hours of community service.

The non-emergency medical transportation (NEMT) project has one dedicated full time investigator. The NEMT project yielded the following:

- 43 new referrals were received in SFY 2019
- \$3,847,010.13 in recoveries
- \$350,699.78 in program savings
- Three successful convictions:
 - One individual sentenced to three years of probation
 - One individual sentenced to three years in prison
 - One individual sentenced to two years in prison and three years' probation.

New areas of expansion continue to develop in PCS, such as with the NEMT project for cases that have settlement discussions and/or joint investigations that may cause recovery abilities to age out. AHCCCS OIG has recently instituted a Statute of Limitations Tolling Agreement. This agreement provides AHCCCS OIG to toll matters, in agreement with the signed parties, that prevent losses to the State.

AHCCCS OIG recently won, again, a case against a provider that had made its appeal all the way to the Arizona Court of Appeals after AHCCCS won the appeal filed in Superior Court in Maricopa County. This decision upheld the imposition of the administrative civil monetary penalty (CMP) and assessment imposed on the provider by AHCCCS of \$701,550.14. This particular case has been through several

rounds of appeals. The original CMP was issued for \$714,494.23; however based upon an ALJ recommendation and upheld Director's Decision, the amount was lowered by approximately \$13,000.

Recently, PCS has coordinated efforts with our Unified Program Integrity Contractor (UPIC) to review a predicated matter involving the Hospice program. As a result, an investigation was opened on an entity that is believed to not have the appropriate clinical oversight to refer patients into hospice. A subsequent referral for members involved in the hospice program was also sent to the AHCCCS, OIG Member Compliance Section (MCS) to investigate as several AHCCCS members whom gave their wealth and property to a religious leader in order to join his organization. As a result of this, these individuals were not able to pay for their own healthcare and applied to become part of the AHCCCS population. Estimated preliminary losses are close to \$650,000 for the PCS case. A second case is also currently active and open with the UPIC for investigation. Identified dollars at risk are \$400,000. In addition to Hospice, PCS is developing case leads in Labs, DME and methadone clinics in conjunction with the UPIC.

Cases of particular interest this past year include accomplishments as follows:

- \$131,250 recovered from a dentist who did not record any pre and/or postoperative vitals on patients who had sedation as mandated by standard of practice, state law and AHCCCS policies.
- \$294,000 from an HCBS provider who failed to maintain records and billed more hours than authorized for its members.
- \$32,986.16 recovered from fraudulent timesheets paid to the member's own mother who was submitting false documents.
- \$105,000 recovered from a pain management clinic who failed to maintain adequate documentation in the member's files and/or failed to produce records

Pharmacy Fraud Investigative Team (PFIT)

In SFY 2019, the PFIT was moved under PCS. PCS continues to oversee the Pharmacy Intelligence Project which led to the creation of PFIT (Pharmaceutical Fraud Intelligence Team) which investigates matters related to opioid and prescription fraud, waste, and abuse. The PFIT has been in operation for approximately two years, consisting of four investigators with provider and member fraud experience. The PFIT also has two Pharmacists on the team. The PFIT continues to work closely with local police departments, MFCU, and federal agencies in working joint investigations.

Accomplishments include:

- 112 referrals received;
- 93 referrals reviewed;
- 20 outbound referrals;
- 75 cases opened;

- 12 joint cases with MFCU,
- 6 lock-down requests;
- Four approved lock-downs;
- 16 Case Management requests;
- 12 Case Management requests granted;
- Zero search warrants issued;
- 6 indictments; and
- 12 convictions.

Member Compliance Section (MCS)

The Fraud Prevention Unit (FPU) is comprised of two unit locations; Tucson and Phoenix. For SFY 2019, the combined total investigations closed were 3,917 cases with a total savings of \$13,024,040.24.

The Criminal Investigations Unit (CIU) is also comprised of two unit locations; Tucson and Phoenix. For SFY 2019, total investigations closed were 1,009 cases with total savings and recoveries of \$4,660,850.60.

- The MCS conducted an investigation into allegations that a self-employed doctor did not report her correct income during the application process. The investigation determined that the member owned and rented out multiple properties. As a result of this investigation, the member's benefits were terminated. The member entered into a settlement agreement with AHCCCS to repay the loss of \$131,134.42.
- An investigation was conducted into allegations that the member and her husband were self-employed and not reporting their correct income. The member and her husband are owners of a socialite magazine and had reputable business owners advertising with their magazine. Investigators found that the member had reserved an entire floor of a local resort for a birthday party for their 15yr old daughter and gifted her a new Mercedes. The investigation found that the member and her husband were laundering money and involved with cartels in Sonora, Mexico. The member and her husband were prosecuted and ordered to pay restitution of \$38,481.96 to AHCCCS.
- An investigation was conducted into allegations that the member failed to report her husband, father of her children, as a household member. The investigation revealed that the member and her husband leased and purchased a Maserati and a Mercedes-Benz SUV while receiving AHCCCS benefits. The investigation led to the discontinuance of the member's benefits and a settlement agreement with AHCCCS to repay the loss of \$60,685.98.

- The MCS received an allegation of members being self-employed and not reporting their correct household income. The investigation discovered that the members had \$1.2 million in a TD Ameritrade account. As a result of this investigation, the members' benefits were terminated and the members entered into a settlement agreement to repay the loss of \$62,809.46.
- The MCS conducted a joint investigation with the Pima County Sheriff's Department. Allegations of the member and her husband were involved in drug trafficking and money laundering were investigated. The member failed to report her correct income. The member and her husband were charged, prosecuted and ordered to pay restitution of \$57,412.52.

Program Integrity Team (PIT)

The PIT continues to handle high volume data requests from internal and external customers. In SFY 2019, PIT received 36 data requests per month, while maintaining an average turnaround time of two days. The National Association of Medicaid Fraud Control Units (NAMFCU) data requests are invariably more complex and take longer to process, but rarely require an extension to the submission deadline. PIT received \$5,216,847 in Global Settlements in SFY 2019.

- In addition to servicing data requests, PIT analysts also conduct investigations which resulted in recoveries of \$60,000 and program savings of over \$2 million.
- Due to staff shortage, Program Integrity Audits and Provider Self-Audits were suspended for much of SFY 2019. However the PIT initiated the processing and reporting of Board Terminations resulting in program savings of over \$13 million.
- Due to Medi-Medi T-MSIS data issues, PIT has been supporting Qlarant, the United Program Integrity Contractor (UPIC), with their data needs (including reports to help identify data issues that are preventing T-MSIS use for program integrity). Meanwhile the PIT will continue to process Medi-Medi data requests in order for Qlarant to perform investigations.
- Within the OIG, development and testing of a new case management system has been supported exclusively by the PIT. Testing is in the final stages and additional PIT resources have recently been assigned to meet a year-end implementation date. Other tasks remaining include a User Guide and staff training.
- PIT continues to work closely with LexisNexis to enhance our data analytic activities and identify quality investigation leads. Recent developments include:
 - Rx Analysis Report (opioid abuse)
 - Billing Provider Search (data analysis via tax ID)

Performance Improvement and Audit Section (PIAS)

PIAS continue to assemble and create numerous charts for the OIG monthly metrics to track key performance indicators. The new monthly metrics include, but are not limited to (1) two-month

comparison charts; (2) individual investigator savings and recovery amounts; and (3) investigator active and suspended case status charts.

At the end of SFY 2019, OIG Monthly Metrics consisted of a 120 page report, an increase of 52%; and contains 126 data sets, an increase of 37%, from all sections, Provider Registration, Fraud Prevention, Member Criminal Investigations, Program Integrity, Provider Compliance, Forensic Accounting, Pharmacy Fraud Intelligence, Collections, Audits, and Referrals.

In SFY 2019, the Collections Team focused on cases that were 60 days or more past due. During that time 1,014 cases were identified as 60 days or more past due, an increase of 18%.

Additional statistical accomplishments include:

- \$6,977,348 total collections (on-time & past-due);
- 1,851 payments received (on-time & past-due);
- 1,014 60-day+ past-due cases identified;
- 235 (23%) 60-day+ past-due cases collected;

In SFY 2019, all OIG sections continued to manage their individual Huddle Boards (Tier 1) in the following 10 areas: Provider Registration, Fraud Prevention, Member Criminal Investigations, Program Integrity, Provider Compliance, Forensic Accounting, Collections, OIG Audits, EHR Post-Pay Audits, and Referrals.

In SFY 2019, the OIG Executive Dashboard (Tier 2 Huddle Board) continued to capture metrics for Provider Compliance, Program Integrity, Collections, Fraud Prevention, Member Criminal Investigations, Provider Registration, Forensic Accounting, EHR Post-Pay Audits, Referrals, Pharmaceutical Fraud Intelligence Team (PFIT), Special Projects, and the Arizona Management System.

In SFY 2019, the OIG Audit Team completed the following Audits:

- 4 Operational Reviews;
- 22 Deficit Reduction Act (DRA) audits;
- 1 provider audit pending;
- Zero Hospital Presumptive Eligibility (HPE) deliverable reviews, no hospitals participated;
- 116 Managed Care Organizations (MCOs) deliverable reviews; and
- 1 FQHC audit pending.

The EHR Post Pay Audit Team completed the following EHR post pay audits in SFY 2019:

- Zero Eligible Hospitals (EH) audits

- All hospital audits were completed and finalized before June 2018 however, they were not notified until CMS approved them in October 2018.
- 196 Adapt, Implement, and Upgrade (AIU) audits completed
- 56 Meaningful Use (MU) audits completed
- 1 Eligible Hospital (EH) appeal; and
- \$1,515,442.37 in total recoupments from Eligible Hospitals and providers.

State Plan Update

SPA #	Description	Filed	Approved	Eff. Date
Title XIX				
SPA 18-011 EMS Rates	Updates the State Plan to make update to EMS rate methodologies	10/03/2018	3/18/2019	10/1/2018
SPA 18-012 - Outpatient Drug Rule	Updates the State Plan to comply with the Outpatient Drug Rule.	11/08/2018	8/26/2019	10/1/2018
SPA 18-013 - Outpatient Hospital Rates	Revises the Outpatient Hospital Rates effective 10/01/2018.	12/26/2018	2/7/2019	10/1/2018
SPA 18-014 - Other Provider Rates	Revises the Other Provider Rates effective 10/01/2018.	12/26/2018	2/7/2019	10/1/2018
SPA 18-015 - DSH 2019	Renews the DSH program for 2019.	12/27/2018	5/28/2019	10/27/2018
SPA 18-016 - Inpatient DAP	Revises the State Plan to update the Inpatient DAP program, effective October 1, 2018.	12/27/2018	3/06/2019	10/1/2018
SPA 18-017 - LTAC and Rehab Rates	Revises the LTAC and Rehab rates effective 10/01/2018.	12/27/2018	2/21/2019	10/1/2018
SPA 18-018 - Nursing Facility DAP	Updates the NF DAP program effective 10/01/2018.	12/27/2018	3/5/2019	10/1/2018
SPA 18-019 - Outpatient DAP	Updates the Outpatient DAP program.	12/27/2018	3/21/2019	10/1/2018
SPA 18-020 - Nursing Facility Rates	Updates the NF rates effective 10/01/2018.	12/28/2018	2/21/2019	10/1/2018
SPA 19-001 -	Updates the State Plan to make	3/13/2019	4/3/2019	1/1/2019

SPA #	Description	Filed	Approved	Eff. Date
Nursing Facility Rates	changes to the NF payments.			
SPA 19-002 – TNC	Updates the transportation section of the State Plan.	6/28/2019	Pending	4/1/2019
SPA 19-004 - Pharmacy Value Based Purchasing (VBP)	Provides the state the authority to enter into value based payment (outcome-based) agreements with pharmacy drug manufacturers.	9/5/2019	Pending	7/1/2019
SPA 19-005 Advanced Directives	Updates the advanced directives section of the State Plan to ensure the advanced directives brochure is always current.	9/30/2019	10/17/2019	7/1/2019
SPA 19-006 - Census Wage Eligibility Groups	Updates the eligibility groups for which wages related to Census activities are excluded.	9/30/2019	Pending	7/1/2019
19-007 - DSH Pool 5	Updates the State Plan to reflect DSH Pool 5 funding and participating hospitals for FY 2020.	9/30/2019	Pending	9/30/2019
19-008 - DSH Budget 2020	Updates the State Plan to reflect DSH funding for SPY 2020 in response to budget changes passed by the Arizona State Legislature.	9/30/2019	Pending	10/1/2019
19-009 - GME 2020	This SPA will update the State Plan to continue the GME program for FY 2020.	9/30/2019	Pending	9/30/2019
19-010 - General Fund GME	Updates the State Plan to detail amounts and methodology related to the GME program General Fund dollars approved by the Arizona State Legislature.	9/30/2019	Pending	9/30/2019
19-011 - 2019 DSH Pool 4	Updates the State Plan to detail the reallocation of excess Pool 4 funding	9/30/2019	Pending	9/30/2019
Title XXI				
SPA 19-003 CHIP MCO Regulations	Updates CHIP State Plan to comply with the Managed Care Regulations release in 2016.	6/28/2019	8/15/2019	7/1/2018

IX. Quality Assurance/Monitoring Activities

AHCCCS has undertaken extensive efforts related to the Quality Strategy and related quality improvement activities over the past year. AHCCCS is committed to development of a thoughtful, data-informed delivery system that incorporates CMS priorities and AHCCCS business needs to promote optimal health outcomes for all members. With support and leadership from the Chief Medical Officer

(CMO), the Quality Improvement team spent a good portion of contract year ending (CYE) 2019 conducting a comprehensive review of all performance measures/metrics, supporting data activities, and general strategies around quality. While refining efforts continue into CYE 2020, AHCCCS has outlined a clear vision that promotes alignment with CMS Core Measures and Scorecard metrics as well as enhanced engagement of contracted MCOs and External Quality Review Organization (EQRO).

a) PERFORMANCE MEASURES

During CYE 2019, AHCCCS initiated a Quality Steering Committee and further advanced its Data Stewardship Committee. AHCCCS has worked to strategically align its performance measure requirements with the CMS Child and Adult Core Sets prior to implementation of mandatory child and behavioral health measure reporting. As a result, substantial updates were made to the Performance Measure Sets found within the MCO Contracts for CYE 2020. AHCCCS intends to prioritize its focus on meaningful measures specific to the population(s) served and high priority agency initiatives, as well as to reevaluate Minimum Performance Standards (MPS) in light of national benchmark data (CMS Scorecard Quartile Rates, NCQA HEDIS® Medicaid Mean) and line of business specific historical performance.

AHCCCS line of business (Acute Care, KidsCare, CMDP, CRS, ALTCS E/PD, ALTCS DD, SMI, and GMH/SU) performance measure rate tables are included below and reflect performance for the CYE 2017 measurement period (October 1, 2016 to September 30, 2017). Performance measure rates are reflective of CMS Child and Adult Core Methodologies, except where otherwise indicated. The tables include the relative percent of change and statistical significance of the rate change from the current reporting compared to the previous year, where possible.

Acute Care

AHCCCS Acute Care Contractors provide physical health services to members enrolled in the Arizona Medicaid program. Beginning October 1, 2018, AHCCCS implemented a delivery system reform that allows members to access physical and behavioral health services through a single integrated health plan, AHCCCS Complete Care (ACC). AHCCCS anticipates that with one plan, one provider network, and one payer, healthcare providers will be better able to coordinate care and members will more easily navigate the system.

