Arizona Health Care Cost Containment System


# Contract Year Ending 2023 External Quality Review Annual Technical Report

*April 2024*

HSAG HEALTH SERVICES ADVISORY GROUP

# Contents

# 1. Executive Summary

## Background

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

- Identify areas for quality improvement
- Ensure alignment among the Contractors' Quality Management/Performance Improvement (QM/PI) Program Plan requirements, the State's Quality Strategy, and the annual EQR activities
- Provide high-value care
- Enhance performance of its healthcare delivery system for Medicaid and CHIP members
- Improve AHCCCS' ability to oversee and manage its Contractors
- Assist Contactors with improving their performance with respect to the quality, timeliness, and accessibility of care

## Contractors Reviewed

AHCCCS maintains managed care agreements with several Contractors to administer its Medicaid Managed Care program. A general description of each AHCCCS program and the associated Contractors reviewed are included below.

[1-1] Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Feb 5, 2024.

[1-2] Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care. Available at: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care. Accessed on: Feb 5, 2024.

## AHCCCS Complete Care (ACC) Program

The **ACC Program** provides integrated care addressing the physical and behavioral health needs for the majority of Medicaid (Title XIX) eligible children and adults as well as addressing the physical and behavioral health needs for the majority of CHIP KidsCare (Title XXI) eligible children (under age 19 years). Seven ACC Contractors are responsible for providing services under the ACC Program. Three of the ACC Contractors are also responsible for providing services for the SMI-Designated population. These Contractors are referred to as ACC-Regional Behavioral Health Agreement (ACC-RBHA) Contractors. Throughout this report, ACC Program discussions are limited to the ACC and ACC-RBHA Contractors' Non-SMI-Designated population.

**Table 1-1—ACC Program Contracted MCOs**

| ACC Program Contractors | |
|---|---|
| **Contractor Name** | **Contractor Abbreviation** |
| Arizona Complete Health – Complete Care Plan | AzCH-CCP ACC-RBHA* |
| Banner-University Family Care | BUFC ACC |
| Care 1st Health Plan | Care 1st ACC-RBHA* |
| Health Choice Arizona | HCA ACC |
| Mercy Care | Mercy Care ACC-RBHA* |
| Molina Healthcare | Molina ACC |
| UnitedHealthcare Community Plan | UHCCP ACC |

* Contractor serves both the ACC and the ACC-RBHA SMI-Designated populations. Throughout this report, ACC Program discussions are limited to the ACC-RBHA Contractors' Non-SMI-Designated population.

## Regional Behavioral Health Authority (RBHA)/ACC-RBHA SMI-Designated Population Program

The **RBHA Program** was active through September 30, 2022, and provided integrated physical and behavioral health services to eligible Medicaid (Title XIX) and CHIP KidsCare (Title XXI) covered members determined to have a serious mental illness (SMI) designation.

The **ACC-RBHA Program** was initiated October 1, 2022, and provides integrated physical and behavioral health services to eligible Medicaid (Title XIX) and CHIP KidsCare (Title XXI) covered members determined to have an SMI designation. ACC-RBHA Contractors are also responsible for providing crisis services to all individuals, including but not limited to crisis telephone services, community-based mobile crisis teams, and facility-based crisis stabilization services. Additionally, ACC-RBHA Contractors are responsible for providing services to the ACC (Non-SMI-Designated) population.

Throughout this report, the RBHA/ACC-RBHA SMI-Designated Population Program sections will present performance measure and performance improvement project (PIP) validation activities that were conducted for the Contractors in CYE 2023 reflective of their CY 2022 performance, as well as network adequacy validation (NAV) activity results conducted in CYE 2023 reflective of their performance as ACC-RBHA Contractors.

**Table 1-2—RBHA/ACC-RBHA SMI-Designated Population Program Contracted MCOs**

| RBHA/ACC-RBHA SMI-Designated Population Program Contractors* | |
|---|---|
| **Contractor Name** | **Contractor Abbreviation** |
| Arizona Complete Health – Complete Care Plan | AzCH-CCP RBHA/AzCH-CCP ACC-RBHA |
| Care 1st Health Plan | Care 1st ACC-RBHA** |
| Health Choice Arizona | HCA RBHA*** |
| Mercy Care | Mercy Care RBHA/Mercy Care ACC-RBHA |

*The ACC-RBHA Contractors serve both the SMI-Designated population (under the ACC-RBHA program) and the Non-SMI-Designated population (under the ACC program).
**Effective October 1, 2022, AHCCCS contracted with Care 1st as an ACC-RBHA.
***Effective September 30, 2022, HCA no longer serves the SMI-Designated population as its RBHA contract with AHCCCS ended September 30, 2022.

## *Arizona Department of Child Safety Comprehensive Health Plan (DCS CHP) Program*

The **DCS CHP Program** provides physical health, dental, and behavioral health services for children and youth in foster care throughout the State of Arizona.

**Table 1-3—DCS CHP Program Contracted MCO**

| DCS CHP Program Contractor | |
|---|---|
| **Contractor Name** | **Contractor Abbreviation** |
| Arizona Department of Child Safety Comprehensive Health Plan | DCS CHP* |

*DCS CHP provides services through a subcontracted MCO, Mercy Care Department of Child Safety Comprehensive Health Plan (Mercy Care DCS CHP). This report uses DCS CHP when referring to activities conducted by the DCS CHP Program and Mercy Care DCS CHP when referring to activities conducted by the DCS CHP subcontracted health plan (Mercy Care).

## *Arizona Long Term Care System Elderly and Physically Disabled (ALTCS-EPD) Program*

The **ALTCS-EPD Program** provides long-term services and supports (LTSS) as well as integrated physical and behavioral health services to eligible members who are elderly and/or have a physical disability.

**Table 1-4—ALTCS-EPD Program Contracted MCOs**

| ALTCS-EPD Program Contractors | |
|---|---|
| **Contractor Name** | **Contractor Abbreviation** |
| Banner-University Family Care | BUFC LTC |
| Mercy Care | Mercy Care LTC |
| UnitedHealthcare Community Plan | UHCCP LTC |

### *ALTCS Developmental Disabilities (ALTCS-DD) Program*

The **ALTCS-DD Program** provides LTSS as well as integrated physical and behavioral health services to eligible members who have an intellectual/developmental disability (IDD) as outlined under Arizona State law.

**Table 1-5—ALTCS-DD Program Contracted MCO**

| ALTCS-DD Program Contractor | |
|---|---|
| **Contractor Name** | **Contractor Abbreviation** |
| Arizona Department of Economic Security, Division of Developmental Disabilities | DES/DDD* |

*DES/DDD provides services through two subcontracted health plans, Mercy Care and UnitedHealthcare Community Plan (UHCCP). The report uses DES/DDD when referring to the DES/DDD Contractor, and Mercy Care DD or UHCCP DD when referring to activities conducted by the DES/DDD subcontracted health plans.

## Program-Level Summary of Findings and Assessment

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

### *ACC Program*

Table 1-6 presents program-level strengths, opportunities for improvement, and recommendations for the ACC Program based on all EQR activities conducted. For additional information about ACC Program-level strengths, opportunities for improvement, and recommendations, see Section 4. ACC (Non-SMI-Designated Population) Program-Level Comparative Results.

**Table 1-6—ACC Program Strengths, Opportunities for Improvement, and Recommendations**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths related to performance measure validation (PMV):<br>• The rates for all seven ACC Program Contractors and the ACC Program Aggregate rate met or exceeded the National Committee for Quality Assurance (NCQA) Quality Compass®, [1-3] national Medicaid health maintenance organization (HMO) mean for Healthcare Effectiveness Data and Information Set (HEDIS®)[1-4] measurement year (MY) 2022 for this measure:<br>– *Follow-Up After Emergency Department (ED) Visit for Substance Use—7-Day Follow-Up—Total* measure rate **[Quality, Timeliness, Access]**<br>• The rates for six of seven ACC Program Contractors and the ACC Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 for these measures:<br>– *Follow-Up After Emergency Department (ED) Visit for Substance Use—30-Day Follow-Up—Total* measure rate **[Quality, Timeliness, Access]**<br>– *Follow-Up After Emergency Department (ED) Visit for Mental Illness—7-Day Follow-Up—Total* measure rate **[Quality, Timeliness, Access]**<br>– *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total* and *Engagement of SUD Treatment—Total* measure rates **[Quality, Timeliness, Access]**<br>– *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*, Cholesterol *Testing—Total, and Blood Glucose and Cholesterol Testing—Total* measure rates **[Quality]**<br>– *Immunizations for Adolescents—Combination 1* measure rate **[Quality]**<br><br>HSAG identified the following strengths related to PIPs:<br>• The ACC Program Contractors were able to perform accurate statistical testing between the baseline and Remeasurement 1 results for the *Back to Basics* PIP. **[Quality, Access]**<br>• For the *Prenatal and Postpartum Care* PIP, the ACC Program Contractors implemented and developed measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 1. **[Quality, Access]**<br><br>HSAG identified the following strengths related to compliance reviews:<br>• The ACC Program Contractors' average compliance score was at or above 95 percent in the following compliance Focus Areas: |

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

| Strengths, Opportunities for Improvement, and Recommendations |
|---|

- Corporate Compliance (CC) **[Quality, Access]**
- Claims and Information Standards (CIS) **[Access]**
- General Administration (GA) **[Timeliness, Access]**
- Grievance Systems (GS) **[Timeliness, Access]**
- Member Information (MI) **[Quality]**
- Reinsurance (RI) **[Quality]**
- Third-Party Liability (TPL) **[Quality, Timeliness, Access]**
- Integrated Systems of Care (ISOC) **[Quality, Access]**

- In CYE 2023, AHCCCS approved all ACC Program Contractors' proposed CAPs for all Focus Areas with scores less than 95 percent.

HSAG identified the following strengths related to NAV:

- The applicable ACC Program Contractors met all minimum time/distance network standards during both quarters in Cochise, Graham, Maricopa, Mohave, Pima, Pinal, Yavapai, and Yuma counties. **[Access]**
- The ACC Program Contractors consistently met the behavioral health residential facility (BHRF); Cardiologist, Adult and Pediatric; OB/GYN; and PCP, Adult and Pediatric standards. **[Access]**

HSAG identified the following strength related to the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-5] results for the ACC (Non-SMI-Designated population) Program's member experience rating:

- The ACC (Non-SMI-Designated population) Program's member experience rating for *Rating of Health Plan* met or exceeded the 75th percentile for the adult Medicaid population. **[Quality]**

HSAG identified the following strengths related to the CAHPS results for the KidsCare Program's member experience rating:

- The KidsCare Program's member experience ratings for *Getting Needed Care* met or exceeded the 75th percentile for the general child population. **[Quality, Access]**
- The KidsCare Program's member experience ratings for *Getting Care Quickly*, *Access to Specialized Services,* and *Family-Centered Care (FCC): Getting Needed Information* met or exceeded the 75th percentiles for the Children with Chronic Conditions (CCC) population. **[Quality, Timeliness, Access]**

[1-5] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Opportunities for Improvement and Recommendations** |

HSAG identified the following opportunities for improvement related to PMV:

- The rates for all seven ACC Program Contractors and the ACC Program Aggregate rate fell below the NCQA Quality Compass national Medicaid HMO mean for MY 2022 and fell below the 25th percentile (i.e., HEDIS measures) for the:
  - *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* measure rate **[Quality]**
  - *Well-Child Visits in the First 30 Months of Life—15 Months–30 Months—Two or More Well-Child Visits* measure rate **[Quality, Access]**

  Recommendations:

  - HSAG recommends that the ACC Program Contractors conduct a root cause analysis or focus study to determine why some members with a diagnosis of schizophrenia were not adhering to continuous medication treatment. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, the ACC Program Contractors should implement appropriate interventions to improve performance related to antipsychotic medication management.
  - HSAG recommends that the ACC Program Contractors conduct a root cause analysis to determine why some children did not receive well-care visits according to the recommended schedule. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, the ACC Program Contractors should implement appropriate interventions.

- The rates for six of seven ACC Program Contractors and the ACC Program Aggregate rate fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and fell below the 25th percentile for this measure:
  - *Prenatal and Postpartum Care—Postpartum Care* measure rate **[Quality, Timeliness, Access]**

    Recommendation: HSAG recommends that the ACC Program Contractors continue to evaluate the effectiveness of the interventions implemented as a result of the root cause analyses completed in the prior year and expand on the interventions with the biggest impact. The ACC Program Contractors should submit the results of these ongoing quality improvement activities as required by AHCCCS.

- For CY 2022 performance measure reporting, race and ethnicity stratifications (RES) were required based on NCQA HEDIS specifications. While HSAG did not identify ACC Contractor-specific opportunities to improve RES, all ACC Contractors could benefit from continuing to focus on refining RES reporting where required per measure specifications. **[Quality]**

**Strengths, Opportunities for Improvement, and Recommendations**

Recommendation: HSAG recommends that the ACC Program Contractors explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratifications related to race and ethnicity. The ACC Program Contractors should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information.

HSAG identified the following opportunities for improvement related to PIPs:

- Overall, the ACC Program Contractors' Remeasurement 1 indicator rates for the *Back to Basics* PIP demonstrated a decline compared to baseline rates. **[Quality, Access]**
- For the *Prenatal and Postpartum Care* PIP, HSAG identified no opportunities for improvement for the ACC Program Contractors.

Recommendations: To support successful progression of both PIPs in the next calendar year, HSAG recommends that the ACC Program Contractors:

- Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.
- Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.
- Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.

HSAG identified the following opportunities for improvement related to compliance reviews:

- The ACC Program Contractors' average score was below 95 percent in the following compliance Focus Areas:
  - Delivery Systems (DS) **[Timeliness, Access]**
  - General Administration (GA) **[Timeliness, Access]**
  - Adult; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT); and Maternal Child Health (MCH) **[Quality, Timeliness, Access]**
  - Medical Management (MM) **[Timeliness, Access]**
  - Quality Management (QM) **[Quality]**
  - Quality Improvement (QI) **[Quality, Access]**

Recommendation: HSAG recommends that the ACC Program Contractors continue to work on outstanding CAPs related to the DS, GA, MCH, MM, QM, and QI Focus Area requirements.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|

HSAG identified the following opportunities for improvement related to NAV:

- Isolated data issues may have contributed to specific instances affecting ACC Program Contractors' compliance with time/distance standards. **[Access]**
- Based on the semiannual NAV results, not all ACC Program Contractors met the standards for Dentist, Pediatric and Pharmacy in Apache, Coconino, Greenlee, and La Paz counties. **[Access]**

Recommendations:

- HSAG recommends that AHCCCS support the ACC Program Contractors in continuing to monitor their processes for creating the Provider Affiliation Transmission (PAT) file and reviewing the PAT file for accuracy prior to submitting to AHCCCS.
- HSAG recommends that AHCCCS support each ACC Program Contractor in continuing to monitor and maintain its existing provider network coverage as of CYE 2023 Q4, with specific attention to ensuring the availability of the following provider types among the applicable ACC Program Contractors:
  - Pediatric dentists in Apache, Coconino, Greenlee, and La Paz counties
  - Pharmacies in La Paz County

HSAG identified the following opportunities for improvement related to CAHPS results for the ACC (Non-SMI-Designated population) Program's member experience ratings:

- The ACC (Non-SMI-Designated population) Program's member experience rating for *Getting Care Quickly*, *Customer Service*, *Coordination of Care*, *Advising Smokers and Tobacco Users to Quit*, and *Discussing Cessation Strategies* were below the 25th percentiles for the adult Medicaid population. **[Quality, Timeliness]**
- The ACC (Non-SMI-Designated population) Program's member experience rating for *Rating of Specialist Seen Most Often, Getting Needed Care, How Well Doctors Communicate,* and *Discussing Cessation Medications* were between the 25th and 49th percentiles for the adult Medicaid population. **[Quality, Access]**

Recommendation: HSAG recommends that the ACC Program Contractors explore what may be driving lower experience scores and develop initiatives designed to improve the quality of and access to care, including a focus on improving adult members' overall experiences with their coordination of care, customer service, and medical assistance with smoking and tobacco use.

HSAG identified the following opportunities for improvement related to CAHPS results for the KidsCare Program's member experience ratings:

- The KidsCare Program's member experience rating for *Rating of Health Plan*, *Rating of All Health Care, Rating of Personal Doctor*, *Getting Care Quickly*, and *Coordination of Care* were below the 25th percentiles for the general child population. **[Quality, Timeliness]**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| • The KidsCare Program's member experience rating for *Rating of All Health Care, Rating of Specialist Seen Most Often*, *Coordination of Care,* and *Family-Centered Care (FCC): Personal Doctor Who Knows Child* were below the 25th percentiles for the CCC population. **[Quality]**<br>• The KidsCare Program's member experience rating for *Customer Service* was between the 25th and 49th percentiles for the general child population. **[Quality]**<br>• The KidsCare Program's member experience rating for *Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Needed Care*, and *Access to Prescription Medicines* were between the 25th and 49th percentiles for the CCC population. **[Quality, Access]**<br>• The KidsCare Program's 2023 scores for *Rating of Health Plan* and *Coordination of Care* were statistically significantly lower than the 2022 scores for the general child population. **[Quality]**<br><br>Recommendation: HSAG recommends that the KidsCare Program Contractors explore what may be driving lower experience scores and develop initiatives designed to improve the quality of and access to care, including a focus on improving parents'/caretakers' overall experiences with the health plan, healthcare, personal doctor, access to care in a timely manner, access to prescription medicines, coordination of care, and customer service for child members. |

## RBHA/ACC-RBHA SMI-Designated Population Program

The Regional Behavioral Health Authority (RBHA) Program was active through September 30, 2022. The ACC-Regional Behavioral Health Agreement (ACC-RBHA) Program became effective October 1, 2022. Table 1-7 presents the EQR activities conducted for RBHA/ACC-RBHA Program Contractors (serving the SMI-Designated Population), which include performance measure and PIP validation activities that were conducted for the ACC-RBHA Contractors in CYE 2023 reflective of their CY 2022 performance as RBHA Contractors as well as NAV activity results conducted in CYE 2023 reflective of their performance as ACC-RBHA Contractors.

**Table 1-7—EQR Activities Presented in the CYE 2023 External Quality Review Annual Technical Report for the RBHA/ACC-RBHA SMI-Designated Population Program**

| Contractors Reviewed | PMV | PIP Validation | Compliance Reviews (Operational Reviews)*** | NAV |
|---|---|---|---|---|
| AzCH-CCP ACC-RBHA | ✓ | ✓ | | ✓ |
| Care 1st ACC-RBHA* | | | | ✓ |
| HCA RBHA** | ✓ | ✓ | ✓ | |
| Mercy Care ACC-RBHA | ✓ | ✓ | | ✓ |

*Effective October 1, 2022, AHCCCS contracted with Care 1st as an ACC-RBHA providing services to the SMI-Designated population; therefore, Care 1st ACC-RBHA PMV and PIP data were not collected and did not undergo validation specific to this population in CYE 2023.