	CYE 2017 Rates	CYE 2016 Rates	Relative Percent Change	Statistical Significance ¹⁰	FFY 2017 CMS Median ¹¹	2017 Medicaid Mean	CYE 2017 MPS
Acute Care Performance Measures							
Children’s and Adolescents’ Access to PCPs, 12 – 24 Months	93.1%	92.1%	1.1%	P<.001	95.2%	n/a ¹²	93%

¹⁰ Significance levels (p values) noted in the table demonstrate whether the differences in performance between CYE 2016 and CYE 2017 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.

¹¹ Medicaid Mean included for measures calculated using NCQA HEDIS® methodology, whereas CMS Median included for measures calculated using CMS Core (Adult and/or Child) Measure methodology.

¹² n/a = Rate, relative percent of change, statistical significance, or minimum performance standard was not measured or applicable for the specific reporting period.

Children's and Adolescents' Access to PCPs, 25 Months – 6 Years	82.9%	85.4%	-2.9%	P<.001	87.4%	n/a	84%
Children's and Adolescents' Access to PCPs, 7 – 11 Years	89.0%	90.6%	-1.8%	P<.001	90.8%	n/a	83%
Children's and Adolescents' Access to PCPs, 12 – 19 Years	86.4%	88.0%	-1.8%	P<.001	90.1%	n/a	82%
Well-child Visits in the First 15 Months of Life	59.5%	57.7%	3.1%	P<.001	59.3%	n/a	65%
Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life	60.7%	61.0%	-0.5%	P=.164	66.7%	n/a	66%
Adolescent Well-care Visits	39.2%	39.2%	0.0%	P=.683	44.7%	n/a	41%
Annual Dental Visits (HEDIS®) ¹³	60.8%	58.6%	3.8%	P<.001	n/a	n/a	60%
Ambulatory Care: ED Visits Total (HEDIS®)	53.4	56.3	-5.2	n/a	n/a	n/a	55
Inpatient Utilization: Total Days per 1,000 MM (HEDIS®)	26.5	27.6	-4.0	n/a	n/a	n/a	33
All-Cause Readmission: Total	12.0%	11.2%	7.1%	P=.001	n/a	n/a	11%
Diabetes Short-Term Complications Admissions	11.2	14.3	-21.7	n/a	18.0	n/a	n/a
COPD or Asthma in Older Adults Admissions	37.0 ¹⁴	44.8	-17.4	n/a	70.4	n/a	n/a
Heart Failure Admissions	18.0 ¹⁴	22.4	-19.6	n/a	21.9	n/a	n/a
Asthma in Younger Adults Admissions	6.5 ¹⁴	6.9	-5.8	n/a	5.8	n/a	n/a
Breast Cancer Screening	54.4%	53.8%	n/a ¹⁵	n/a ¹⁵	57.4%	n/a	50%

¹³ Annual Dental Visits – NCQA has this measure broken down by age group; therefore N/A was utilized as the Medicaid Mean.

¹⁴ A data issue was identified post reporting for the CYE 2017 PQI measure rates. Efforts have been taken to address this concern in CYE 2018 calculation and reporting.

¹⁵ Due to changes in the technical specifications for this measure, the relative percent of change and statistical significance were not calculated.

Contraceptive Care – Postpartum Women Most or Moderately Effective FDA-Approved within 3 Days of Delivery Ages 21-44	7.6%	n/a	n/a	n/a	n/a	n/a	n/a
Contraceptive Care – Postpartum Women Most or Moderately Effective FDA-Approved within 60 Days of Delivery Ages 21-44	33.4%	n/a	n/a	n/a	n/a	n/a	n/a
Contraceptive Care – Postpartum Women LARC within 3 Days of Delivery Ages 21-44	0.2%	n/a	n/a	n/a	n/a	n/a	n/a
Contraceptive Care – Postpartum Women LARC within 60 Days of Delivery Ages 21-44	9.0%	n/a	n/a	n/a	n/a	n/a	n/a
Contraceptive Care – Postpartum Women Most or Moderately Effective FDA-Approved within 3 Days of Delivery Ages 15-20	1.1%	n/a	n/a	n/a	n/a	n/a	n/a
Contraceptive Care – Postpartum Women Most or Moderately Effective FDA-Approved within 60 Days of Delivery Ages 15-20	31.4%	n/a	n/a	n/a	n/a	n/a	n/a

Contraceptive Care – Postpartum Women LARC within 3 Days of Delivery Ages 15-20	0.6%	n/a	n/a	n/a	n/a	n/a	n/a
Contraceptive Care – Postpartum Women LARC within 60 Days of Delivery Ages 15-20	10.7%	n/a	n/a	n/a	n/a	n/a	n/a
Cervical Cancer Screening	50.5%	50.6%	-0.2%	P=.265	55.0%	n/a	64%
Chlamydia Screening in Women (Child and Adult Combined)	48.3%	47.4%	1.9%	P=.004	n/a	57.6%	63%
Annual Monitoring for Patients on Persistent Medications (Total)	87.8%	86.7%	1.3%	P<.001	86.8%	n/a	n/a
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	23.8%	n/a	n/a	n/a	22.9%	n/a	Baseline Year

Acute Care Performance Summary

The Acute Care Contractors demonstrated strength when compared to the MPS in the following CYE 2017 performance measures:

- Children and Adolescents’ Access to Primary Care Practitioners 7-11 Years
- Children and Adolescents’ Access to Primary Care Practitioners 12-19 Years
- Breast Cancer Screening
- Ambulatory Care (per 1,000 Member Months) – ED Visits (Total)

Additionally, when compared to the FFY 2017 CMS Median, the Acute Care Contractors demonstrated strength in the following measures:

- Well-Child Visits in the First 15 Months of Life
- Annual Monitoring for Patients on Persistent Medications (Total)
- Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk

AHCCCS identified an opportunity for improvement in well-child, adolescent well-care, and dental visit rates for Contractors providing care and services to children. As such, AHCCCS has implemented a Back to Basics Performance Improvement Project (PIP) aimed at improving the overall well-being of children and adolescents. This PIP focuses on improving the rates of Well-Child Visits in the First 15 Months of

Life (W15); Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34); Adolescent Well-Care Visits (AWC); and Annual Dental Visits (ADV). Increasing the rates for these measures also impacts other measures and focus areas, including, but not limited to, childhood and adolescent immunizations, dental sealants for children at elevated caries risk, and developmental screenings.

Additionally, Acute Care Contractors have focused efforts on improving performance measure rates for the Cervical Cancer Screening and Chlamydia Screening in Women measures. Contractors have implemented interventions such as:

- Providing gaps in care reports to providers which identify members who are in need of preventive screenings
- Enhancing member and provider outreach related to the importance of preventive screenings
- Offering member incentives for the completion of cervical cancer and chlamydia screenings
- Creating automated reminder programs to outreach members via phone call or text message
- Improving member focused education to diminish misconceptions and promote the benefits of preventive screenings

KidsCare

In 2016, the enrollment freeze on the Arizona CHIP program (KidsCare) ended, allowing children up to age 19 to be enrolled in the KidsCare program. The table below includes performance measure data for CYE 2017. Performance measure data specific to this population is not available for CYE 2016 (October 1, 2015 to September 30, 2016) as many members did not meet the methodology requirements for enrollment inclusion.

	CYE 2017 Rates	CYE 2016 Rates	Relative Percent Change	Statistical Significance	FFY 2017 CMS Median	2017 Medicaid Mean	CYE 2017 MPS
KidsCare Performance Measure Rates¹⁶							
Children’s and Adolescents’ Access to PCPs, 12 – 24 Months	97.4%	n/a	n/a	n/a ¹⁷	95.2%	n/a	93%
Children’s and Adolescents’ Access to PCPs, 25 Months – 6 Years	92.3%	n/a	n/a	n/a	87.4%	n/a	84%
Children’s and Adolescents’ Access to PCPs, 7 – 11 Years	100.0%	n/a	n/a	n/a	90.8%	n/a	83%
Children’s and Adolescents’ Access to PCPs, 12 – 19 Years	95.1%	n/a	n/a	n/a	90.1%	n/a	82%

¹⁶ KidsCare data is not available for the CYE 2016 measurement period as the CHIP Program was reopened, but due to the timing, many members did not meet the methodology requirements for enrollment inclusion.

¹⁷ n/a = Rate, relative percent of change, statistical significance, or minimum performance standard was not measured or applicable for the specific reporting period. Medicaid Mean included for measures calculated using NCQA HEDIS® methodology, whereas CMS Median included for measures calculated using CMS Core (Adult and/or Child) Measure methodology.

Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life	75.8%	n/a	n/a	n/a	66.7%	n/a	66%
Adolescent Well-care Visits	61.1%	n/a	n/a	n/a	44.7%	n/a	41%
Annual Dental Visits (HEDIS®)	74.3%	n/a	n/a	n/a	n/a	n/a	60%

KidsCare Performance Summary

The KidsCare aggregate rates demonstrated overall strength in CYE 2017, as all performance measure rates exceeded the established MPS.

The KidsCare population is included within the Back to Basics PIP that is aimed at improving the rates of Well-Child Visits in the First 15 Months of Life (W15); Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34); Adolescent Well-Care Visits (AWC); and Annual Dental Visits (ADV). Increasing the rates for these measures also impacts other measures and focus areas, including, but not limited to, childhood and adolescent immunizations, dental sealants for children at elevated caries risk, and developmental screenings. Additionally, AHCCCS required individual Contractors to implement Corrective Action Plans (CAPs) for measures not meeting the MPS to promote improvement in performance measure rates.

Comprehensive Medical and Dental Program

Arizona children involved in the foster care system receive physical health care and services through the Comprehensive Medical and Dental Program (CMDP) and receive their behavioral health care through the Regional Behavioral Health Authorities (RBHAs). Children in foster care are anticipated to receive care and services through an integrated delivery model under CMDP starting in CYE 2021.

	CYE 2017 Rates	CYE 2016 Rates	Relative Percent Change	Statistical Significance¹⁸	CYE 2017 MPS
CMDP Performance Measure Rates					
Children's and Adolescents' Access to PCPs, 12 – 24 Months	97.9%	98.3%	-0.4%	P=.562	93%
Children's and Adolescents' Access to PCPs, 25 Months – 6 Years	91.8%	93.2%	-1.5%	P=.053	84%
Children's and Adolescents' Access to PCPs, 7 – 11 Years	96.8%	96.0%	0.8%	P=.299	83%
Children's and Adolescents' Access to PCPs, 12 – 19 Years	97.1%	95.9%	1.3%	P=.111	82%

¹⁸ Significance levels (p values) noted in the table demonstrates whether the differences in performance between CYE 2016 and CYE 2017 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤ 0.05 . Significance levels (p values) in bold font indicate statistically significant values.

Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life	74.5%	70.7%	5.4%	P=.006	66%
Adolescent Well-care Visits	72.3%	68.3%	5.9%	P=.002	41%
Annual Dental Visits (HEDIS®)	73.8%	68.0%	8.5%	P<.001	60%
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	27.1%	n/a	n/a	n/a	Baseline Year
CMDP GMH/SU Performance Measure Rates					
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	0.5%	1.4%	-65.0%	P=.124	n/a
Metabolic Monitoring for Children and Adolescents on Antipsychotics	58.8%	n/a	n/a	n/a ¹⁹	n/a
7 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined)	63.4%	65.1%	-2.6%	P=.596	n/a
30 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined)	82.8%	81.7%	1.3%	P=.686	n/a

Comprehensive Medical and Dental Program Performance Summary

CMDP demonstrated strength in all CYE 2017 performance measures. CMDP also demonstrated strength when compared to the Acute Care performance in all measures, as all performance measure rates were above the Acute Care aggregate. CMDP was not required to implement a CAP as all CYE 2017 performance measures were above the MPS. Of note, the following performance measure rates demonstrated significant improvements from CYE 2016 to CYE 2017:

- Annual Dental Visits
- Adolescent Well-Care Visits
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Additionally, CMDP demonstrated strength in the following CYE 2017 performance measures when compared to GMH/SU aggregate performance:

- Use of Multiple Concurrent Antipsychotics in Children and Adolescents
- Metabolic Monitoring for Children and Adolescents on Antipsychotics

The CMDP population is included within the Back to Basics PIP that is aimed at improving the rates of Well-Child Visits in the First 15 Months of Life (W15); Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34); Adolescent Well-Care Visits (AWC); and Annual Dental Visits (ADV). Increasing the rates for these measures also impacts other measures and focus areas, including, but not limited to,

¹⁹ n/a = Rate, relative percent of change, statistical significance, or minimum performance standard was not measured or applicable for the specific reporting period.

childhood and adolescent immunizations, dental sealants for children at elevated caries risk, and developmental screenings.

Children’s Rehabilitative Services

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. Beginning October 1, 2018, the CRS program was integrated into the ACC program and CRS eligible members now receive integrated care and services through an ACC Contractor

	CYE 2017 Rates	CYE 2016 Rates	Relative Percent Change	Statistical Significance ²⁰	CYE 2017 MPS
CRS Performance Measure Rates					
Children’s and Adolescents’ Access to PCPs, 12 – 24 Months	96.9%	97.6%	-0.7%	P=.502	93%
Children’s and Adolescents’ Access to PCPs, 25 Months – 6 Years	92.7%	92.2%	0.5%	P=.419	84%
Children’s and Adolescents’ Access to PCPs, 7 – 11 Years	95.8%	95.2%	0.6%	P=.183	83%
Children’s and Adolescents’ Access to PCPs, 12 – 19 Years	95.1%	94.0%	1.2%	P=.013	82%
Well-child Visits in the First 15 Months of Life	49.2%	56.0%	-12.1%	P=.075	65%
Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life	65.8%	65.1%	1.1%	P=.560	66%
Adolescent Well-care Visits	48.9%	46.4%	5.4%	P=.005	41%
Annual Dental Visits (HEDIS®)	67.4%	67.3%	0.1%	P=.897	60%
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	23.1%	n/a	n/a	n/a ²¹	Baseline Year
Ambulatory Care: ED Visits Total (HEDIS®)	55.4	58	-4.5%	n/a	43
Inpatient Utilization: Total Days per 1,000 MM (HEDIS®)	78.5	75.2	4.4%	n/a	51

²⁰ Significance levels (p values) noted in the table demonstrates whether the differences in performance between CYE 2016 and CYE 2017 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.

²¹ n/a = Rate, relative percent of change, statistical significance, or minimum performance standard was not measured or applicable for the specific reporting period.

7 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined)	70.5%	n/a	n/a	n/a	n/a
30 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined)	84.1%	n/a	n/a	n/a	n/a
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	0.7%	n/a	n/a	n/a	n/a
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	58.8%	n/a	n/a	n/a	n/a
Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS®)	46.6%	n/a	n/a	n/a	n/a

Children’s Rehabilitative Services Performance Summary

The CRS program demonstrated strength when compared to the MPS in the following CYE 2017 performance measures:

- Children and Adolescents’ Access to Primary Care Practitioners 12-24 Months
- Children and Adolescents’ Access to Primary Care Practitioners 25 Months – 6 Years
- Children and Adolescents’ Access to Primary Care Practitioners 7-11 Years
- Children and Adolescents’ Access to Primary Care Practitioners 12-19 Years
- Adolescent Well-Care Visits
- Annual Dental Visits

Due to the integration of CRS into ACC beginning October 1, 2018, the CRS population was not included as part of the Back to Basics PIP; however, AHCCCS has enhanced its requirements for the ACC Contractors’ subpopulation analysis. As part of this subpopulation analysis, ACC Contractors will be required to monitor the care and services received by members with a CRS diagnosis and identify any disparities. AHCCCS reserves the right to require Contractors to implement CAPs for any noted disparities or gaps in care.