**HCA's RBHA contract with AHCCCS ended September 30, 2022.
*** AHCCCS reviewed Compliance Review CAP close-out documents for HCA in CYE 2023.

The ACC-RBHA contracts went into effect on 10/1/2022. AHCCCS conducted an extensive readiness review for these Contractors during CYE 2022. The Compliance Review for the ACC-RBHAs will be conducted in CYE 2024 and will therefore be included in the CYE 2024 annual technical report.

For additional information and Contractor-specific findings for PMV and PIP validation, see Section 7. RBHA/ACC-RBHA SMI-Designated Population Program Contractor-Specific Results.

Table 1-8 presents program-level strengths and opportunities for improvement for Contractors that provided services under either the RBHA or ACC-RBHA Programs for the SMI-Designated Population. Strengths and Opportunities for Improvement are based on the EQR activities conducted in CYE 2023. PMV[1-6] and PIP data are reflective of CY 2022.

Program-level strengths, opportunities for improvement, and recommendations by EQR activity are provided in Section 7. RBHA/ACC-RBHA SMI-Designated Population Program Contractor-Specific Results.

**Table 1-8—RBHA/ACC-RBHA Program Strengths and Opportunities for Improvement**

| Strengths and Opportunities for Improvement |
|---|
| **Strengths** |
| HSAG identified the following strengths related to PMV:<br>• Each of the Contractors' (serving the SMI-Designated Population in CYE 2022) measure rates and the RBHA Program Aggregate rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 for these measures:<br>– *Follow-Up After Emergency Department (ED) Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure rates **[Quality, Timeliness, Access]**<br>– *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure rates **[Quality, Timeliness, Access]**<br>– *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure rates **[Quality, Timeliness, Access]**<br>• Two of the three Contractors' (serving the SMI-Designated population in CYE 2022) measure rates and the RBHA Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 for these measures:<br>– *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total* measure rate **[Quality, Timeliness, Access]** |

[1-6] The RBHA/ACC-RBHA Program-Level results include all validated and aggregated RBHA/ACC-RBHA data, as applicable; however, HCA RBHA's contract terminated as of October 1, 2022. This resulted in reduced denominators and minimal contributions by HCA RBHA to overall statewide aggregate rates for the following performance measures: *Use of Opioids at High Dosage*, *Adherence to Antipsychotic Medications for Individuals with Schizophrenia, Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication, Controlling High Blood Pressure, Hemoglobin A1c Control for Patients With Diabetes, Oral Evaluation, Dental Services, Breast Cancer Screening,* and *Cervical Cancer Screening*.

| Strengths and Opportunities for Improvement |
|---|
| • Each of the Contractors (serving the SMI-Designated population in CYE 2022) that had denominators large enough to report valid rates, and the RBHA Program Aggregate rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 for these measures:<br>– *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure rate **[Quality, Timeliness, Access]**<br>– *Controlling High Blood Pressure* measure rate **[Quality]**<br>– *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* and *HbA1c Poor Control (>9.0%)* measure rates **[Quality]**<br><br>HSAG identified the following strengths related to PIPs:<br>• Each of the Contractors (serving the SMI-Designated population in CYE 2022) were able to perform accurate statistical testing between the baseline and Remeasurement 1 results for the *Preventive Screening* PIP. **[Quality, Access]**<br>• For the *Prenatal and Postpartum Care* PIP, the Contractors (serving the SMI-Designated population in CYE 2022) implemented and developed measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 1. **[Quality, Access]**<br><br>HSAG identified the following strengths related to compliance[1-7]:<br>• The compliance reviews for ACC-RBHA Program Contractors are scheduled for CYE 2024.<br><br>HSAG identified the following strengths related to NAV:<br>• Each of the Contractors (serving the SMI-Designated Population in CYE 2023) met all minimum time/distance network standards during both quarters in Apache, Cochise, Coconino, Greenlee, La Paz, Maricopa, Mohave, Navajo, Pima, Pinal, Yavapai, and Yuma counties. **[Access]**<br>• Each of the Contractors (serving the SMI-Designated population in CYE 2023) consistently met the Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult and Pediatric; Crisis Stabilization Facility, Hospital; OB/GYN; PCP, Adult; and Pharmacy standards. **[Access]** |
| **Opportunities for Improvement** |
| HSAG identified the following opportunities for improvement related to PMV:<br>• The rates for each of the Contractors (serving the SMI-Designated population in CYE 2022) that had denominators large enough to report valid rates, and the RBHA Program Aggregate rate did |

[1-7] The ACC-RBHA contracts went into effect on 10/1/2022. AHCCCS conducted an extensive readiness review for these Contractors during CYE 2022. The Compliance Review for the ACC-RBHAs will be conducted in CYE 2024 and will therefore be included in the CYE 2024 annual technical report.

**Strengths and Opportunities for Improvement**

not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and fell below the 25th percentile for these measures:

- *Breast Cancer Screening* **[Quality]**
- *Cervical Cancer Screening* **[Quality]**

Recommendations:

- HSAG recommends that each of the Contractors' (serving the SMI-Designated population in CYE 2022) conduct a root cause analysis or focus study to determine why most women did not receive breast cancer screenings. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services. Upon identification of a root cause, the Contractors' (serving the SMI-Designated population in CYE 2022) should leverage the current PIP activities to implement appropriate interventions and improve performance related to breast cancer screenings.
- HSAG recommends that Contractors' (serving the SMI-Designated population in CYE 2022) conduct a root cause analysis to determine why most women did not receive cervical cancer screenings. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services. Upon identification of a root cause, the Contractors' (serving the SMI-Designated population in CYE 2022) should leverage the current PIP activities to implement appropriate interventions and improve performance related to cervical cancer screenings.

- For CY 2022 performance measure reporting, race and ethnicity stratifications (RES) were required based on NCQA HEDIS specifications. While HSAG did not identify Contractor-specific opportunities to improve RES, all Contractors (serving the SMI-Designated population in CYE 2022) could benefit from continuing to focus on refining RES reporting where required per measure specifications. **[Quality]**

  Recommendation: HSAG recommends that the Contractors (serving the SMI-Designated population in CYE 2022) explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratifications related to RES. The Contractors should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information.

HSAG identified the following opportunities for improvement related to PIPs:

- Two of the three Contractors' (serving the SMI-Designated population in CYE 2022) indicator 2 rates demonstrated a decline at Remeasurement 1 compared to the baseline indicator rates for the Preventive Screening PIP. **[Quality, Access]**

| Strengths and Opportunities for Improvement |
|---|
| • HSAG identified no opportunities for improvement for the Contractors (serving the SMI-Designated population in CYE 2022) for the Prenatal and Postpartum Care PIP. **[Quality, Access]**<br><br>Recommendations: To support successful progression of the Preventive Screening and Prenatal and Postpartum Care PIPs in the next calendar year, HSAG recommends that the ACC-RBHA Program Contractors:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that effect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.<br><br>HSAG identified no opportunities for improvement related to compliance reviews:<br>• The compliance reviews for ACC-RBHA Program Contractors are scheduled for CYE 2024.<br><br>HSAG identified the following opportunities for improvement related to NAV:<br>• Isolated data issues may have contributed to specific instances affecting Contractors' (serving the SMI-Designated population in CYE 2023) compliance with time/distance standards. **[Access]**<br>• Not all Contractors (serving the SMI-Designated population in CYE 2023) met the standards for Dentist, Pediatric in Santa Cruz County. **[Access]**<br><br>Recommendations:<br>• HSAG recommends that AHCCCS support the ACC-RBHA Program Contractors in continuing to monitor their processes for creating the PAT file and reviewing the PAT file for accuracy prior to submitting to AHCCCS.<br>• HSAG recommends that AHCCCS support each ACC-RBHA Program Contractor in continuing to monitor and maintain its existing provider network coverage as of CYE 2023 Q4, with specific attention to ensuring the availability of the following provider types among the applicable ACC-RBHA Program Contractors:<br>– Dentist, Pediatric in Santa Cruz County |

## *DCS CHP Program*

Table 1-9 presents program-level strengths, opportunities for improvement, and recommendations for the DCS CHP Program based on all EQR activities conducted. DCS CHP strengths, opportunities for

improvement, and recommendations by EQR activity are provided in Section 8. DCS CHP Program Results.