Arizona Long Term Care System (Elderly/Physically Disabled)

The Arizona Long Term Care System Elderly/Physically Disabled (ALTCS E/PD) program delivers long-term, acute, behavioral health, and case management services to eligible members who are elderly and/or have physical disabilities.

	CYE 2017 Rates	CYE 2016 Rates	Relative Percent Change	Statistical Significance ²²	CYE 2017 MPS
ALTCS E/PD Performance Measure Rates					
Adults Access to Preventive/Ambulatory Health Services	91.8%	91.5%	0.3%	P=.177	75%
Ambulatory Care: ED Visits (HEDIS®)	66.7	71.3	-6.5%	n/a ²³	80
Inpatient Utilization: Total Days per 1,000 MM (HEDIS®)	194.4	205.8	-5.5%	n/a	95
All-Cause Readmission: Total	15.9%	11.7%	35.9%	P<.001	17%
Diabetes Short-Term Complications Admissions	9.1 ²⁴	19.5	-53.3%	n/a	n/a
COPD or Asthma in Older Adults Admissions	112.2 ²⁴	88.3	27.1%	n/a	n/a
Heart Failure Admissions	107.7 ²⁴	129.3	-16.7%	n/a	n/a
7 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined)	30.3%	28.2%	n/a ²⁵	n/a ²⁵	85%
30 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined)	51.0%	50.8%	n/a ²⁵	n/a ²⁵	95%
Annual Monitoring for Patients on Persistent Medications (Total)	90.8%	93.6%	-3.0%	P=.006	75%

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

The ALTCS E/PD program demonstrated strength when compared to the MPS in the following CYE 2017 performance measures:

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

²² Significance levels (p values) noted in the table demonstrates whether the differences in performance between CYE 2016 and CYE 2017 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤ 0.05 . Significance levels (p values) in bold font indicate statistically significant values.

²³ n/a = Rate, relative percent of change, statistical significance, or minimum performance standard was not measured or applicable for the specific reporting period.

²⁴ A data issue was identified post reporting for the CYE 2017 PQL measure rates. Efforts have been taken to address this concern in CYE 2018 calculation and reporting .

²⁵ Due to changes in the technical specifications for this measure, the relative percent of change and statistical significance were not calculated.

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

- Increasing care coordination
- Assisting members in scheduling follow-up appointments
- Enhancing education and outreach to members and providers detailing the importance of follow-up visits
- Implementing a self-selected Performance Improvement Project (PIP) focused on improving performance measure rates for Follow-Up After Hospitalization for Mental Illness (7 Day and 30 Day)

Arizona Long Term Care System (Division of Developmental Disabilities)

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

	CYE 2017 Rates	CYE 2016 Rates	Relative Percent Change	Statistical Significance ²⁶	CYE 2017 MPS
ALTCS DD Performance Measure Rates					
Children’s and Adolescents’ Access to PCPs, 12 – 24 Months	96.2%	100.0%	-3.8%	P=.234	93%
Children’s and Adolescents’ Access to PCPs, 25 Months – 6 Years	89.2%	89.6%	-0.4%	P=.645	84%
Children’s and Adolescents’ Access to PCPs, 7 – 11 Years	92.1%	92.0%	0.1%	P=.854	83%
Children’s and Adolescents’ Access to PCPs, 12 – 19 Years	89.6%	88.5%	1.2%	P=.048	82%
Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life	53.4%	51.2%	4.3%	P=.102	66%
Adolescent Well-care Visits	43.4%	43.5%	-0.2%	P=.923	41%
Annual Dental Visits (HEDIS®)	56.5%	51.9%	8.9%	P<.001	60%
Ambulatory Care: ED Visits (HEDIS®)	39.1	43	-9.1%	n/a ²⁷	43
Inpatient Utilization: Total Days per 1,000 MM (HEDIS®)	43.4	48.2	-10.0%	n/a	51

²⁶ Significance levels (p values) noted in the table demonstrates whether the differences in performance between CYE 2016 and CYE 2017 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values

²⁷ n/a = Rate, relative percent of change, statistical significance, or minimum performance standard was not measured or applicable for the specific reporting period

All-Cause Readmission: Total	11.3%	7.3%	54.8	P=.004	11%
Diabetes Short-Term Complications Admissions	4.0 ²⁸	4.2	-4.8%	n/a	n/a
COPD or Asthma in Older Adults Admissions	9.5 ²⁸	9.8	-3.1%	n/a	n/a
Heart Failure Admissions	2.9 ²⁸	4.8	-39.6%	n/a	n/a
ALTCS DD GMH/SU Performance Measure Rates					
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	2.6%	2.9%	-10.3%	P=.715	n/a
Metabolic Monitoring for Children and Adolescents on Antipsychotics	36.9%	n/a	n/a	n/a	n/a
7 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined)	73.9%	72.9%	1.4%	P=.758	n/a
30 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined)	91.3%	87.7%	4.1%	P=.122	n/a

Arizona Long Term Care System (Developmental Disabilities) Performance Summary

The ALTCS DD program demonstrated strength when compared to the MPS in the following CYE 2017 performance measures:

- Adult’s Access to Preventive/Ambulatory Health Services
- Children and Adolescents’ Access to Primary Care Practitioners 12-24 Months
- Children and Adolescents’ Access to Primary Care Practitioners 25 Months – 6 Years
- Children and Adolescents’ Access to Primary Care Practitioners 7-11 Years
- Children and Adolescents’ Access to Primary Care Practitioners 12-19 Years
- Adolescent Well-Care Visits
- Ambulatory Care (per 1,000 Member Months) – ED Visits (Total)
- Inpatient Utilization: Total Days per 1,000 Member Months

The ALTCS DD program also demonstrated strength in the following CYE 2017 performance measures when compared to GMH/SU aggregate performance:

- 7 Day Follow-Up After Hospitalization for Mental Illness
- 30 Day Follow-Up After Hospitalization for Mental Illness

Additionally, the ALTCS DD program demonstrated improvement in the rates for the Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life and Annual Dental Visits performance measures when compared to CYE 2016 performance.

²⁸A data issue was identified post reporting for the CYE 2017 PQI measure rates. Efforts have been taken to address this concern in CYE 2018 calculation and reporting.

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

General Mental Health/Substance Use

GMH/SU members received behavioral health care through the RBHAs until September 30, 2018. Beginning October 1, 2018, GMH/SU members (not enrolled in CMDP or ALTCS DDD) began receiving integrated services through ACC Contractors

	CYE 2017 Rates	CYE 2016 Rates	Relative Percent Change	Statistical Significance	FFY 2017 CMS Median ²⁹	2017 Medicaid Mean	CYE 2017 MPS
GMH/SU Performance Measure Rates							
7 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined)	48.1%	51.5%	n/a ³⁰	n/a ³⁰	n/a ³¹	37.0%	85%
30 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined)	67.2%	69.0%	n/a ³⁰	n/a ³⁰	n/a ³¹	58.0%	95%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	1.0%	1.1%	-9.1%	P=.531	2.7%	n/a	Baseline Year
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	68.5%	n/a	n/a	n/a	n/a	n/a	n/a
Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS®)	42.7%	n/a	n/a	n/a	n/a	34.6%	n/a

²⁹ Significance levels (p values) noted in the table demonstrates whether the differences in performance between CYE 2016 and CYE 2017 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values

³⁰ Due to changes in the technical specifications for this measure, the relative percent of change and statistical significance were not calculated. n/a = Rate, relative percent of change, statistical significance, or minimum performance standard was not measured or applicable for the specific reporting period

³¹ FFY 2017 CMS Median rates are separated by age group, whereas rates reported within this table are reflective of all age groups combined. As such, CMS Median rates are not included within the above table. Medicaid Mean included for measures calculated using NCQA HEDIS® methodology, whereas CMS Median included for measures calculated using CMS Core (Adult and/or Child) Measure methodology

General Mental Health/Substance Use Performance Summary

The GMH/SU program demonstrated strength when compared to the 2017 NCQA HEDIS® Medicaid Mean in the following CYE 2017 performance measures:

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

Additionally, the GMH/SU program demonstrated strength when compared to the CMS Median for the Use of Multiple Concurrent Antipsychotics in Children and Adolescents measure.

RBHA GMH/SU Contractors have focused efforts on improving rates for the Follow-Up After Hospitalization for Mental Illness (7 Day and 30 Day) measures through the implementation of CAPs. Contractors have implemented interventions to enhance member and provider outreach detailing the importance of follow-up visits, as well as increase care coordination for members who have been hospitalized with a behavioral health primary diagnosis.

In addition, with the integration of the GMH/SU program into ACC beginning October 1, 2018, AHCCCS has enhanced its requirements for the ACC Contractors’ subpopulation analysis. As part of this subpopulation analysis, ACC Contractors will be required to monitor the care and services received by the GMH/SU population and identify any disparities. AHCCCS reserves the right to require Contractors to implement CAPs for any noted disparities or gaps in care.

Members Determined to have a Serious Mental Illness

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

	CYE 2017 Rates	CYE 2016 Rates	Relative Percent Change	Statistical Significance ³²	CYE 2017 MPS
SMI Performance Measures					
Adults’ Access to Preventive/ Ambulatory Health Services	92.2%	92.8%	-0.6%	P=.004	75%
Plan All-Cause Readmission	22.7%	19.6%	15.8%	P<.001	TBD
Ambulatory Care: ED Visits (HEDIS®)	133.1	132.3	0.6%	n/a	TBD

³² Significance levels (p values) noted in the table demonstrates whether the differences in performance between CYE 2016 and CYE 2017 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.

Diabetes Short-Term Complications Admissions	35.8 ³³	33.9	5.6%	n/a	TBD
COPD or Asthma in Older Adults Admissions	81.8 ³³	24.7	231.2%	n/a	TBD
Heart Failure Admissions	28.3 ³³	31.7	-10.7%	n/a	TBD
Asthma in Younger Adults Admissions	14.6 ³³	19.1	-23.6%	n/a	TBD
Inpatient Utilization: Total Days per 1,000 MM (HEDIS®)	72.8	332.1 ³⁴	-78.1%	n/a	TBD
7 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined)	71.8%	74.4%	n/a ³⁴	n/a ³⁴	85%
30 Day Follow-Up After Hospitalization for Mental Illness (Child and Adult Combined)	87.7%	87.4%	n/a ³⁴	n/a ³⁴	95%
7 Day Follow-Up After ED Visit for Mental Illness	63.2%	n/a	n/a	n/a	n/a
30 Day Follow-Up After ED Visit for Mental Illness	79.9%	n/a	n/a	n/a	n/a
7 Day Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence	19.9%	n/a	n/a	n/a	n/a
30 Day Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence	27.1%	n/a	n/a	n/a	n/a
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of AOD (Total)	42.5%	n/a	n/a	n/a	n/a
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of AOD (Total)	9.2%	n/a	n/a	n/a	n/a
Breast Cancer Screening	38.7%	35.5%	n/a ³⁴	n/a ³⁴	50%
Cervical Cancer Screening	45.6%	22.5% ³³	102.7%	P<.001	64%
Chlamydia Screening in Women (Child and Adult Combined)	51.5%	54.9%	-6.2%	P=.285	63%

Serious Mental Illness Performance Summary

The SMI program demonstrated strength when compared to the MPS in the Adults' Access to Preventive/Ambulatory Health Services measure, as well as demonstrated an increase in performance for Breast Cancer Screening

³³ A data issue was identified post reporting for the CYE 2017 PQI measure rates. Efforts have been taken to address this concern in CYE 2018 calculation and reporting.

n/a = Rate/percentage was not measured or reported for the specific reporting period, or rate unable to be calculated based on reporting type.

TBD = Minimum Performance Standard (MPS) to be determined

³⁴ Due to changes in the technical specifications for this measure, the relative percent of change and statistical significance were not calculated.

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

- Increasing care coordination
- Enhancing outreach and education to members and providers detailing the importance of follow-up visits
- Improving communication with health homes to assist in scheduling follow-up appointments
- Incentivizing providers through Value Based Purchasing programs

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

- Enhancing member and provider education and outreach detailing the importance of preventive screenings
- Offering member incentives for completing preventive screenings
- Improving communication with health homes to assist in the identification of members in need of preventive screenings
- Incentivizing providers through Value Based Purchasing programs

CYE 2017 Childhood and Adolescent Immunizations

AHCCCS line of business (Acute Care, CMDP, CRS, and ALTCS DD) and statewide aggregate Childhood Immunization Status and Immunizations for Adolescents performance measure rates are included within the tables below. These rates are reflective of performance for the CYE 2017 measurement period (October 1, 2016 to September 30, 2017) and were calculated using hybrid methodology.

CYE 2017 Rates	Acute	CMDP	ALTCS DD	CRS	Statewide Aggregate	CYE 2017 MPS
Childhood Immunization Status Performance Measure Rates						
DTaP	76.0%	89.2%	81.0%	85.7%	78.9%	85%
IPV	85.4%	96.0%	88.4%	92.9%	87.7%	91%
MMR	86.4%	96.7%	90.9%	92.3%	88.5%	91%
HIB	84.9%	95.1%	90.1%	92.7%	87.2%	90%
Hepatitis B	85.2%	95.4%	83.5%	91.8%	87.2%	90%
VZV	85.7%	96.2%	90.1%	91.8%	87.8%	88%
PCV	74.0%	81.9%	79.3%	83.4%	76.3%	82%
Hepatitis A	85.5%	95.8%	90.9%	92.3%	87.7%	40%

Rotavirus	62.0%	58.5%	30.6%	64.0%	60.8%	60%
Influenza	33.0%	61.4%	64.5%	52.1%	39.8%	45%
Combination 2	72.3%	86.3%	71.9%	82.1%	75.2%	n/a
Combination 3	68.6%	78.6%	67.8%	78.4%	70.9%	68%
Combination 4	67.9%	78.4%	66.9%	77.9%	70.4%	n/a
Combination 5	53.3%	53.4%	24.8%	57.2%	52.9%	n/a
Combination 6	29.7%	53.4%	47.1%	45.9%	35.1%	n/a
Combination 7	52.9%	53.4%	24.8%	56.7%	52.5%	n/a
Combination 8	29.5%	53.4%	47.1%	45.7%	34.9%	n/a
Combination 9	24.7%	32.0%	37.5%	18.2%	26.9%	n/a
Combination 10	24.5%	31.8%	37.5%	18.2%	26.8%	n/a

CYE 2017 Rates	Acute	CMDP	ALTCS DD	CRS	Statewide Aggregate	CYE 2017 MPS
Immunizations for Adolescents Performance Measure Rates						
MCV	85.0%	95.6%	83.2%	94.9%	86.8%	75%
Tdap/TD	89.0%	97.2%	84.5%	95.8%	89.9%	75%
HPV	40.5%	59.9%	22.5%	43.9%	40.4%	n/a
Combination 1	84.6%	95.3%	81.7%	94.3%	86.2%	75%
Combination 2	39.5%	59.2%	22.1%	43.3%	39.5%	n/a

Childhood Immunizations Performance Summary

AHCCCS Contractors demonstrated strength when comparing the statewide aggregate to the MPS in the following Childhood Immunization measures:

- Hepatitis A
- Rotavirus
- Combination 3

The CRS program demonstrated strength in all Childhood Immunization measures by exceeding the established MPS. The CMDP program demonstrated strength in many of the Childhood Immunization measures with opportunities for improvement identified for PCV and Rotavirus. The ALTCS DD program

demonstrated strength in the HiB, VZV, Hepatitis A, and Influenza measures. Additionally, the Acute Care Contractors demonstrated strength in the Hepatitis A, Rotavirus, and Combination 3 measures.