**Table 1-9—DCS CHP Program Strengths, Opportunities for Improvement, and Recommendations**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths related to PMV:<br>• DCS CHP met or exceeded the NCQA Quality Compass national Medicaid HMO mean and the 90th percentile for HEDIS MY 2022 for these measures:<br>– *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total, Cholesterol Testing—Total,* and *Blood Glucose and Cholesterol Testing—Total* **[Quality]**<br>– *Child and Adolescent Well-Care Visits—Total* **[Quality, Timeliness]**<br>– *Immunizations for Adolescents—Combination 1* and *Combination 2* **[Quality]**<br><br>HSAG identified the following strengths related to PIPs:<br>• DCS CHP was able to perform accurate statistical testing between the baseline and Remeasurement 1 for the *Back to Basics* PIP. **[Quality, Access]**<br>• DCS CHP implemented and developed measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 2. **[Quality, Access]**<br><br>HSAG identified the following strengths related to compliance reviews:<br>• DCS CHP's average compliance score was at or above 95 percent in the following compliance Focus Areas:<br>– Corporate Compliance (CC) **[Quality, Access]**<br>– Claims and Information Standards (CIS) **[Access]**<br>– Grievance Systems (GS) **[Timeliness, Access]**<br>– Reinsurance (RI) **[Quality]**<br>– Third-Party Liability (TPL) **[Quality, Timeliness, Access]**<br>– Integrated Systems of Care (ISOC) **[Quality, Access]**<br>• AHCCCS approved DCS CHP's proposed CAPs for all Focus Areas with scores less than 95 percent. DCS CHP will provide evidence of CAP completion in CYE 2024.<br><br>HSAG identified the following strengths related to NAV:<br>• DCS CHP met all time/distance network standards during both quarters in Cochise, Maricopa, Mohave, Navajo, Pinal, Santa Cruz, Yavapai, and Yuma counties. **[Access]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| • DCS CHP met the Behavioral Health Outpatient and Integrated Clinic, Pediatric; Cardiologist, Pediatric; Hospital; and OB/GYN standards. **[Access]**<br><br>HSAG identified the following opportunities for improvement related to CAHPS:<br>• DCS CHP's member experience rating for *How Well Doctors Communicate* met or exceeded the 90th percentile for the general child and CCC populations. **[Quality]**<br>• DCS CHP's member experience rating for *Rating of Personal Doctor* met or exceeded the 75th percentile for the general child population. **[Quality]** |
| **Opportunities for Improvement and Recommendations** |
| HSAG identified the following opportunities for improvement related to PMV:<br>• For CY 2022 performance measure reporting, race and ethnicity stratifications (RES) were required based on NCQA HEDIS specifications. While HSAG did not identify specific opportunities for DCS CHP to improve RES, DCS CHP could benefit from continuing to focus on refining RES reporting where required per measure specifications. **[Quality]**<br><br>Recommendation: HSAG recommends that DCS CHP explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratifications related to RES. DCS CHP should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information.<br><br>HSAG identified the following opportunities for improvement related to PIPs:<br>• For indicator 2, DCS CHP had a decline in the indicator rate between the baseline year and Remeasurement Year 1. **[Quality, Access]**<br><br>Recommendations: As the PIP progresses, HSAG recommends that DCS CHP:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that effect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.<br><br>HSAG identified the following opportunities for improvement related to compliance reviews:<br>• DCS CHP has remaining CAPs in the following Focus Areas:<br>– Delivery Systems (DS) **[Timeliness, Access]**<br>– General Administration (GA) **[Timeliness, Access]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|

- Adult, EPSDT and Maternal Child Health (MCH) **[Quality, Timeliness, Access]**
- Medical Management (MM) **[Timeliness, Access]**
- Member Information (MI) **[Quality]**
- Quality Management (QM) **[Quality]**
- Quality Improvement (QI) **[Quality, Access]**

Recommendation: HSAG recommends that DCS CHP continue to work on outstanding CAP items and submit to AHCCCS in the approved time frame.

HSAG identified the following opportunities for improvement related to NAV:

- DCS CHP did not meet standards for at least one quarter and/or county for the BHRF; Dentist, Pediatric; and Pharmacy standards. **[Access]**

Recommendation: DCS CHP should maintain current compliance with network standards but continue to address network gaps, as applicable.

HSAG identified the following opportunities for improvement related to the CAHPS results for the DCS CHP Program's member experience ratings:

- DCS CHP's member experience rating for *Rating of Health Plan*, *Rating of All Health Care*, and *Coordination of Care* were below the 25th percentiles for the general child and CCC populations. **[Quality]**
- DCS CHP's member experience rating for *Customer Service* was below the 25th percentile for the general child population. **[Quality]**
- DCS CHP's member experience rating for *Getting Needed Care*, *Access to Specialized Services*, *FCC: Personal Doctor Who Knows Child*, *Coordination of Care for Children with Chronic Conditions*, and *Access to Prescription Medicines* were below the 25th percentiles for the CCC population. **[Quality, Access]**
- DCS CHP's member experience rating for *Getting Needed Care* was between the 25th and 49th percentiles for the general child population. **[Quality, Access]**
- DCS CHP's member experience rating for *Rating of Personal Doctor* and *Getting Care Quickly* were between the 25th and 49th percentiles for the CCC population. **[Quality, Timeliness]**

Recommendation: HSAG recommends that DCS CHP explore what may be driving lower experience scores and develop initiatives designed to improve the quality of and access to care, including a focus on improving parents'/caretakers' overall experiences with the health plan, healthcare, personal doctor, access to care in a timely manner, access to prescription medicines, coordination of care, and customer service for child members.

## ALTCS-EPD Program

Table 1-10 presents program-level strengths, opportunities for improvement, and recommendations (as applicable) for the ALTCS-EPD Program based on all EQR activities conducted. For additional information about ALTCS-EPD Program-level results, see Section 9. ALTCS-EPD Program-Level Comparative Results.

**Table 1-10—ALTCS-EPD Program Strengths, Opportunities for Improvement, and Recommendations**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths related to PMV:<br>• All three ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 for these measures:<br>– *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure rates **[Quality]**<br>– *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total* measure rate **[Quality, Timeliness, Access]**<br>– *Controlling High Blood Pressure* measure rate **[Quality]**<br>– *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* and *HbA1c Poor Control (>9.0%)* measure rates **[Quality]**<br>• Two of the three ALTCS-EPD Program Contractors' rates as well as the ALTCS-EPD Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 for these measures:<br>– *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure rates **[Quality, Timeliness, Access]**<br>– *Plan All-Cause Readmissions—O/E Ratio—Total* measure rate **[Quality]**<br><br>HSAG identified the following strengths related to PIPs:<br>• HSAG noted that two of the three Contractors performed accurate statistical testing between the baseline and Remeasurement Year 1. **[Quality, Access]**<br>• ALTCS-EPD Program Contractors implemented and developed measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 2. **[Quality, Access]**<br><br>HSAG identified the following strengths related to compliance reviews:<br>• The ALTCS-EPD Program Contractors' average compliance score was at or above 95 percent in the following Focus Areas: |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| – Corporate Compliance (CC) **[Quality, Access]**<br>– Claims and Information Standards (CIS) **[Access]**<br>– General Administration (GA) **[Timeliness, Access]**<br>– Grievance Systems (GS) **[Timeliness, Access]**<br>– Member Information (MI) **[Quality]**<br>– Reinsurance (RI) **[Quality]**<br>– Third-Party Liability (TPL) **[Quality, Timeliness, Access]**<br><br>HSAG identified the following strengths related to NAV:<br>• The applicable ALTCS-EPD Program Contractors met all minimum time/distance network standards during both quarters in Apache, Cochise, Gila, Graham, Greenlee, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. **[Access]**<br>• The ALTCS-EPD Program Contractors consistently met the Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; BHRF; Cardiologist, Adult and Pediatric; Dentist, Pediatric; Hospital; OB/GYN; and PCP, Adult and Pediatric standards. **[Access]** |
| **Opportunities for Improvement and Recommendations** |
| HSAG identified the following opportunities for improvement related to PMV:<br>• All three ALTCS-EPD Program Contractors' rates and the ALTCS-EPD Program Aggregate rate failed to meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and fell below the 25th percentile for these measures:<br>– *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD—Total—Total* **[Quality, Timeliness, Access]**<br>– *Breast Cancer Screening* **[Quality]**<br>– *Child and Adolescent Well-Care Visits* **[Quality, Access]**<br>– *Use of Opioids at High Dosage* **[Quality]**<br><br>Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors conduct a root cause analysis or focus study and implement appropriate interventions to improve the performance. Of note, the ALTCS-EPD Contractors are currently conducting the *Breast Cancer Screening* PIP, which includes a root cause analysis and interventions to address the *Breast Cancer Screening* measure rate.<br><br>For CY 2022 performance measure reporting, race and ethnicity stratifications (RES) were required based on NCQA HEDIS specifications. While HSAG noted that two of the three ALTCS-EPD Contractors could benefit from improvement in performance measure reporting using RES, all ALTCS-EPD Contractors could benefit from continuing to focus on refining RES reporting where required per measure specifications. **[Quality]** |

**Strengths, Opportunities for Improvement, and Recommendations**

Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratifications related to RES. The ALTCS-EPD Program Contractors should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race and/ ethnicity data and explore other methods to augment enrollment data information.

Although HSAG did not identify any program-level opportunities for improvement, to support successful progression of the PIP in the next CY, HSAG recommends that the ALTCS-EPD Program Contractors:

- Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.
- Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.
- Develop interventions that effect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.

HSAG identified the following opportunities for improvement related to compliance reviews:

- The ALTCS-EPD Program Contractors' average score for compliance was below 95 percent in the following Focus Areas:
  - Case Management (CM) **[Quality, Access]**
  - Delivery Systems (DS) **[Timeliness, Access]**
  - Adult, EPSDT, and Maternal Child Health (MCH) **[Quality, Timeliness, Access]**
  - Medical Management (MM) **[Timeliness, Access]**
  - Quality Management (QM) **[Quality]**
  - Integrated Systems of Care (ISOC) **[Quality, Access]**

  Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors propose and implement CAPs related to the CM, DS, MCH, MM, QM, and ISOC Focus Area requirements.

HSAG identified the following opportunities for improvement related to NAV:

- Based on the semiannual NAV results, not all ALTCS-EPD Program Contractors met the Nursing Facility standard in Coconino County and Pharmacy standard in La Paz County. **[Access]**

  Recommendations:
  - HSAG recommends that AHCCCS support the ALTCS-EPD Program Contractors in continuing to monitor their processes for creating the PAT file and reviewing the PAT file for accuracy prior to submitting to AHCCCS.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| • HSAG recommends that AHCCCS support each ALTCS- EPD Program Contractor in continuing to monitor and maintain its existing provider network coverage as of CYE 2023 Q4, with specific attention to ensuring the availability of the following provider types among the applicable ALTCS-EPD Program Contractors:<br>– Nursing Facility in Coconino County<br>– Pharmacy in La Paz County |

## ALTCS-DD Program

Table 1-11 presents program-level strengths, opportunities for improvement, and recommendations for the ALTCS-DD Program based on all EQR activities conducted. ALTCS-DD strengths, opportunities for improvement, and recommendations by EQR activity are provided in Section 11. ALTCS-DD Program Results.

**Table 1-11—ALTCS-DD Program Strengths, Opportunities for Improvement, and Recommendations**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths related to PMV:<br>• DES/DDD's performance measure rates were at or above the 90th percentile for these measures:<br>– *Antidepressant Medication Management—Effective Acute Phase Treatment* **[Quality, Timeliness, Access]**<br>– *Antidepressant Medication Management—Effective Continuation Phase Treatment*, *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* **[Quality, Timeliness, Access]**<br>– *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 Percent)—Total (18–75 Years)* and *HbA1c Poor Control (>9.0 Percent)* [**Quality**]<br>– *Controlling High Blood Pressure* [**Quality**]<br><br>HSAG identified the following strengths related to the *Back to Basics* PIP:<br>• HSAG noted that DES/DDD performed accurate statistical testing between the baseline and Remeasurement 1 and that the indicator had a statistically significant improvement from the baseline year at Remeasurement 1. **[Quality, Access]**<br>• DES/DDD implemented and developed measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 2. **[Quality, Access]**<br><br>HSAG identified the following strengths related to compliance reviews: |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| • DES/DDD successfully closed CAPs in the following Focus Areas:<br>– Case Management (CM) **[Quality, Access]**<br>– Corporate Compliance (CC) **[Quality, Access]**<br>– Claims and Information Standards (CIS) **[Access]**<br>– Delivery Systems (DS) **[Timeliness, Access]**<br>– General Administration (GA) **[Timeliness, Access]**<br>– Adult, EPSDT, and Maternal Child Health (MCH) **[Quality, Timeliness, Access]**<br>– Medical Management (MM) **[Timeliness, Access]**<br>– Member Information (MI) **[Quality]**<br>– Quality Management (QM) **[Quality]**<br>– Quality Improvement (QI) **[Quality, Access]**<br><br>HSAG identified the following strengths related to NAV:<br>• The applicable DES/DDD Contractors consistently met the BHRF; OB/GYN; and PCP, Adult and Pediatric standards. **[Access]** |
| **Opportunities for Improvement and Recommendations** |
| HSAG identified the following opportunities for improvement related to PMV:<br>• DES/DDD performance measure rates fell below the 25th percentile for these measures:<br>– *Initiation and Engagement of Substance Use Disorder (SUD) Treatment Abuse or Dependence Engagement of SUD Treatment–Total* **[Quality, Timeliness, Access]**<br>– *Childhood Immunization Status—Combination 7* and *Combination 10* **[Quality]**<br>– *Cervical Cancer Screening* **[Quality]**<br><br>Recommendation: HSAG recommends that DES/DDD conduct a root cause analysis or focus study and implement appropriate interventions to improve the performance.<br><br>• For CY 2022 performance measure reporting, race and ethnicity stratifications (RES) were required based on NCQA HEDIS specifications. While HSAG did not identify specific opportunities for DES/DDD to improve RES, DES/DDD could benefit from continuing to focus on refining RES reporting where required per measure specifications. **[Quality]**<br><br>Recommendation: HSAG recommends that DES/DDD explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratifications related to RES. DES/DDD should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information. |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|

HSAG identified no opportunities for improvement related to the *Back to Basics* PIP:

Recommendations: Although there were no opportunities for improvement identified, HSAG recommends that as the PIP progresses, that DES/DDD:

- Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.
- Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.
- Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates.

HSAG did not identify opportunities for improvement related to compliance reviews, as DES/DDD successfully closed all CAPs in CYE 2023.

Recommendation: HSAG recommends that DES/DDD review all Focus Area requirements in preparation for its next full compliance review.

HSAG identified the following opportunities for improvement related to NAV:

- DES/DDD did not meet standards for at least one quarter and/or county for Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult; Dentist, Pediatric; Hospital; and Pharmacy standards in Apache, Greenlee, Gila, and La Paz counties. **[Access]**

Recommendations:

- HSAG recommends that AHCCCS support DES/DDD in continuing to monitor its processes for creating the PAT file and reviewing the PAT file for accuracy prior to submitting to AHCCCS.
- HSAG recommends that AHCCCS support DES/DDD in continuing to monitor and maintain existing provider network coverage as of CYE 2023 Q4, with specific attention to ensuring the availability of the following provider types:
  - Behavioral Health Outpatient and Integrated Clinic, Adult in Apache County
  - Cardiologist, Adult in Apache County
  - Dentist, Pediatric in Apache, Greenlee, Gila, and La Paz counties
  - Hospital in Apache and Greenlee counties
  - Pharmacy in Apache County
- DES/DDD should maintain current compliance with network standards but continue to address network gaps, as applicable.

# 2. Introduction to the EQR Technical Report

This section provides the purpose and overview of this annual EQR technical report; CMS' definitions for Quality and Access; the NCQA and AHRQ definitions for Timeliness; and an overview of how this EQR technical report is organized.

Table 2-1 through Table 2-5 describe the activities reviewed for the Contractors in each program.

## ACC Program

The **ACC Program** provides integrated care addressing the physical and behavioral health needs for the majority of Medicaid (Title XIX) eligible children and adults as well as addressing the physical and behavioral health needs for the majority of CHIP KidsCare (Title XXI) eligible children (under age 19 years). ACC and ACC-RBHA Contractors are responsible for providing services under the ACC Program.

Table 2-1 presents the EQR activities reviewed in this report for ACC Program Contractors. In addition to the activities listed in the table below, CAHPS survey results for the KidsCare and ACC (Non-SMI-Designated) populations are presented at the aggregate level in Section 4. ACC (Non-SMI-Designated Population) Program-Level Comparative Results.

**Table 2-1—EQR Activities Presented in the CYE 2023 External Quality Review Annual Technical Report for the ACC Program**

| Contractors Reviewed | PMV | PIP Validation | Compliance Reviews (Operational Reviews) | NAV |
|---|---|---|---|---|
| AzCH-CCP ACC-RBHA* | ✓ | ✓ | | ✓ |
| BUFC ACC | ✓ | ✓ | ✓ | ✓ |
| Care 1st ACC-RBHA* | ✓ | ✓ | | ✓ |
| HCA ACC | ✓ | ✓ | ✓ | ✓ |
| Mercy Care ACC-RBHA* | ✓ | ✓ | | ✓ |
| Molina ACC | ✓ | ✓ | ✓ | ✓ |
| UHCCP ACC | ✓ | ✓ | ✓ | ✓ |

* Contractor serves both the ACC and the ACC-RBHA SMI-Designated populations. Throughout this report, ACC Program discussions are limited to the ACC-RBHA Contractors' Non-SMI-Designated population. The ACC-RBHA contracts went into effect on 10/1/2022. AHCCCS conducted an extensive readiness review for these Contractors during CYE 2022. The ACC-RBHAs' compliance review will be conducted in CYE 2024 and will therefore be included in the CYE 2024 annual technical report.

For additional information and Contractor-specific findings for PMV (performance measure list beginning on page A-9), PIP validation, compliance reviews, and NAV, see Section 5. ACC Program Contractor-Specific Results.

## RBHA/ACC-RBHA SMI-Designated Population Program

The **RBHA Program** was active through September 30, 2022, and provided integrated physical and behavioral health services to eligible Medicaid (Title XIX) and CHIP KidsCare (Title XXI) covered members determined to have an SMI designation.

The **ACC-RBHA Program**, initiated October 1, 2022, provides integrated physical and behavioral health services to eligible Medicaid (Title XIX) and CHIP KidsCare (Title XXI) covered members determined to have an SMI designation. ACC-RBHA Contractors are also responsible for providing crisis services to all individuals, including but not limited to crisis telephone services, community-based mobile crisis teams, and facility-based crisis stabilization services. Additionally, ACC-RBHA Contractors are responsible for providing services to the ACC (Non-SMI-Designated) population.

Table 2-2 presents the EQR activities conducted for RBHA/ACC-RBHA Program Contractors (serving the SMI-Designated Population), which include performance measure and PIP validation activities that were conducted for the ACC-RBHA Contractors in CYE 2023 reflective of their CY 2022 performance as RBHA Contractors as well as NAV activity results conducted in CYE 2023 reflective of their performance as ACC-RBHA Contractors.

**Table 2-2—EQR Activities Presented in the CYE 2023 External Quality Review Annual Technical Report for the RBHA/ACC-RBHA SMI-Designated Population Program**

| Contractors Reviewed | PMV | PIP Validation | Compliance Reviews (Operational Reviews)*** | NAV |
|---|---|---|---|---|
| AzCH-CCP ACC-RBHA | ✓ | ✓ | | ✓ |
| Care 1st ACC-RBHA* | | | | ✓ |
| HCA RBHA** | ✓ | ✓ | ✓ | |
| Mercy Care ACC-RBHA | ✓ | ✓ | | ✓ |

*Effective October 1, 2022, AHCCCS contracted with Care 1st as an ACC-RBHA providing services to the SMI-Designated population; therefore, Care 1st ACC-RBHA PMV and PIP data were not collected and did not undergo validation specific to this population in CYE 2023.
**HCA's RBHA contract with AHCCCS ended September 30, 2022.
*** AHCCCS reviewed Compliance Review CAP close-out documents for HCA in CYE 2023.