Contractors focused efforts on improving the Childhood Immunization rates through the implementation of CAPs. Contractors have implemented interventions such as:

- Enhancing member and provider outreach to address barriers in immunization completion
- Emphasizing the importance of immunizations to parents/guardians of members
- Increasing contact with the parents/guardians of members from birth to 15 months of age to encourage the scheduling of well-child visits and receiving immunizations
- Offering incentives to parents/guardians for the completion of immunizations
- Providing gaps in care reports to providers which identify members who are in need of immunizations

Additionally, AHCCCS analyzed the CYE 2017 data to establish an MPS for the Combination 2, Combination 4, Combination 5, Combination 6, Combination 7, Combination 8, Combination 9, and Combination 10 measures which will be utilized to monitor performance in the CYE 2019 (October 1, 2018 to September 30, 2019) Childhood Immunization Status hybrid audit.

Adolescent Immunizations Performance Summary

AHCCCS Contractors demonstrated strength when comparing the statewide aggregate to the MPS in the following Adolescent Immunization measures:

- MCV
- Tdap/TD
- Combination 1

The CMDP, ALTCS DD, and CRS programs demonstrated strength in all Adolescent Immunization measures with an established MPS; however, an opportunity for improvement was identified for HPV. Additionally, the Acute Care Contractors demonstrated strength in the Tdap/TD, HPV, and Combination 1 measures with an opportunity for improvement identified for MCV.

Contractors focused efforts on improving the Childhood Immunization rates through the implementation of CAPs. Contractors have implemented interventions such as:

- Enhancing member and provider outreach to address barriers in immunization completion
- Emphasizing the importance of immunizations to parents/guardians of members
- Outreaching members to provide education related to the HPV vaccine
- Providing gaps in care reports to providers which identify members who are in need of immunizations
- Participating in community outreach events such as school programs

Additionally, AHCCCS analyzed the CYE 2017 data to establish an MPS for the HPV and Combination 2 measures which will be utilized to monitor performance in the CYE 2019 (October 1, 2018 to September 30, 2019) Immunizations for Adolescents hybrid audit.

FORM CMS-416 AHCCCS Medicaid and KidsCare rates for EPSDT Participation, Total Eligibles Receiving Preventive Dental Services, and Total Eligibles Receiving Any Dental Services are included in table below. This data is reflective of CYE 2018 (October 1, 2017 to September 30, 2018) and are inclusive of the information reported to CMS on the annual Form CMS-416 Report. Please note that although KidsCare is not formally reported to CMS via the CMS-416 Report, AHCCCS monitors this population using the same methodology as the Form CMS-416 Report for comparison purposes

	CYE 2018 Rates	CYE 2018 MPS
Acute Care CMS-416 Rates		
EPSDT Participation (%)	50.8%	68%
Total Eligibles Receiving Preventive Dental Services (%)	47.9%	46%
Total Eligibles Receiving Any Dental Services (%)	48.9%	n/a
KidsCare CMS-416 Rates		
EPSDT Participation (%)	68.1%	68%
Total Eligibles Receiving Preventive Dental Services (%)	52.5%	46%
Total Eligibles Receiving Any Dental Services (%)	55.1%	n/a

PERFORMANCE IMPROVEMENT PROJECTS (PIPS)

AHCCCS had the following PIPs in place during CYE 2018 (October 1, 2017 to September 30, 2018)

E-Prescribing PIP

Population(s): RHBA GMH/SU and SMI Integrated*

The purpose of this Performance Improvement Project is to increase the number of prescribers electronically prescribing prescriptions and to increase the percentage of prescriptions which are submitted electronically in order to improve patient safety. The goal is to demonstrate a statistically significant increase in the number of providers submitting electronic prescriptions and the number of electronic prescriptions submitted followed by increase sustainment for one year.

Line of Business	Percent of Providers who Prescribed at Least One Prescription Electronically	Percent of Prescriptions Prescribed Electronically
RBHA GMH/SU		
CYE 2018	67.9%	70.0%
CYE 2017	62.0%	62.0%
RBHA SMI Integrated		
CYE 2018	69.8%	67.5%

CYE 2017	64.0%	62.1%
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**Varied Baseline Year across lines of business/Managed Care Organizations (MCOs). PIP Closed in CYE 2017 for populations not included above. Final reporting year anticipated to be CYE 2019.*

Developmental Screening (DEV) PIP

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

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

Line of Business	Percentage of Members Screened in the Twelve Months Preceding their First Birthday	Percentage of Members Screened in the Twelve Months Preceding their Second Birthday	Percentage of Members Screened in the Twelve Months Preceding their Third Birthday	Percentage of Members Screened in the Twelve Months Preceding their First, Second, and Third Birthday
Acute*				
CYE 2018 (Remeasurement 1)	Rate Pending	Rate Pending	Rate Pending	Rate Pending
CYE 2016 (Baseline)	21.1%	27.5%	23.1%	23.7%
CMDP				
CYE 2018 (Remeasurement 1)	Rate Pending	Rate Pending	Rate Pending	Rate Pending
CYE 2016 (Baseline)	23.8%	36.2%	29.0%	30.0%
ALTCS DD				
CYE 2018 (Remeasurement 1)	n/a ³⁵	Rate Pending	Rate Pending	Rate Pending
CYE 2016 (Baseline)	n/a ³⁵	24.4%	25.1%	24.9%

**Acute Aggregate rate inclusive of the CMDP population*

Long Term Services and Supports (LTSS) - Assessment and Care Planning PIP

Population(s): ALTCS E/PD

The purpose of this Performance Improvement Project is to establish a foundation that provides insight into the Contractors' current levels of performance (including the identification of notable areas needing improvement) and promote the evaluation/engagement of interventions aimed towards enhancing the Contractors' performance related to LTSS/MLTSS assessment and care planning measures through the newly developed Center for Medicaid and CHIP Services and CMS measures. The goal is to demonstrate

³⁵ Rates are not available for the ALTCS DD population as this population does not generally meet the continuous enrollment requirements specific to this age group

a statistically significant increase, followed by sustained improvement for one consecutive year, for each of the included indicators:

- LTSS Comprehensive Assessment and Update
- LTSS Comprehensive Care Plan and Update
- LTSS Shared Care Plan with Primary Care Practitioner

In addition, AHCCCS has implemented an additional PIP starting CYE 2019 (October 1, 2018 to September 30, 2019):

Back to Basics Performance Improvement Project (PIP)

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

The purpose of this Performance Improvement Project is to increase the number of child and adolescent Well-Child/Well-Care Visits, as well as increase the number of children and adolescents receiving Annual Dental Visits. The goal is to demonstrate a statistically significant increase in the number and percentage of child and adolescent Well-Child/Well-Care Visits, as well as a statistically significant increase in the number and percentage of children and adolescents receiving an Annual Dental Visit, followed by sustained improvement for one consecutive year.

Baseline Rates will be reported once they become available.

X. Demonstration Implementation Update

AHCCCS Acute Care Program Demonstration

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

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

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

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

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

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

Three Regional Behavioral Health Authorities (RBHAs) retain contracts with AHCCCS for the provision of services for the following populations:

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

Arizona Long Term Care Program (ALTCS) Demonstration

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

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

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

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

Effective October 1, 2019, members served through DES/DDD began receiving integrated physical and behavioral health services, including services for CRS eligible conditions, through the ALTCS/DD program.

Targeted Investments (TI) Program Demonstration

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

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

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

Estimated Annual Funding Distribution for the Targeted Investments Program

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Targeted	\$19 m.	\$66.5 m.	\$85.5 m.	\$66.4 m.	\$47.5 m.	\$285 m.

Investments						
Administrative Expenses	\$1 m.	\$3.5 m.	\$4.5 m.	\$3.5 m.	\$2.5 m	\$15 m.
Totals	\$20 m.	\$70 m.	\$90 m.	\$70 m.	\$50 m.	\$300 m.

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

Total Computable DSHP at Risk for Each Demonstration Year

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

TI Program Updates

Below is a summary of the TI program implementation activities conducted by AHCCCS in FY 2019:

- Enhanced the reporting system for TI program participants to submit attestations of milestone completion and to upload documents for validation.
- Collaborated with Health Current, Arizona’s Health Information Exchange (HIE) to onboard TI participants in order to ensure that they are able to receive admission, discharge, and transfer (ADT) alerts from the HIE, and to send EHR core data to the HIE.
- Developed resources to support TI participants’ work to meet program objectives including a [video](#) of participant experience/success.
- Enabled implementation of a Peer/Family training curriculum to meet a TI milestone for co-located justice clinics that requires training of peer and family support staff. The TI Program partnered with Maricopa Integrated Health System to develop the first phase of the Peer/Family training curriculum which is being used to train individuals providing Peer/Family services to the justice involved individuals who are served by the TI co-located justice sites.
- Consulted with the Arizona Department of Child Safety on development of provider participant milestone requirements related to children in foster care.
- Developed and implemented multiple communication avenues for participants and stakeholders including a detailed and regularly updated Targeted Investments webpage, direct email, a dedicated Targeted Investments email address and social media posts.
- Made demonstration Year Two incentive payments to providers that met the TI program eligibility and milestone implementation requirements.
- Made numerous presentations on the TI program to a range of internal and external stakeholders, explaining the integration and whole person care goals and objectives of the TI Program.

- Established an ongoing dialogue between AHCCCS and its MCOs to facilitate alignment between the TI program guidance on enhanced provider level integration and the MCOs' provider network integration initiatives, including regular meetings between AHCCCS and MCO medical directors.
- TI participants were engaged by AHCCCS through electronic and in-person forums, surveys, and webinars including (1) monthly newsletters sent to all the participants which includes pertinent information, tips and reminders, program updates and upcoming due dates; (2) surveys to gather feedback from all TI participants that generated over 70 responses and (3) the robust and up-to-date TI webpage with resources and communications.
- Toured and evaluated the program's co-located justice sites (CHA Tucson November 2018; Terros December 2019; Spectrum, Southwest Behavioral and Terros August 2019; and MIHS September 2019).
- Instituted participant focus groups to solicit input and feedback on Year 3 milestone requirements.
- Held multiple regional forums for TI Program participants on the Year 3 milestone requirements.
- Instituted participant focus groups to solicit input and feedback on potential Year 4 performance measure milestones
- Teamed with Arizona State University to develop a Quality Improvement Collaborative for Program participants that provides timely and actionable performance metric information and a performance management system to share best practices and disseminate the practical content needed to enhance program participants' milestone achievement.
- Through in-person and multiple virtual meetings, TI providers participating in the QIC will be provided with timely and actionable performance metric information calculated by ASU, utilizing a performance management system to share best practices and disseminate the practical content needed to enhance participants' TI milestone achievement.
- Pursuant to Arizona's 1115 waiver demonstration STC 67, AHCCCS submitted a Sustainability Plan on March 29, 2019. This Sustainability Plan was approved by CMS on August 12, 2019.
- Pursuant to STC 57, AHCCCS is required to submit the baseline data for the TI program Statewide Focus Population Measures and Targets. The revised baseline measures can be found in **Appendix C**.

Waiver Evaluation Update

In accordance with STC 59, AHCCCS must submit a draft Waiver Evaluation Design for its 1115 waiver demonstration programs including research questions, hypotheses, and proposed measures for the AHCCCS Complete Care (ACC) Program, Arizona Long Term Care System (ALTCS) Program, Comprehensive Medical and Dental Program (CMDP), Regional Behavioral Health Authorities (RBHA), Targeted Investments Program (TI), AHCCCS Works and Retroactive Coverage Waiver. In addition,

AHCCCS is required by CMS to submit an Interim Evaluation Report and a Summative Evaluation Report of the 1115 waiver demonstration by September 30, 2020 and February 12, 2023 respectively.

Pursuant to Arizona's 1115 Waiver STCs, AHCCCS submitted the draft Evaluation Design Plans to CMS for review. AHCCCS worked with an independent evaluator to develop waiver evaluation design plans for the following programs;

- AHCCCS Complete Care (ACC) Program
- Arizona Long Term Care System (ALTCS) Program
- Comprehensive Medical and Dental Program (CMDP)
- Regional Behavioral Health Authorities (RBHA)
- Targeted Investments (TI) Program
- AHCCCS Works program
- Retroactive Coverage Waiver

On July 17, 2019, AHCCCS submitted the waiver evaluation design plans for AHCCCS Works and Prior Quarter Coverage waivers. On November 13, 2019 AHCCCS submitted the Waiver Evaluation Design Plans for AHCCCS Core programs (ACC, ALTCS, CMDP, and RBHA) and Targeted Investments program to CMS. The waiver evaluation design plans are currently under CMS review.

In FY 2020, AHCCCS will continue to work with CMS to conduct Interim Evaluations and submit the Interim Evaluation Report for the TI program, AHCCCS Complete Care, ALTCS, CMDP, Retroactive coverage waiver and RBHA demonstrations.

XI. Notable Achievements

Achievements Noted below:

- On January 18 2019, CMS approved Arizona's community engagement waiver (AHCCCS Works). It is the first in the nation to exempt members of federally recognized tribes, including those enrolled in the American Indian Health Program, and allow members who are suspended to automatically re-enroll at the expiration of the suspension period as long as they meet all other eligibility criteria.
- AHCCCS has implemented an updated Value Based Purchasing (VBP) Alternative Payment Model (APM) for the ACC, ALTCS and RBHA populations that is designed to encourage MCO activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, and those related to child and adolescent health.
- AHCCCS significantly increased access to behavioral health services in schools. Specifically, the number of members receiving behavioral health services in schools increased by 250% from SFY 18 to SFY 19.
- DES/DDD awarded new contracts with MCOs, called "DDD Health Plans," effective October 1, 2019. These DDD Health Plans offer eligible members physical and behavioral health services, Children's Rehabilitative Services (CRS) and limited long term services and supports (LTSS) including nursing facilities, and emergency alert system services, and habilitative physical

therapy for members age twenty-one (21) and over. All other LTSS will continue to be provided by DDD.

- In 2019, AHCCCS continues to have overall employee engagement scores that far exceed the statewide average. In addition, AHCCCS consistently achieves employee engagement scores well above that of an average organization with 7.4 engaged employees for every 1 disengaged employee. This is compared to the 2019 statewide average of 2.7 engaged employees for every 1 disengaged employee and the average organization of 1.8 engaged employees for every 1 disengaged employee.
- In FFY 2019, OIG Fraud Prevention Unit (FPU) implemented a new investigation process that involved investigators riding alone. This new initiative resulted in the FPU completing 4,727 investigations, or an increase of 77%. This result produced a savings increase from \$7,223,804 in FFY2018 to \$16,127,671 in FFY 2019, an increase of 110%.
- AHCCCS introduced new provider types to better serve geographically isolated tribal members by introducing new Non-Emergency Medical Transportation via helicopter and equine. These new provider types are now reimbursable.
- AHCCCS partnered with Indian Health Services and Tribal pharmacies to implement a major transition to Optum, the AHCCCS Division of Fee for Service Management pharmacy benefits manager, allowing for more real time data to reduce adverse drug interactions and incorporated clinical safety edits.
- AHCCCS implemented global updates to its telehealth policy, expanding services which can be delivered via telemedicine, store and forward, and tele-monitoring.
- Effective May 1, 2019, AHCCCS began allowing Transportation Network Companies (also known as “rideshare” companies) to register as non-emergency medical transportation providers. Adding rideshare companies as providers of non-emergency medical transportation adds flexibility to the health care delivery system and increases transportation options for Medicaid members.

APPENDIX A: 1115 WAIVER COMMUNITY PRESENTATION SLIDES





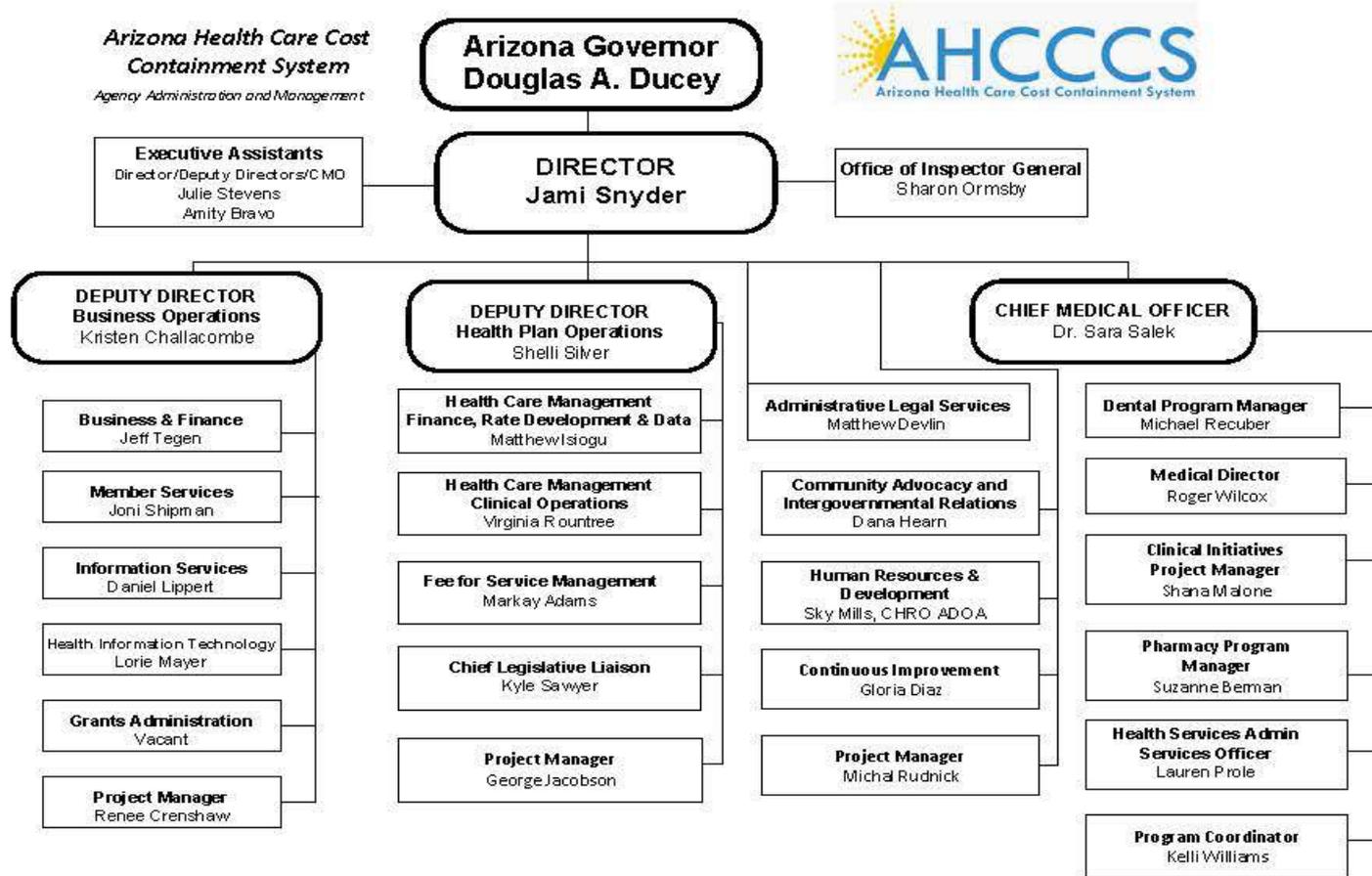
Community Forum Presentation



Division of Community Advocacy & Intergovernmental Relations (DCAIR)



Agency Org Chart



Division of Community Advocacy & Intergovernmental Relations (DCAIR)

The Division of Community Advocacy and Intergovernmental Relations (DCAIR) houses all of the functions that interface with our Members, Peers, Family Members, Federal partners (CMS), Tribal community, and other stakeholders in our program.



Division of Community Advocacy & Intergovernmental Relations (DCAIR)

Offices and Committees:

- Office of Federal Relations and Communications (FRAC)
- The Office of Individual and Family Affairs (OIFA)
- The Office of Human Rights (OHR)
- Human Rights Committees (HRC) Liaison
- The State Medicaid Advisory Committee (SMAC)
- Arizona Long Term Care System (ALTCS) Advisory Committee
- Behavioral Health Planning Council

Your Voice – Heard!

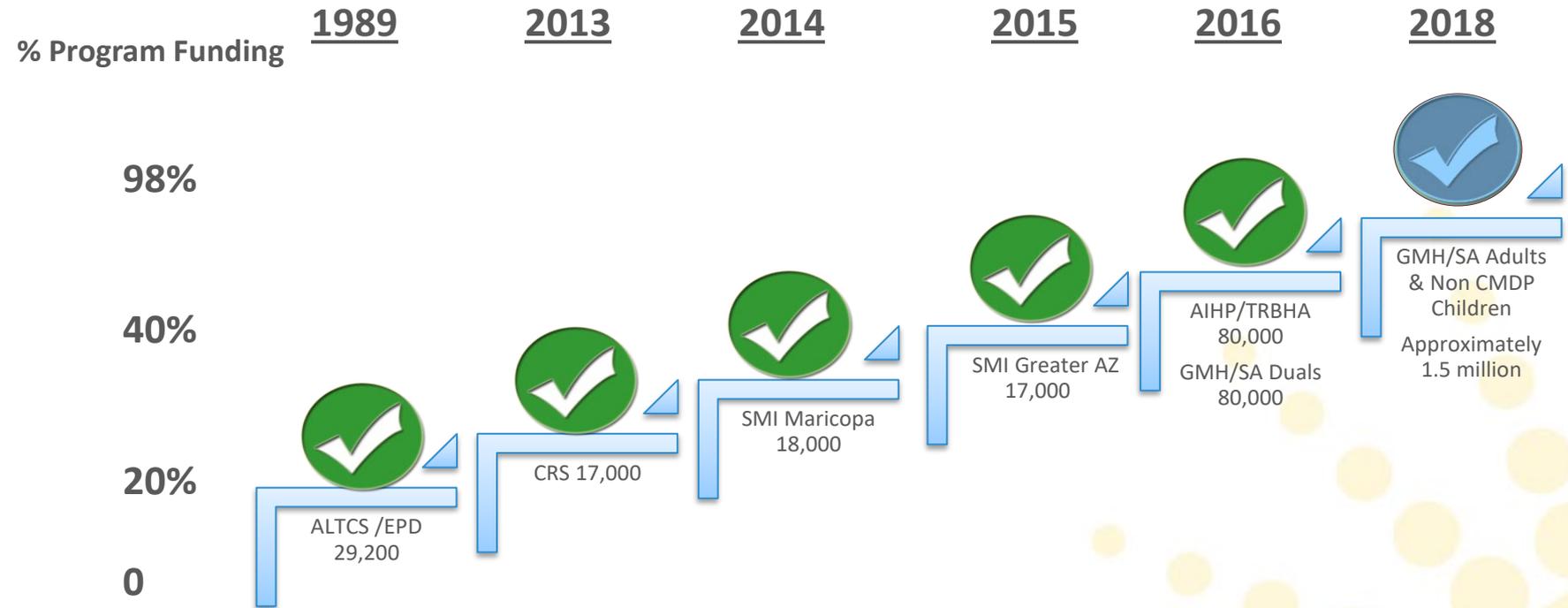
DCAIR provides the much needed voice to members seeking assistance, clarification, or representation. DCAIR staff have experiences, which give a unique position to support the members.

Whether ensuring compliance, or advocating for rights during a hearing, DCAIR goes above and beyond!

Recent Integration Efforts



MCO Integration Progress To Date

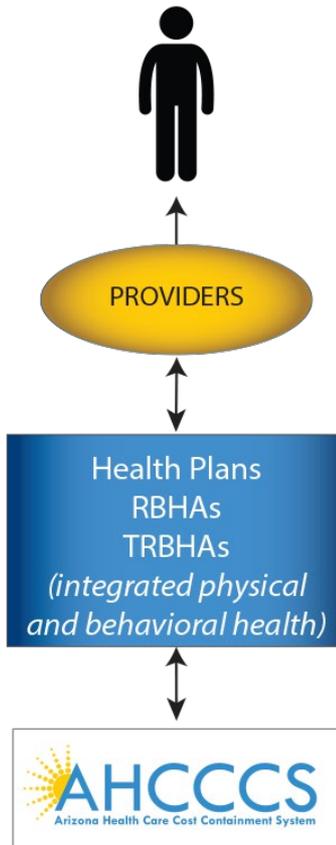


AHCCCS Complete Care

A HUGE step to integrate healthcare in a single ACC Health Plan that:

- Includes physical and behavioral healthcare service providers (including CRS – 18k)
- Manages the provider network for all healthcare services
- Provides comprehensive managed care for the whole person

Integration at all 3 Levels



- New provider type - Integrated Clinics
- Licensure changes
- Provider payment incentives
- Targeted Investment - \$300M

- ALTCS – EPD
- Individuals with SMI
- Non-SMI Dual Eligible Members
- Children’s Rehabilitative Services (one plan)
- **Oct 2018 – ACC/AIHP - 1.5M Children/Adults**
- **ALTCS DD – 2019/2020**
- **Foster Children - 2020**

- Administrative Simplification – ADHS/BHS joins AHCCCS Administration
- Grant/Housing Funding into Medicaid System

Reaching across Arizona to provide comprehensive quality health care for those in need

The Benefits of Integration

1

- One Plan
- One Payer
- One Provider Network
- Easier to Navigate
- Streamline care coordination to get better outcomes
- Improve a person's whole health

Integration Effort Outcomes



Methodology: SMI Evaluation Timeframe

Pre-Integration Baseline

October 1, 2012 –
March 31, 2014

Post-Integration Period 1

April 1, 2014 –
March 31, 2015

Post-Integration Period 2

April 1, 2015 –
March 31, 2016

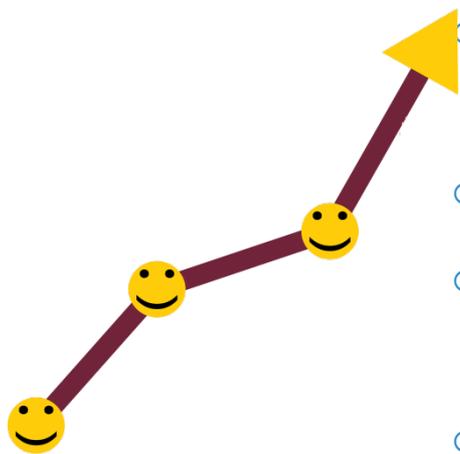
Post-integration Period 3

April 1, 2016 –
March 31, 2017



SMI Integration Evaluation Findings

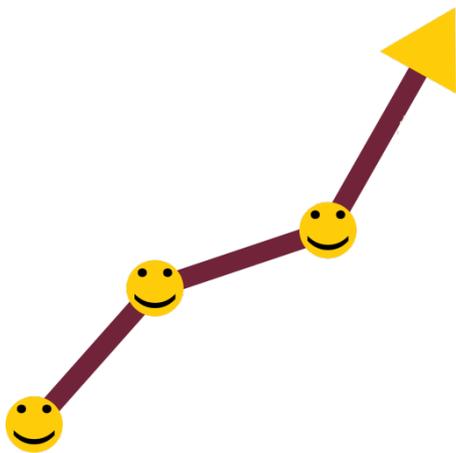
- All measures of ambulatory care, preventive care, and chronic disease management demonstrated improvement



- Adult access to preventive/ambulatory health services: **+2%**
- Comprehensive Diabetes Care - HbA1c: **+ 4%**
- Medication management for people with Asthma (50% compliance): **+ 32%**
- Medication management for people with Asthma (75% compliance): **+ 35%**

SMI Integration Evaluation Findings

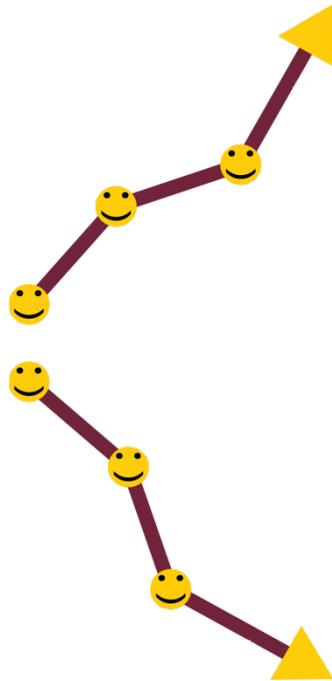
- All indicators of patient experience improved, with 5 of the 11 measures exhibiting double digit increases



- Rating of Health Plan: + **16%**
- Rating of All Health Care: + **12%**
- Rating of Personal Doctor: + **10%**
- Shared Decision Making: + **61%**
- Coordination of Care: + **14%**

SMI Integration Evaluation Findings

- Of the 8 hospital-related measures:
 - 5 measures showed improvement

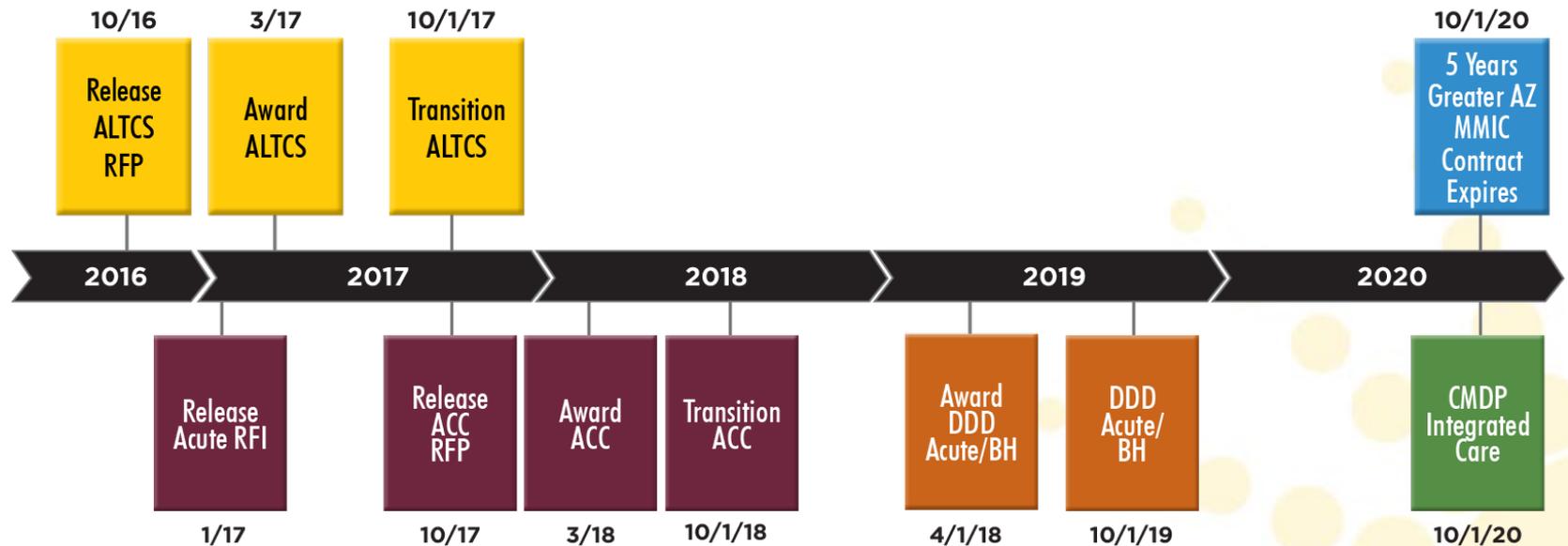


- Emergency Department Utilization rate **decreased by 10%**
- Readmission rate **declined by 13%**
- Admissions for short term complications for diabetes **decreased by 6%**
- Admissions for COPD/Asthma **decreased by 25%**
- 30-day post hospitalization for mental illness follow up rate **increased by 10%**

Integration... still to go...