The ACC-RBHA contracts went into effect on 10/1/2022. AHCCCS conducted an extensive readiness review for these Contractors during CYE 2022. The Compliance Review for the ACC-RBHAs will be conducted in CYE 2024 and will therefore be included in the CYE 2024 annual technical report.

For additional information and Contractor-specific findings for PMV and PIP validation, see Section 7. RBHA/ACC-RBHA SMI-Designated Population Program Contractor-Specific Results.

## DCS CHP Program

Table 2-3 presents the EQR activities reviewed in this report for the DCS CHP Program. In addition to the activities listed in the table below, CAHPS survey results for the DCS CHP population are presented at the aggregate level in Section 8. DCS CHP Program Results.

**Table 2-3—EQR Activities Presented in the CYE 2023 External Quality Review Annual Technical Report for the DCS CHP Program**

| Contractors Reviewed | PMV | PIP Validation | Compliance Reviews (Operational Reviews) | NAV |
|---|---|---|---|---|
| DCS CHP | ✓ | ✓ | ✓ | ✓ |

For additional information and Contractor-specific findings for PMV, PIP validation, compliance reviews, and NAV, see Section 8. DCS CHP Program Results.

## ALTCS-EPD Program

Table 2-4 presents the EQR activities reviewed in this report for ALTCS-EPD Program Contractors.

**Table 2-4—EQR Activities Presented in the CYE 2023 External Quality Review Annual Technical Report for the ALTCS-EPD Program**

| Contractors Reviewed | PMV | PIP Validation | Compliance Reviews (Operational Reviews) | NAV |
|---|---|---|---|---|
| BUFC LTC | ✓ | ✓ | ✓ | ✓ |
| Mercy Care LTC | ✓ | ✓ | ✓ | ✓ |
| UHCCP LTC | ✓ | ✓ | ✓ | ✓ |

For additional information and Contractor-specific findings for PMV, PIP validation, compliance reviews, and NAV, see Section 10. ALTCS-EPD Program Contractor-Specific Results.

## ALTCS-DD Program

Table 2-5 presents the EQR activities reviewed in this report for the ALTCS-DD Program.

**Table 2-5—EQR Activities Presented in the CYE 2023 External Quality Review Annual Technical Report for the ALTCS-DD Program**

| Contractors Reviewed | PMV | PIP Validation | Compliance Reviews (Operational Reviews) | NAV |
|---|---|---|---|---|
| DES/DDD | ✓ | ✓ | ✓ | ✓ |

For additional information and Contractor-specific findings for PMV, PIP validation, compliance reviews, and NAV, see Section 11. ALTCS-DD Program Results.

## Assessing Quality, Timeliness, and Access

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

### *Quality*

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

> Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or primary care case management (PCCM) entity (described in 438.310[c][2]) increases the likelihood of desired outcomes of its enrollees through:
>
> - Its structural and operational characteristics
> - The provision of services that are consistent with current professional, evidence-based knowledge
> - Interventions for performance improvement[2-1]

### *Timeliness*

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

> The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation.[2-2] NCQA further discusses the intent of this standard as being to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.
[2-2] National Committee for Quality Assurance. 2023 Standards and Guidelines for Accreditation of Health Plans.

managed care provisions that impact services to beneficiaries and that require timely response by the Contractor—e.g., processing expedited appeals and providing timely follow-up care.

AHRQ defines "Timeliness" as follows:

> Timeliness is the health care system's capacity to provide health care quickly after a need is recognized. Timeliness includes the interval between identifying a need for specific tests and treatments and receiving those services.[2-3]

### Access

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

> Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 42 CFR §438.68 (Network adequacy standards) and 42 CFR §438.206 (Availability of services).[2-4]

## Overview of the Report Sections

*Section 1—Executive Summary* describes the authority under which the report must be provided, as well as the Contractors reviewed during CY 2023. In addition, this section includes a program-level summary of strengths, opportunities for improvement, and recommendations for program-level performance improvement.

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

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

- Medicaid Managed Care Program History
- Waivers and Legislative Updates
- Strategic Plan
- Key Initiatives and Accomplishments

[2-3] Agency for Healthcare Research and Quality. *National Healthcare Quality and Disparities Reports.* Elements of Access to Health Care: Timeliness. Available at: https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/access/elements3.html. Accessed on: Feb 12, 2024.

[2-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

- Medicaid and CHIP Quality Strategy as well as HSAG's recommendations for targeting goals and objectives for quality improvement

*Section 4—ACC (Non-SMI-Designated Population) Program-Level Comparative Results* includes ACC program-level comparative results organized by EQR-related activity, strengths, opportunities for improvement, and recommendations for program-level performance improvement. This section also includes aggregate CAHPS survey results for the KidsCare and ACC (Non-SMI-Designated) populations.

*Section 5—ACC Program Contractor-Specific Results* provides, by ACC and ACC-RBHA Contractor, activity-specific strengths, opportunities for improvement, and HSAG's recommendations for performance improvement for the ACC (Non-SMI-Designated) population. This section also includes information about the extent to which each Contractor was able to address the prior year's recommendations for each activity. ACC and ACC-RBHA Contractors are responsible for the provision of services under the ACC Program.

*Section 6—RBHA/ACC-RBHA SMI-Designated Population Program-Level Comparative Results* includes RBHA and ACC-RBHA program-level comparative results for the SMI-Designated population, organized by EQR-related activity, which includes strengths, opportunities for improvement, and HSAG's recommendations for program-level performance improvement.

*Section 7—RBHA/ACC-RBHA SMI-Designated Population Program Contractor-Specific Results* provides, by RBHA and ACC-RBHA Contractor, activity-specific strengths, opportunities for improvement, and HSAG's recommendations for performance improvement. This section also includes information about the extent to which each Contractor was able to address the prior year's recommendations for each activity, as applicable.

*Section 8—DCS CHP Program Results* provides, by EQR activity, DCS CHP activity-specific strengths, opportunities for improvement, and HSAG's recommendations for performance improvement. This section also includes information about the extent to which DCS CHP was able to address the prior year's recommendations for each activity. This section also includes CAHPS survey results for the DCS CHP Program. DCS CHP provides services through a subcontracted health plan, Mercy Care DCS CHP.

*Section 9—ALTCS-EPD Program-Level Comparative Results* includes ALTCS- EPD comparative results organized by EQR-related activity, strengths, opportunities for improvement, and HSAG's recommendations (as applicable) for program-level performance improvement.

*Section 10—ALTCS-EPD Program Contractor-Specific Results* provides, by ALTCS-EPD Contractor, activity-specific strengths, opportunities for improvement, and HSAG's recommendations (as applicable) for performance improvement. This section also includes information about the extent to which each Contractor was able to address the prior year's recommendations.

*Section 11—ALTCS-DD Program Results* provides, by EQR activity, ALTCS-DD activity-specific strengths, opportunities for improvement, and HSAG's recommendations for performance improvement.

This section also includes information about the extent to which DES/DDD was able to address the prior's year recommendations.

*Appendix A. Methodology* presents, for each EQR activity:

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

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

*Appendix B—Acknowledgements and Copyrights*

# 3. Overview of AHCCCS

This section provides a description of AHCCCS':

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

## AHCCCS Medicaid Managed Care Program History

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

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

KidsCare Program. Children who qualify for KidsCare receive care through AHCCCS Contractors.[3-1] In October 2013, children enrolled in the Acute Care Program who had a Children's Rehabilitative Services (CRS) qualifying diagnosis were enrolled into one integrated CRS Contractor, UHCCP. This was done to decrease fragmentation and reduce member confusion; ensure optimal access to primary, specialty, and behavioral health care; enhance coordination of all service delivery; improve member outcomes and satisfaction; and streamline administration. At the same time, children with CRS qualifying conditions who were enrolled in the ALTCS Program, other than in DDD, were fully integrated into their ALTCS-EPD Contractors' provided services, including all primary, specialty, long-term, and behavioral healthcare related to the members' CRS conditions.

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

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

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

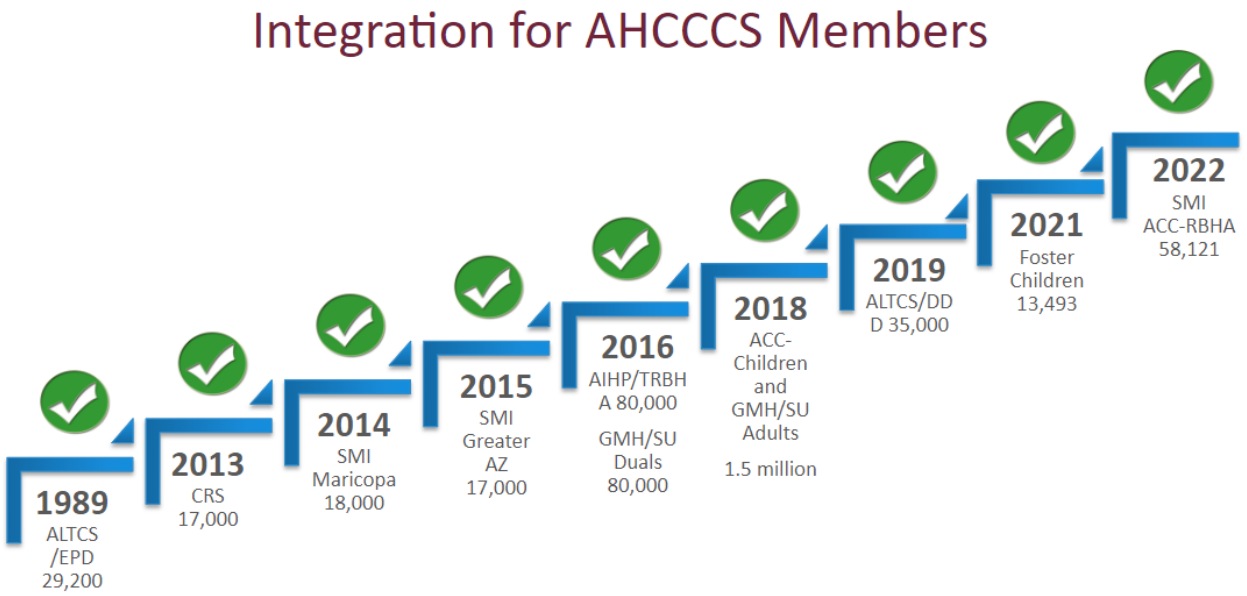
Effective October 1, 2018, AHCCCS implemented a delivery system reform that allows members who are not enrolled in an ALTCS-EPD Program to access physical as well as general mental health and substance use behavioral healthcare services, previously provided through a RBHA, through a single integrated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

[3-1] While most children who qualify for KidsCare receive care through AHCCCS Contractors, a small portion of children who qualify for KidsCare receive care through the FFS delivery system.