AHCCCS Contract Timeline



RBHA Services Transfer RFI

Requests for Information (RFIs)

YH19-0084 RBHA Services Transfer

- **Due Date:** March 14, 2019, 3:00 P.M. Arizona Time
- **Deadline for Questions:** February 21, 2019 5:00 P.M. Arizona Time
- Notice of Request for Information 
 - Questions and Answers Form 
 - Solicitation Amendment 1 
 - Appendix 
 - Revised Appendix 3/8/19 
 - Solicitation Amendment 2 

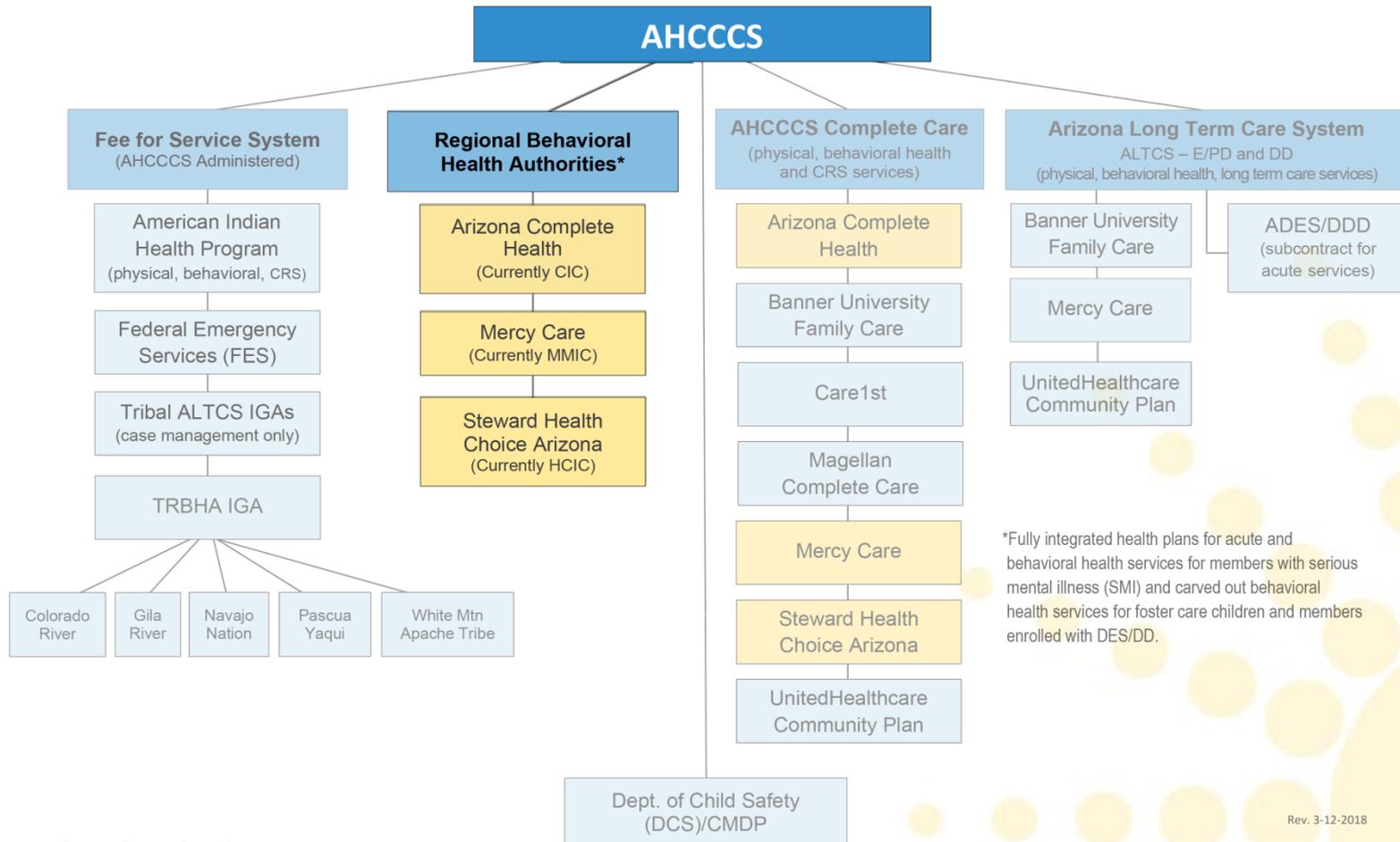


What is an RFI?

- A request for information allows AHCCCS to engage stakeholders and gain feedback on a path forward continuing the journey of integrated health care in Arizona.
- Responding to an RFI allows you the chance to inform AHCCCS of opinions and matters to be considered in next steps.

AHCCCS Care Delivery System

October 1, 2018



*Fully integrated health plans for acute and behavioral health services for members with serious mental illness (SMI) and carved out behavioral health services for foster care children and members enrolled with DES/DD.

Rev. 3-12-2018

Current status with RBHA services

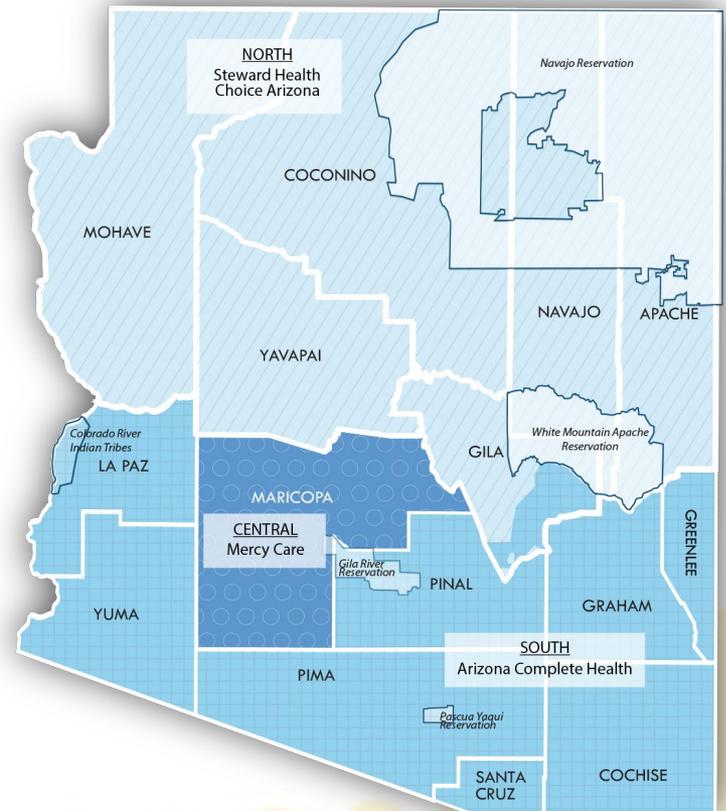
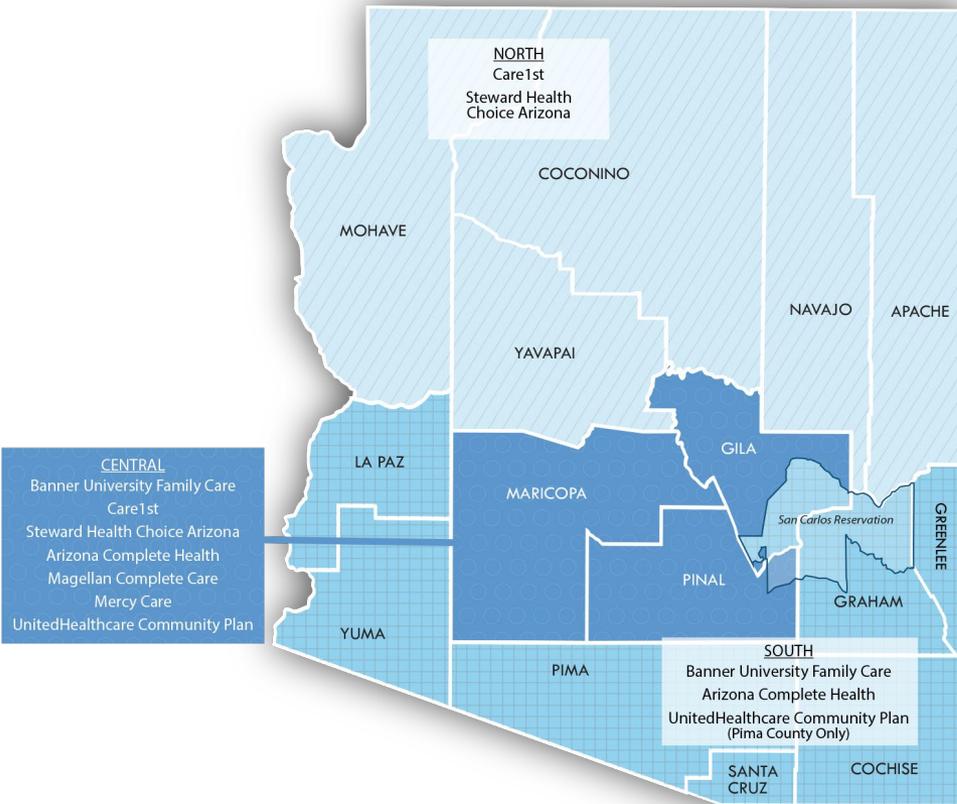
Regional Behavioral Health Authorities (RBHAs) currently continue to provide and serve:

- Foster children enrolled in CMDP
- Members enrolled with DES/DD;
- Individuals determined to have a serious mental illness (SMI)
- Crisis services, grant funded, and state-only funded services
 - Populations:
 - Northern GSA Enrollment 5,725
 - Central GSA Enrollment 21,597
 - South GSA Enrollment 13,352

Geographic Service Areas

AHCCCS Complete Care (ACC) Services Map

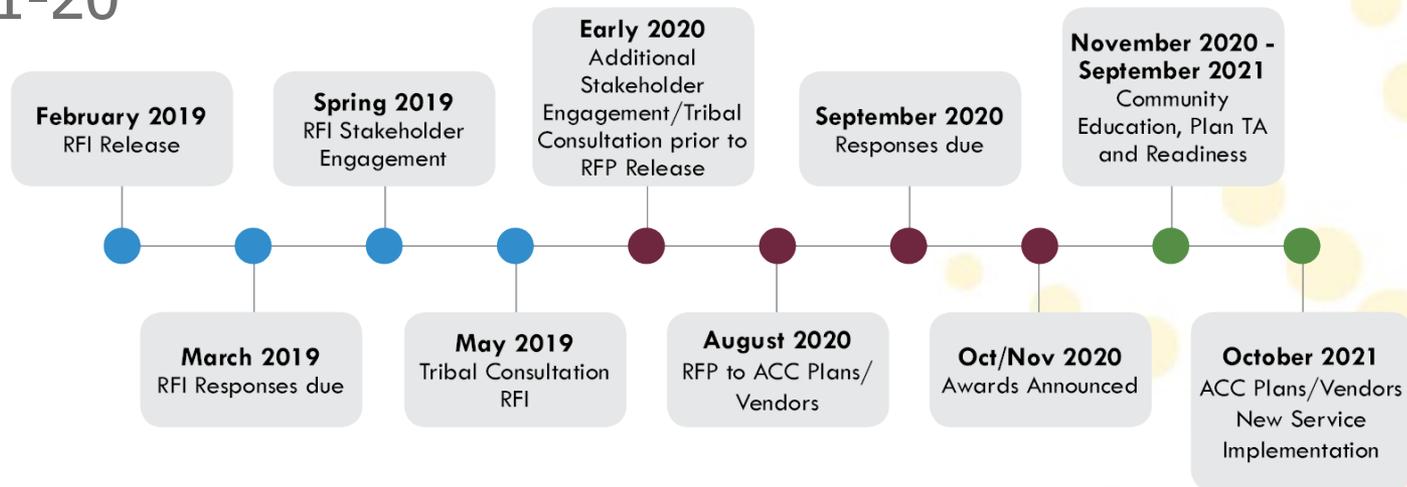
RBHA/TRBHA and Crisis Services Map



Note: Zip codes 85542, 85192, 85550 representing San Carlos Tribal area are included in the South GSA.

Next steps

- In ACC RFP it announced AHCCCS sole discretion to allow at least one ACC plan in each GSA to expand services to those served by a RBHA
- No sooner than 10-1-20



Announcements

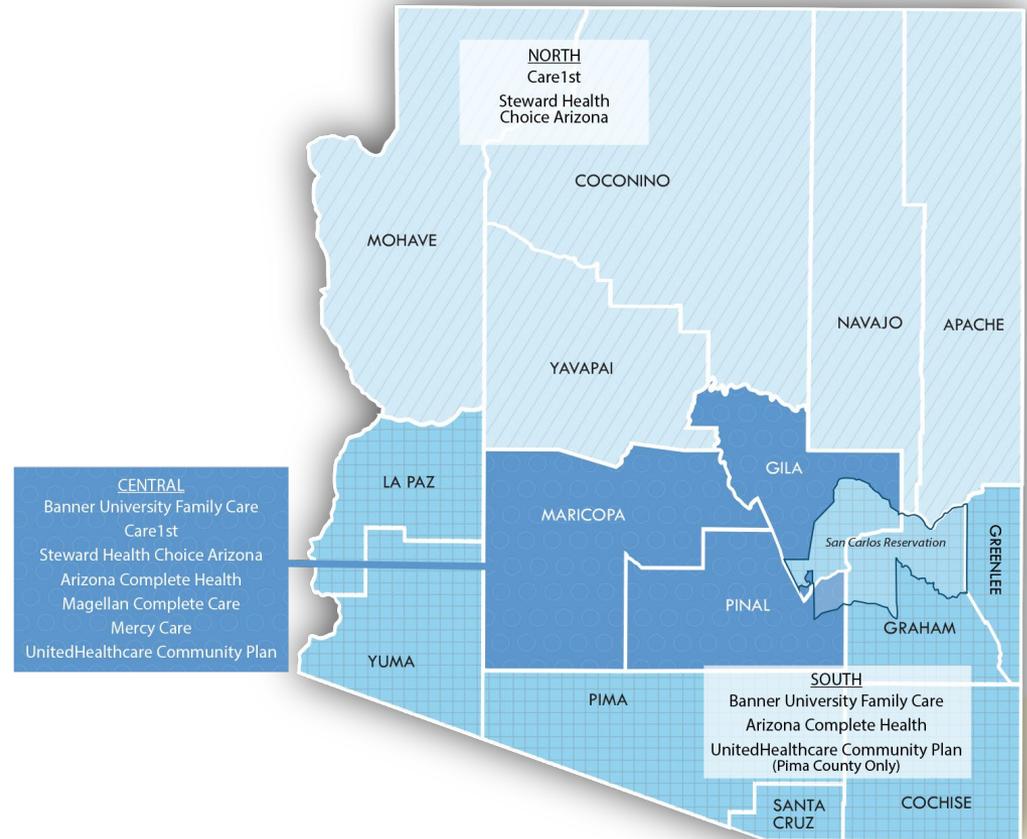
1. Mercy Care extended so all RBHA services will be transitioned at same time - Oct 2021



2. We will be limiting our RFP (or transfer of services) to the current ACC plans in each area - known contractors already with providers and members.