Members continue to have a choice of Contractors in their GSA and to have access to a network of providers and the same array of covered services.

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

Effective October 1, 2022, AHCCCS, through its competitive contract expansion (CCE), expanded the contracts for three ACC Contractors to include RBHA services, thus furthering integration efforts, under the AHCCCS Complete Care–Regional Behavioral Health Agreement (ACC-RBHA) Program. ACC-RBHAs continue to provide specific services to individuals with an SMI designation who are not in an ALTCS Program, as well as the first 24 hours of crisis services.[3-2]




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

[3-2] Effective October 1, 2022, the acronym 'RBHA' changed from Regional Behavioral Health Authority to Regional Behavioral Health Agreement. Services are provided by AHCCCS Complete Care Contractors with Regional Behavioral Health Agreements (ACC-RBHAs).

# AHCCCS Waivers and Legislative Updates

## *1115 Waiver Update*

On October 14, 2022, AHCCCS received approval for its five-year renewal of Arizona's Demonstration project under Section 1115 of the Social Security Act. This renewal is effective through September 30, 2027. The current Demonstration exempts Arizona from particular provisions of the Social Security Act and also includes expenditure authority permitting federal financial participation (FFP) for State expenditures that would not otherwise qualify for federal participation. Moreover, Demonstration projects, including Arizona's, must establish budget neutrality when Medicaid costs to the federal government are not expected to exceed the costs incurred in the absence of the Demonstration.

The current 1115 Waiver approval continues the long-standing authorities and programs that have made Arizona's Medicaid program innovative, effective, and efficient, including integrated managed care for AHCCCS populations through ACC; ALTCS; DCS CHP for children in foster care; and ACC-RBHAs for individuals with an SMI designation, payments to providers participating in the Targeted Investments 2.0 (TI 2.0) Program, and Waiver of Prior Quarter Coverage for specific populations.

More details on Arizona's Section 1115 Waiver renewal approval (2022–2027), along with the proposal, approval letter, Special Terms and Conditions (STCs), and supplemental documentation can be found on the AHCCCS Section 1115 Demonstration Waiver (2022–2027) webpage.[3-3]

In addition to renewing these historic programs, this 1115 Waiver includes approval for transformative projects intended to advance member health outcomes including:

- Authority to enhance and expand housing services and interventions for AHCCCS members who are homeless or at risk of becoming homeless through the Housing and Health Opportunities (H2O) program with a target implementation date of October 1, 2024
- Authority to direct Contractors to make specific incentive payments to providers that meet the criteria for receiving these payments with the goal of improving health equity for target populations by addressing health-related social needs (HRSN) through the Targeted Investments 2.0 (TI) Program
- Authority to reimburse IHS and Tribal 638 facilities to cover the cost of adult dental services that are eligible for 100 percent FFP, that are in excess of the $1,000 emergency dental limit for adult members in Arizona's State Plan, and that are in excess of the $1,000 dental limit for individuals ages 21 years or older enrolled in AHCCCS.

[3-3] Arizona Section 1115 Demonstration Waiver. Available at: https://www.azahcccs.gov/Resources/Federal/waiver.html. Accessed on: Jan 10, 2024.

In its approval notice, CMS recognized the State's interest in reimbursing for traditional healing services offered by tribal nations and will continue to work with Arizona on this request.

On March 30, 2023, the State submitted an 1115 Waiver Amendment Proposal in alignment with House Bill (HB) 2622 passed by Arizona's 55th Legislature. Subject to approval from CMS, AHCCCS will annually renew the eligibility of an individual who was in the custody of the Arizona Department of Child Safety (DCS) when the individual reached 18 years of age without requiring additional information from the individual until the individual reaches 26 years of age, unless the individual notifies AHCCCS that the individual moved out of Arizona or has provided information indicating that the individual may qualify for a different eligibility category. If approved, the amendment will run concurrently with AHCCCS' requested renewal period through September 30, 2027. The negotiations with CMS on this proposal are yet to begin, and the State is awaiting the approval of this authority.

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

- Strengthen the provider workforce and remove barriers to care for AHCCCS members
- Enhance Medicaid services and supports for vulnerable members for the duration of the emergency period
- Remove cost sharing and other administrative requirements to support continued access to services

Throughout the pandemic, CMS approved components of Arizona's requests under the 1135 Waiver, Appendix K, and State Plan, all of which were set to end along a time frame attached with the expiration of the Public Health Emergency declaration. AHCCCS's extension of the previously approved Emergency Preparedness and Response Attachment K authority is set to expire November 11, 2023, which includes the flexibility to allow parents of minor children and spouses to receive payment for direct care services. AHCCCS is seeking to make the Parents as Paid Caregivers program a more permanent flexibility of the State's 1115 Demonstration Waiver and submitted its proposal to CMS on September 27, 2023. On October 31, 2023, CMS issued a temporary extension letter for the Appendix K Parents as Paid Caregivers program which will extend the authority to March 29, 2024, allowing additional time for negotiations and implementation planning while also ensuring there is no lapse in program authority.

On June 6, 2023, CMS approved Arizona's application request for continuous coverage for individuals determined ineligible for CHIP due to a change in circumstances. This amendment will allow Arizona to align its policies for young adults in Medicaid and CHIP, and thereby prevent gaps in coverage during the PHE unwinding and redetermination period.

Information regarding the status of AHCCCS Emergency Authority Requests (for the federally declared COVID-19 PHE) is available on the AHCCCS COVID-19 Federal Emergency Authorities Request webpage.[3-4]

## New Waiver Program Implementation Updates

### Housing and Health Opportunities (H2O)

In accordance with STCs, AHCCCS has completed the following H2O-related deliverables and tasks:

- Submitted the Maintenance of Effort (MOE) which detailed how the State will determine baseline spending for the Housing and Health Opportunities (H2O) Program along with responses to CMS questions
- Submitted the Designated State Health Programs (DSHP) list along with responses to three rounds of CMS questions
- Submitted and updated the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for H2O services and replied to two rounds of CMS questions
- Submitted the New Initiatives Implementation Plan and HRSN Monitoring and Oversight deliverables
- Submitted the DSHP Claiming Protocol
- Held workgroup meetings with internal AHCCCS subject matter experts to continue to develop items related to the 1115 Waiver such as home and community based (HCBS) data collection and implementation of the program
- Collaborated internally about key H2O Program decisions such as items related to the Program Administrator and eligible chronic conditions

CMS has issued approval letters for the DSHP List and the Provider Payment Rate Attestation Table Deliverables.

AHCCCS has now held three rounds of stakeholder feedback sessions including 11 total presentations and a Tribal Consultation where input was received on various components of the program including but not limited to services, eligibility for target populations and prioritizations, provider qualifications, infrastructure, and more.

Due to the unprecedented nature of the H2O Program, CMS and AHCCCS have agreed to postpone the planned start date of the program to October 1, 2024, which will allow CMS adequate review time for previous and future deliverables along with an extended implementation period to ensure the success of the program.

[3-4] COVID-19 Federal Emergency Authorities Request. Available at: https://azahcccs.gov/Resources/Federal/PendingWaivers/1135.html. Accessed on: Jan 10, 2024.

### Targeted Investments (TI) 2.0

For the last five years, the TI Program has helped providers integrate physical and behavioral health care at the point of service, increasing members' access to a full array of services and demonstrating significant improvements in health outcomes. TI 2.0 will extend the program to additional providers and continue provider incentive funding to further integration efforts, including a range of initiatives aimed at addressing social drivers of health.