Let's talk about our questions...

Should AHCCCS allow choice of plan by allowing more than one ACC plan to address unique RBHA services for Central and Pima?



Note: Zip codes 85542, 85192, 85550 representing San Carlos Tribal area are included in the South GSA.

Should decertification remain?

Individuals with an SMI who have not received behavioral health services in two years are allowed to decertify as SMI to receive services through another ACC Plan. Should this remain?

What about Crisis Services?

- Should there be a single statewide vendor for crisis services? Single regional vendor?
- Should there be a single statewide number for crisis services?
- Other thoughts to improve the first 24 hours of crisis service delivery?
- For more info on crisis services now:
www.azahcccs.gov/AHCCCS/Downloads/ACC/View_Crisis_System_FAQs.pdf



Crisis and NTXIX Services on Tribal Lands

- What feedback do you have on AHCCCS coordinating crisis services with the 22 Tribes across Arizona?

American Indian Members

- AHCCCS is meeting with the 22 Tribes in Arizona to discuss:
 - Should AI members continue to have choice of enrollment with portions of their services delivered through managed care, AIHP, RBHAs and TRBHAs?
 - Should the change be consistent with ACC choice for members not determined to be SMI, allowing integrated options.

OIFA

- AHCCCS, RBHAs and ACC Plans are required to have an Individual and Family Affairs (OIFA) Administrator and unit including a member liaison for adults and children. Any thoughts?



SMI Specific Responsibilities

- What should AHCCCS consider to maintain focus on the needs of individuals with an SMI as the responsibilities are blended within one plan?

Next Steps

What other feedback should AHCCCS consider during our next step of integration?



Questions?



AHCCCS Works & Prior Quarter Coverage Overview



Section 1115 Waiver

- Section 1115 of the Social Security Acts gives states authority to be waived from selected Medicaid requirements in federal law
- Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for the oversight of 1115 waivers
- States must obtain approval from CMS before implementing 1115 waivers

1115 Waiver Approval Process

**Develop Draft
Waiver
Application**

**Submit Final
Waiver
Application to
CMS**

**Receive Waiver
Approval or
Denial from
CMS**

**Provide at least
45 days of
Public Notice,
Conduct Public
Forums, and
Tribal
Consultation**

**Negotiate
Terms and
Conditions
with CMS**

The Waiver Allows Arizona to

- Run its unique Medicaid model built around a statewide managed care system
- Serve members enrolled in the Arizona Long Term Care System (ALTCS) in the community rather than more costly institutions
- Provide health care to expanded populations
- Implement AHCCCS Works and Prior Quarter Coverage changes

Presentation Overview

- AHCCCS Works & Prior Quarter Coverage Background
- AHCCCS Works Requirements
- AHCCCS Works Exemptions
- Community Engagement Orientation Period
- Reporting Requirements, Suspensions, & Automatic Reinstatement
- Geographic Phase-in Recommendation
- Waiver of Prior Quarter Coverage
- Populations Affected by Waiver of Prior Quarter Coverage
- Next Steps

AHCCCS Works Timeline and Law Requirement

2015

AZ law amended to include work requirements & 5-year lifetime limit for AHCCCS members

January - March 2017

AHCCCS Works Public Comment Period

December 19, 2017
AHCCCS Works Waiver submitted to CMS

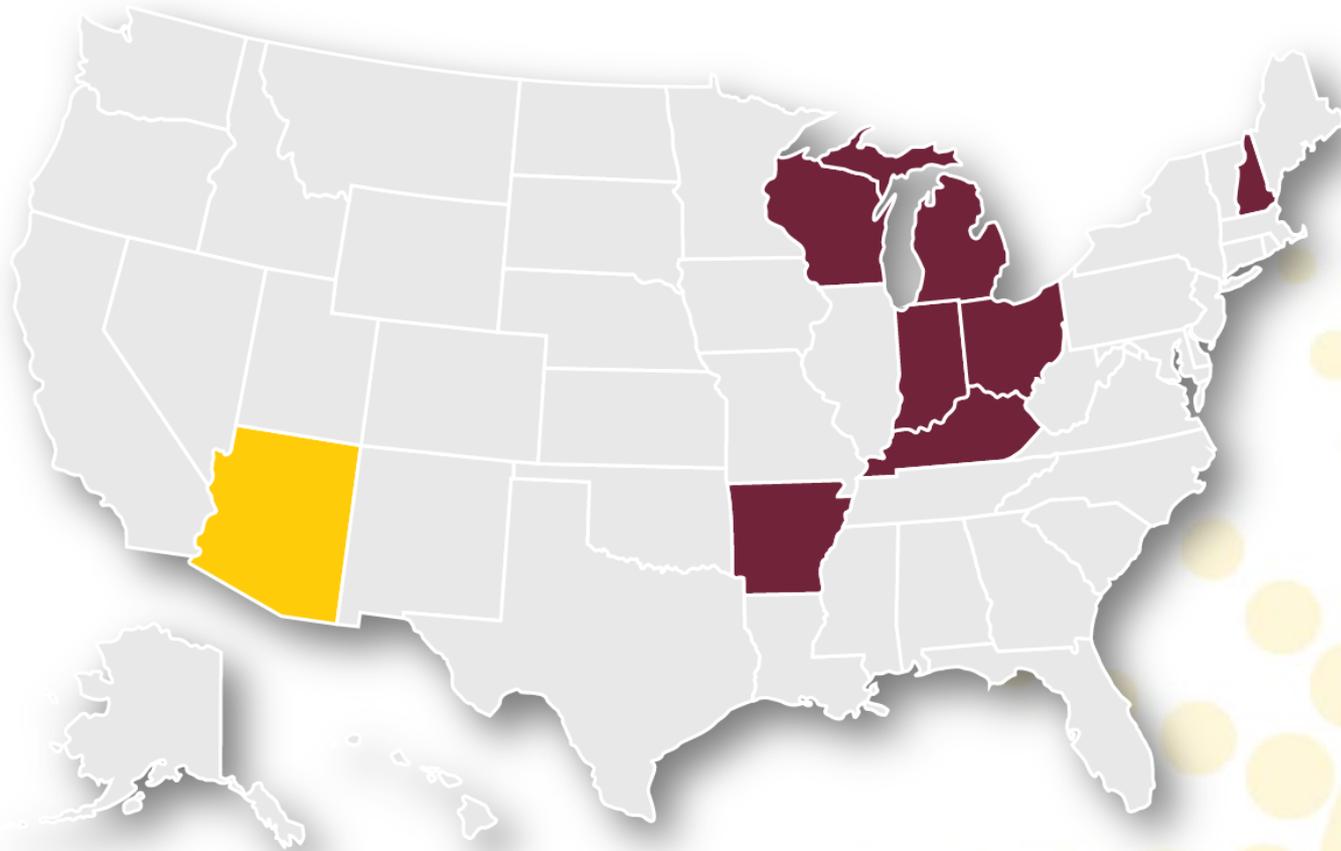
AHCCCS Works Timeline and Law Requirement (Cont.)

January 18,
2019
CMS approves
AHCCCS Works

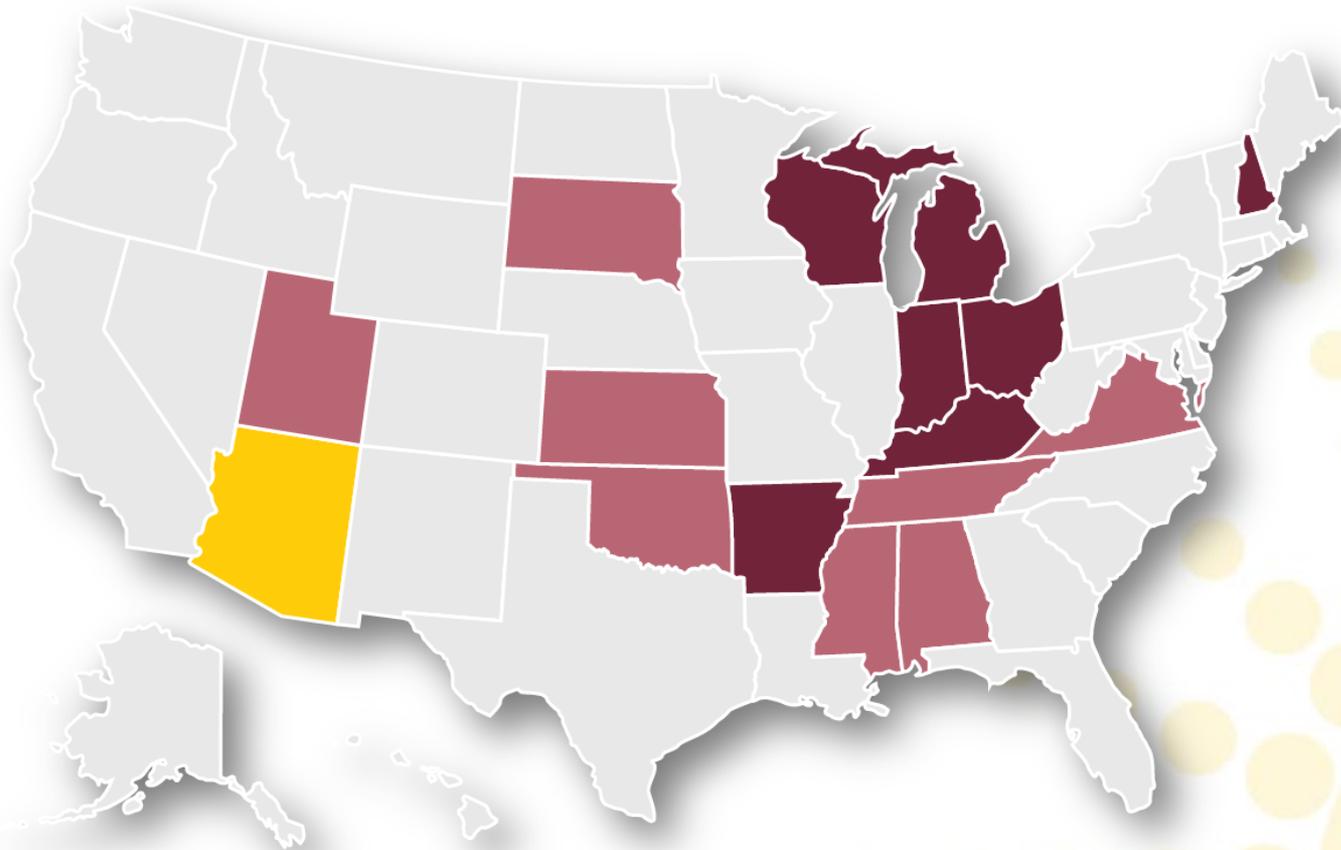
March – July
2019
Conduct 12
Community
Presentations
Across The State

No Sooner Than
Spring 2020
Implementation

National Landscape: Community Engagement Waivers



National Landscape: Community Engagement Waivers



AHCCCS Works Unique Program Features

1st

- First in the nation to exempt members of federally recognized tribes
- First in the nation to allow members who are suspended to automatically re-enrolled at the expiration of the Suspension Period as long as they meet all other eligibility criteria

AHCCCS Works Requirements

- No sooner than **January 1, 2020**, able-bodied adults* 19-49 who do not qualify for an exemption must, for at least 80 hours per month:
 - Be employed (including self-employment);
 - Actively seek employment;
 - Attend school (less than full time);
 - Participate in other employment readiness activities, i.e., job skills training, life skills training & health education; or
 - Engage in Community Service.

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

Who is Exempt

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

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



JANUARY

AHCCCS sends an AHCCCS Works orientation packet. Her 3-month grace period begins February 1.

FEBRUARY

Jane learns about the AHCCCS Works requirements and explores opportunities to engage in her community. In April, she receives a reminder notice that she must participate in at least 80 hours of community engagement activities per month beginning in May.

MARCH

APRIL

MAY

Jane completes 80 hours of community engagement activities in May. She begins reporting these hours, and must complete May's reporting by June 10.

May participation

AUGUST

Because Jane failed to comply in July, AHCCCS sends her a notice on August 11 that her AHCCCS coverage will be suspended for two months beginning September 1.

July reporting

JULY

Jane reports her June hours by July 10, but does not complete 80 hours of community engagement activities in July. If Jane has good cause for not complying in July, she can tell AHCCCS anytime next month.

June reporting
 July participation

JUNE

By June 10, Jane reports the 80 hours of community engagement activities she completed in May. She also completes 80 hours of community engagement activities in June.

May reporting
 June participation

SEPTEMBER

Jane's coverage is suspended for two months. In October, AHCCCS reminds Jane that her enrollment in AHCCCS will be automatically reinstated on November 1.

OCTOBER

NOVEMBER

Jane's AHCCCS coverage is automatically reinstated as of November 1. She completes 80 hours of community engagement activities in November, and must report them by December 10.

November participation

DECEMBER

By December 10, Jane reports November's hours and completes 80 hours of community engagement activities in December.

November reporting
 December participation



Reporting Requirement

- Must complete at least 80 hours of qualifying activities each month and report these hours by the 10th day of the following month
- Members will be allowed report AW activities through several methods including in a state portal, by phone, and in person

Reactivation of Eligibility During Suspension Period

- Member is automatically reinstated immediately following the 2 month suspension period
- Member who is suspended will have eligibility reactivated immediately during the suspension period if:
 - Member is found eligible for another eligibility category
 - Verifies that he or she currently qualifies for an AW exemption

AHCCCS Works Geographic Phase-in Recommendation

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

Why:

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

AHCCCS Works Geographic Phase-in Recommendation

Counties	Percentage of the County Population Residing in Rural Areas as of the 2010 Census.	Percentage of AW Members Residing in the County	AW Implementation Phases
Maricopa	2.4	56.9	Phase I 2020 – 2021
Pima	7.5	17.6	
Yuma	10.4	4.1	
Total Phase I	-	78.6	
Pinal	21.9	4.7	Phase II 2021 – 2022
Mohave	23	5	
Santa Cruz	26.9	1	
Coconino	31.5	1.5	
Yavapai	33.2	3.3	
Cochise	36.3	2.6	
Total Phase II	-	18.1	
Gila	41.1	0.9	Phase III 2022 – 2023
Graham	46.4	0.6	
Greenlee	46.6	0.1	
Navajo	54.1	1	
La Paz	56.3	0.3	
Apache	74.1	0.4	
Total Phase III	-	3.3	

Key:

 = < 20% Low Rural Population
 = > 40% High Rural Population

 = 40% - 20% Moderate Rural Population

Next Steps: AHCCCS Works

February 18, 2019
Waiver Acceptance
Letter and Technical
Corrections



July 17, 2019
Waiver
Evaluation
Design Plan
(In Progress)



**No sooner than
Spring 2020**
AHCCCS Works
program begins



July 1, 2019
Implementation
Plan

August 16, 2019
Monitoring Protocol
(In Progress)

Implementation Plan

- Describes the state's approach to implementing the AHCCCS Works program, including exemptions, coordination with other agencies, member protections, and outreach.

Evaluation Design Plan

- Specifies the state's plan for evaluating the success of the AHCCCS Works and Retroactive Coverage Waivers
- The Evaluation Design Plan includes research questions, hypotheses, and proposed measures, and method for conducting evaluation.
- The Evaluation Design Plan must be developed by an independent party.

Monitoring Protocol

- Specifies the state's plan for reporting required monitoring metrics and implementation updates to CMS.
- CMS will provide the state with a set of required metrics including:
 - Total members exempted from AHCCCS Works requirement in the month
 - Members with approved good cause circumstances
 - Total members whose benefits were reinstated after being in suspended status for non-compliance

Waiver of Prior Quarter Coverage

- CMS has approved Arizona's waiver request to limits retroactive coverage to the month application for all AHCCCS members except for children under the age of 19 and women who are pregnant (including post-partum) once they become eligible
- The waiver of Prior Quarter Coverage is **effective July 1, 2019**



Thank You!

**APPENDIX B:
TI PROGRAM
STATEWIDE FOCUS
POPULATION
MEASURES AND
TARGETS**



Table 8 – Statewide Focus Population Measures and Targets

Child Physical and Behavioral Health Integration Measures			
Year of DSHP	Proposed Measure	Numerator and Denominator Definition	Proposed Target
3	Practice has executed an agreement with Health Current and Health Current and routinely receives ADT alerts	<u>numerator:</u> An executed agreement with Health Current and Health Current confirmation of practice routine receipt of ADT alerts	5 points over baseline
	<u>Baseline:</u> to be calculated during Year 1	<u>denominator:</u> Primary care and behavioral health practices participating in the child integration project	
4	Well-child visits in the third, fourth, fifth and sixth years of life for children with a behavioral health diagnosis (HEDIS, modified) <u>Baseline:</u> To be calculated during Year 1	<u>numerator:</u> AHCCCS members with a BH diagnosis who are age 3-6 years as of the last calendar day of the measurement year, and are attributed to a primary care provider participating in the child integration project, who have at least one well-child visit with any PCP during the measurement year ¹ <u>denominator:</u> AHCCCS members with a BH diagnosis who are age 3–6 years as of the last calendar day of the measurement year and are attributed to a child integration project participating primary care provider	2 points over baseline
5	Well-child visits in the third, fourth, fifth and sixth years of life for children with a behavioral health diagnosis (HEDIS, modified) <u>Baseline:</u> To be calculated during Year 1	<u>numerator:</u> AHCCCS members with a BH diagnosis who are age 3-6 years as of the last calendar day of the measurement year, and are attributed to a primary care provider participating in the child integration project, who have at least one well-child visit with any PCP during the measurement year. <u>denominator:</u> AHCCCS members with a BH diagnosis who are age 3–6 years as of the last calendar day of the measurement year and are attributed to a child integration project participating primary care provider	5 points over baseline

Adult Physical and Behavioral Health Integration Measures			
Year of DSHP	Proposed Measure	Numerator and Denominator Definition	Proposed Target
3	Practice has executed an agreement with Health Current and routinely receives ADT alerts <u>Baseline</u> : To be calculated during Year 1	<u>numerator</u> : An executed agreement with Health Current and Health Current confirmation of practice routine receipt of ADT alerts <u>denominator</u> : Adult primary care and behavioral health practices participating in the adult integration project	5 points over baseline
4	Follow-up after hospitalization for mental illness (HEDIS, modified ²) <u>Baseline</u> : To be calculated during Year 1	<u>numerator</u> : AHCCCS members 18 years of age and older at any time during the measurement period who had a follow-up visit with a mental health practitioner within 7 days after a denominator-qualifying discharge, including visits that occur on the date of discharge. ³ <u>denominator</u> : Acute hospital discharges of AHCCCS members 18 years of age and older at any time during the measurement period for treatment of selected mental illness diagnoses ⁴ for members discharged from an adult integration project participating hospital or attributed to an adult integration project participating primary care or behavioral health provider	2 points over baseline
5	Follow-up after hospitalization for mental illness (HEDIS, modified) <u>Baseline</u> : To be calculated during Year 1	<u>numerator</u> : AHCCCS members 18 years of age and older at any time during the measurement period who had a follow-up visit with a mental health practitioner within 7 days after a denominator-qualifying discharge, including visits that occur on the date of discharge. <u>denominator</u> : Acute hospital discharges of AHCCCS members 18 years of age and older at any time during the measurement period for treatment of selected mental illness diagnoses for members discharged from an adult integration project participating hospital or attributed to an adult integration project participating primary care or behavioral health provider	4 points over baseline

¹ Well-care visit as defined in the HEDIS 2017 Well-Care Value Set. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child or be within the Targeted Investment provider entity.

² Modified to apply only to adults, as the HEDIS specifications include those six years and older in the denominator.

³ The follow-up visit must be with a mental health practitioner as defined by the following NCQA HEDIS value sets: FUH Stand Alone Visits Value Set, (FUH Visits Group 1 Value Set *and* FUH POS Group 1 Value Set), and FUH Visits Group 2 Value Set *and* FUH POS Group 2 Value Set.

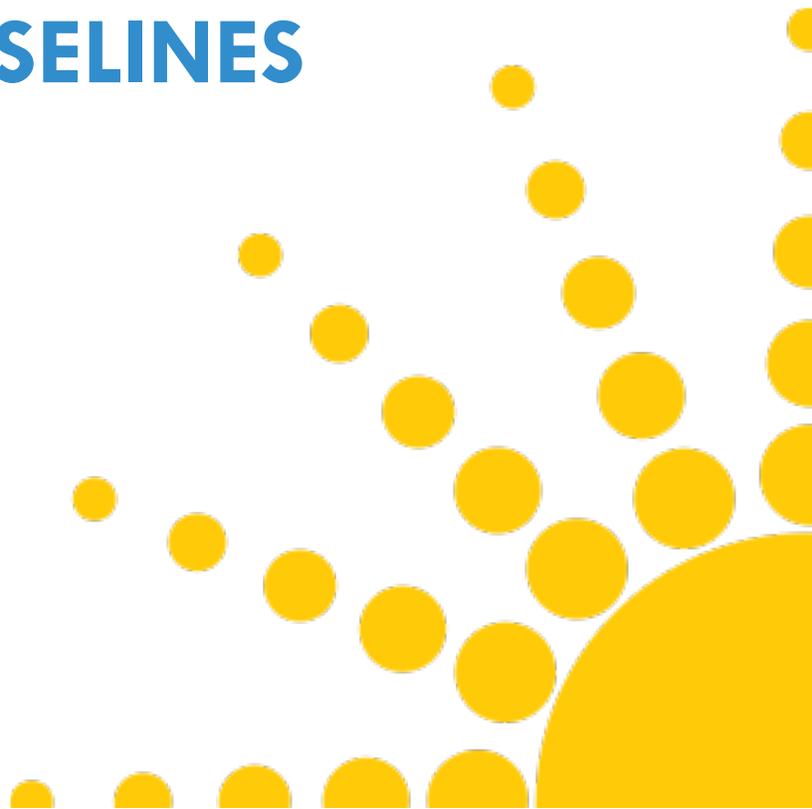
⁴ A principal diagnosis of mental illness is defined by the NCQA HEDIS Mental Illness Value Set. Inpatient stay is defined by the Inpatient Stay Value Set, but excludes the Nonacute Inpatient Stay Value Set.

Care Coordination Measures for Medicaid Enrolled Released from Criminal Justice Facilities			
Year of DSHP	Proposed Measure	Numerator and Denominator Definition	Proposed Target
3	Practice has executed an agreement with Health Current and routinely receives ADT alerts <u>Baseline:</u> To be calculated during Year 1	<u>numerator:</u> An executed agreement with Health Current and Health Current confirmation of practice routine receipt of ADT alerts <u>denominator:</u> Integrated practices participating in the justice transition	100%
4	Adults access to preventive/ambulatory health services (HEDIS, modified ⁵) <u>Baseline:</u> To be calculated during Year 1	<u>numerator:</u> AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated who had one or more ambulatory or preventive care visits ⁶ during the measurement year <u>denominator:</u> AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated	2 points over baseline
5	Adults access to preventive/ambulatory health services (HEDIS, modified) <u>Baseline:</u> To be calculated during Year 1	<u>numerator:</u> AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated who had one or more ambulatory or preventive care visits during the measurement year <u>denominator:</u> AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated	5 points over baseline

⁵ Modified to apply to only those AHCCCS members recently released from a criminal justice facility at which a new integrated clinic has been situated. "Recently released" is defined as excluding those individuals released 60 days prior to end of the measurement period.

⁶ Visits defined by the following NCQA HEDIS measure sets: Ambulatory Visits Value Set and Other Ambulatory Visits Value Set.

**APPENDIX C:
TI PROGRAM
STATEWIDE FOCUS
POPULATION
MEASURES AND
TARGETS REVISED
BASELINES**



Child Physical and Behavioral Health Integration Measures			
Year of DSHP	Proposed Measure	Numerator and Denominator Definition	Proposed Target
3	Practice has executed an agreement with Health Current and routinely receives ADT alerts <u>Baseline:</u> to be calculated during Year 1	<u>numerator:</u> An executed agreement with Health Current and Health Current confirmation of practice routine receipt of ADT alerts <u>denominator:</u> Primary care and behavioral health practices participating in the child integration project	Target: 35.77% Baseline: 20/65= 30.77% 5 points over baseline
4	Well-child visits in the third, fourth, fifth and sixth years of life for children with a behavioral health diagnosis (HEDIS, modified) Baseline: To be calculated during Year 1	<u>numerator:</u> AHCCCS members with a BH diagnosis who are age 3-6 years as of the last calendar day of the measurement year, and are attributed to a primary care provider participating in the child integration project, who have at least one well-child visit with any PCP during the measurement year ¹ <u>denominator:</u> AHCCCS members with a BH diagnosis who are age 3-6 years as of the last calendar day of the measurement year and are attributed to a child integration project participating primary care provider	Target: 78.46% Baseline: 5606/ 7332= 76.46% 2 points over baseline
5	Well-child visits in the third, fourth, fifth and sixth years of life for children with a behavioral health diagnosis (HEDIS, modified) Baseline: To be calculated during Year 1	<u>numerator:</u> AHCCCS members with a BH diagnosis who are age 3-6 years as of the last calendar day of the measurement year, and are attributed to a primary care provider participating in the child integration project, who have at least one well-child visit with any PCP during the measurement year. <u>denominator:</u> AHCCCS members with a BH diagnosis who are age 3-6 years as of the last calendar day of the measurement year and are attributed to a child integration project participating primary care provider	Target: 81.46% Baseline: 5606/ 7332= 76.46% 5 points over baseline

¹ Well-care visit as defined in the HEDIS 2017 Well-Care Value Set. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child or be within the Targeted Investment provider entity

Adult Physical and Behavioral Health Integration Measures			
Year of DSHP	Proposed Measure	Numerator and Denominator Definition	Proposed Target
3	Practice has executed an agreement with Health Current and routinely receives ADT alerts <u>Baseline:</u> To be calculated during Year 1	<u>numerator:</u> An executed agreement with Health Current and Health Current confirmation of practice routine receipt of ADT alerts <u>denominator:</u> Adult primary care and behavioral health practices participating in the adult integration project	Target: 32.48% Baseline: 36/131= 27.48% 5 points over baseline
4	Follow-up after hospitalization for mental illness (HEDIS, modified ²) Baseline: To be calculated during Year 1	<u>numerator:</u> AHCCCS members 18 years of age and older at any time during the measurement period who had a follow-up visit with a mental health practitioner within 7 days after a denominator- qualifying discharge, including visits that occur on the date of discharge ³ . <u>denominator:</u> Acute hospital discharges of AHCCCS members 18 years of age and older at any time during the measurement period for treatment of selected mental illness diagnoses ⁴ for members discharged from an adult integration project participating hospital or attributed to an adult integration project participating primary care or behavioral health provider	Target: 72.74% Baseline: 3777/ 5339= 70.74% 2 points over baseline
5	Follow-up after hospitalization for mental illness (HEDIS, modified) Baseline: To be calculated during Year 1	<u>numerator:</u> AHCCCS members 18 years of age and older at any time during the measurement period who had a follow-up visit with a mental health practitioner within 7 days after a denominator- qualifying discharge, including visits that occur on the date of discharge. <u>denominator:</u> Acute hospital discharges of AHCCCS members 18	Target: 74.74% Baseline: 3777/ 5339= 70.74%

		years of age and older at any time during the measurement period for treatment of selected mental illness diagnoses for members discharged from an adult integration project participating hospital or attributed to an adult integration project participating primary care or behavioral health provider.	4 points over baseline
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² Modified to apply only to adults, as the HEDIS specifications include those six years and older in the denominator

³ The follow-up visit must be with a mental health practitioner as defined by the following NCQA HEDIS value sets: FUH Stand Alone Visits Value Set, (FUH Visits Group 1 Value Set *and* FUH POS Group 1 Value Set), and FUH Visits Group 2 Value Set *and* FUH POS Group 2 Value Set

⁴ A principal diagnosis of mental illness is defined by the NCQA HEDIS Mental Illness Value Set. Inpatient stay is defined by the Inpatient Stay Value Set, but excludes the Nonacute Inpatient Stay Value Set.

Care Coordination Measures for Medicaid Enrolled Released from Criminal Justice Facilities			
Year of DSHP	Proposed Measure	Numerator and Denominator Definition	Proposed Target
3	Practice has executed an agreement with Health Current and routinely receives ADT alerts <u>Baseline:</u> To be calculated during Year 1	<u>numerator:</u> An executed agreement with Health Current and Health Current confirmation of practice routine receipt of ADT alerts <u>denominator:</u> Integrated practices participating in the justice transition	100%
4	Adults access to preventive/ambulatory health services (HEDIS, modified ⁵) <u>Baseline:</u> To be calculated during Year 1	<u>numerator:</u> AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated who had one or more ambulatory or preventive care visits ⁶ during the measurement year <u>denominator:</u> AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated	Target: 46.21% Baseline: 3168/7166= 44.21% 2 points over baseline
5	Adults access to preventive/ambulatory health services (HEDIS, modified) <u>Baseline:</u> To be calculated during Year 1	<u>numerator:</u> AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated who had one or more ambulatory or preventive care visits during the measurement year <u>denominator:</u> AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated	Target: 49.21% Baseline: 3168/7166= 44.21% 5 points over baseline

⁵ Modified to apply to only those AHCCCS members recently released from a criminal justice facility at which a new integrated clinic has been situated. "Recently released" is defined as excluding those individuals released 60 days prior to end of the measurement period.

⁶ Visits defined by the following NCQA HEDIS measure sets: Ambulatory Visits Value Set and Other Ambulatory Visits Value Set.