Between January 2023 and June 2023, the TI 2.0 program has:

- Previewed Year 6 end performance measure target attainment results
- Published TI 2.0 eligibility requirements and required documentation
- Designed and launched a pre-application document review process
- Drafted a tentative Quality Improvement Collaborative (QIC) structure and scheduled an in-person kickoff meeting
- Drafted a needs assessment and led focus groups to review annual requirements for all areas of concentration
- Continued revisions to draft documentation requirements that participants will need to submit to AHCCCS to meet annual requirements
- Collaborated with Contexture (Arizona Health Information Exchange [HIE]) and Arizona State University (ASU), Arizona Department of Health Services (ADHS), Arizona Department of Housing (ADOH), and other data sources to explore future demographic data enrichment strategies and electronic clinical quality measurement (eCQM) opportunities
- Began programming the TI 2.0 application portal
- Collaborated with NCQA, contracted health plans, their sub-contracted accountable care organizations, provider organizations, and other key stakeholders to operationalize simultaneous Health Equity accreditation for each layer of Arizona's healthcare system
- Collaborated with Contexture, State agencies, and counties to explore ways to complement programs with mutual initiatives, such as the closed-loop referral system (CommunityCares), housing support, Community Health Worker/Representative reimbursement, and Tobacco Cessation
- Facilitated open-registration TI 2.0 Information Sessions as well as individualized presentations to various networks, provider organizations, and justice partners to broadcast awareness of the TI 2.0 program and provide technical support with the application

### IHS/638 Tribal Dental Services

Effective October 14, 2022, the $1,000 emergency dental services limit for AI/AN members over 21 years of age, and the $1000 limit for AI/AN ALTCS members receiving services for medically necessary diagnostic, therapeutic, and preventive dental services at IHS/638 facilities were eliminated. This flexibility applies to medically necessary diagnostic, therapeutic, and preventive dental services for

beneficiaries who are AI/AN as long as the services are received at participating IHS facilities and/or Tribal 638 facilities.

The $1,000 limit on emergency services and the $1,000 dental limit for ALTCS beneficiaries ages 21 or older still applies when performed outside of the IHS/638 Tribal facilities.

### 1115 Waiver Evaluation Update

In accordance with the STCs of the 2016–2022 and 2022–2027 1115 Waiver Demonstrations, AHCCCS must submit a Waiver Evaluation Design and Interim and Summative Evaluation Reports. AHCCCS has contracted with HSAG to serve as the independent evaluator for both of Arizona's 1115 Waiver Demonstrations.

AHCCCS has also continued to work with HSAG on the Demonstration's 2016–2022 Summative Evaluation Report, in alignment with the approved Evaluation Design. The Summative Evaluation Report will include a longer implementation period with more robust analyses and promises to provide additional evidence to support a fuller understanding of the effects of each of the programs included in the Demonstration. This report is due for submission to CMS by April 14, 2024.

AHCCCS, in collaboration with HSAG, has developed and submitted the new 2022–2027 Draft Waiver Evaluation Design Plan for all historical programs within Arizona's 1115 Demonstration Waiver. Development of the Evaluation Design Plan for new programs, including TI 2.0 and H2O, is currently underway with an anticipated submission date of January 30, 2024. Arizona and HSAG plan to build on the foundation established during the previous waiver period to create a more robust Evaluation Design Plan with new metrics, data, and hypotheses, wherever possible.

## *Legislative Update*

The Arizona State Legislature passed a number of bills in the 2023 legislative session that will impact the agency, including:

- HB 2624 ("AHCCCS; redeterminations") requires AHCCCS to submit a monthly report on redeterminations during the Medicaid Unwinding period, and contains certain requirements related to redeterminations in alignment with AHCCCS' Unwinding plan submitted to CMS.
- HB 2432 ("supplemental appropriation; AHCCCS; adjustments") provides expenditure authority to AHCCCS for adjustments in formula requirements.
- HB 2826 ("health boards; AHCCCS; continuation") In Arizona, State agencies and boards are subject to statutory sunset provisions. HB 2826 continues the agency through June 30, 2029.
- SB 1720/SB 1726 (budget bills) contain appropriations for State agencies and programs. Specific to the AHCCCS Administration, the budget included the following items:
  - Continued funding for AHCCCS' Medicaid Enterprise System (MES) Modernization, to come into compliance with federal interoperability regulations.

- Provides state-only funding for qualifying Community Health Clinics in low-volume obstetric delivery areas and rural communities for "unreimbursed costs" to pay for on-call OB/GYN services.
- Provides time-limited funding to create a separate reimbursement program for rapid whole genome sequencing for certain members under 1 year of age within inpatient hospital/neonatal intensive care units, subject to CMS approval.
- Increases eligibility for KidsCare (CHIP) from 200% Federal Poverty Level (FPL) to 225% FPL, contingent upon approval by CMS.

The Arizona Legislature adjourned sine die on July 31, 2023. The General Effective Date (GED) is October 30, 2023. The next legislative session will begin in mid-January 2024.

## AHCCCS' Strategic Plan

AHCCCS' Strategic Plan for state fiscal year (SFY) 2024[3-5] presents the strategy and direction for AHCCCS, including new programs, initiatives, and past accomplishments. The Strategic Plan identifies AHCCCS' mission, vision, and core values:

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

The Strategic Plan offers three multi-year strategies:

1. Provide equitable access to high quality, whole-person care
   - Increase the amount of funding to direct care workers providing HCBS
   - Reduce health disparities
   - Obtain CMS approval of all H2O waiver implementation plan deliverables
   - Increase AHCCCS member connectivity to critical social services
   - Determine what will be needed to transform the FFS Program
2. Implement solutions that ensure optimal member and provider experience
   - Implement a system integrator environment that will connect multiple components of the AHCCCS MES
   - Increase transparency into delivery system performance

[3-5] AHCCCS Fiscal Year 2024 Strategic Plan 2-pager. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/Plans/2PageStrategicPlan.pdf. Accessed on: Jan 10, 2024.

3. Maintain core organizational capacity, infrastructure and workforce planning that effectively serves AHCCCS operations
   - Increase employee engagement
   - Reduce employee turnover
   - Reduce the occurrence of unauthorized software subscriptions

## Key Initiatives and Accomplishments for AHCCCS

AHCCCS' current initiatives are aimed at building a more cohesive and effective healthcare system in Arizona by reducing fragmentation, structuring provider reimbursements to incentivize quality outcomes, leveraging health information technology (HIT), and working with private sector partners to further innovation to the greatest extent. The AHCCCS webpage highlights ongoing and completed initiatives with links to more detailed information and is updated as more information becomes available. Following are highlights of AHCCCS' key initiatives and accomplishments in CYE 2023.[3-6]

### *Accessing Behavioral Health Services in Schools*

AHCCCS covers medically necessary behavioral health services for Medicaid-enrolled students. Many of these services are provided directly on school campuses, making it easier for students to get services where they are, and as soon as they need help.[3-7]

#### Jake's Law and the Children's Behavioral Health Services Fund

In 2020, the Arizona State Legislature allocated $8 million in school settings for students who are underinsured or uninsured. This special allocation of one-time State funding, known as the Children's Behavioral Health Services fund, or Jake's Law, allows schools to refer students for behavioral health services for anxiety, depression, social isolation, stress, behavioral issues, or any other mental health concern. Families will not receive a bill for these services; they are covered by tax dollars. Jake's Law requires that schools develop a policy to refer students for behavioral health services, and to allow families to opt in or out of the referral process each year. Behavioral health services under this funding are provided to students by participating healthcare providers contracted with AHCCCS through the three ACC-RBHAs, Mercy Care (in Central Arizona), AzCH-CCP (in Southern Arizona), and Care 1st (in Northern Arizona).[3-8]

[3-6] Arizona Health Care Cost Containment System. AHCCCS Initiatives and Best Practices (azahcccs.gov). Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/. Accessed on: Jan 10, 2024.
[3-7] Arizona Health Care Cost Containment System. Accessing Behavioral Health Services in Schools (azahcccs.gov). Available at: . Accessed on: Jan 10, 2024.
[3-8] Arizona State Legislature. 36-3436.01 - School-based behavioral health services; referrals; requirements; annual report (azleg.gov). Available at: https://www.azleg.gov/ars/36/03436-01.htm. Accessed on: Jan 10, 2024.

### Resource Guide

The Arizona Department of Education (ADE) and AHCCCS created the School and Behavioral Health Partnerships Resource Guide for principals, other education administrators, school mental health professionals and anyone who wishes to be a voice that promotes the need for school mental health resources in Arizona. Seven AHCCCS Contractors collaborated to provide a resource for each designated health plan's point of contact for Behavioral Health Services in Schools. [3-9]

## *American Rescue Plan Allocations*

AHCCCS is working to implement the recently passed federal law, American Rescue Plan (ARP) Act of 2021.[3-10] The ARP is an emergency legislative package to fund vaccinations; provide immediate, direct relief to families impacted by the COVID-19 PHE; and support struggling communities.

### Home and Community Based Services Enhanced Federal Match

The Home and Community Based Services Enhanced Federal Match[3-11] provision allows states to supplement existing funding. AHCCCS' ARP spending plan can be found on the AHCCCS website.[3-12]

Services eligible to claim the ARP 10 percent Federal Medical Assistance Percentage (FMAP) increase:

- Rehabilitative Services (including mental health and SUD services)
- Private Duty Nursing
- Alternative Benefit Plans
- Home Health Care
- Personal Care Services
- Self-Directed Personal Care Services
- Case Management
- School Based Services

[3-9] Arizona Health Care Cost Containment System. ACC Cobranded Behavioral Health School-based Services Flyer.pdf (azahcccs.gov). Available at: https://www.azahcccs.gov/AHCCCS/Downloads/Initiatives/BehavioralHealthServices/BHS_InSchoolsFlyer.pdf. Accessed on: Jan 10, 2024.

[3-10] Congress.gov. H.R.1319-American Rescue Plan Act of 2021. Available at: https://www.congress.gov/bill/117th-congress/house-bill/1319/text. Accessed on: Jan 10, 2024.

[3-11] Ibid.

[3-12] Arizona Health Care Cost Containment System. Spending Plan for Implementation of the American Rescue Plan Act of 2021, Section 9817: Revised Spending Plan: July 18, 2022. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/Initiatives/ARPA/AHCCCS_ARPA_HCBS_SpendingPlan_Revised.pdf . Accessed on: Jan 10, 2024.

The funding is short-term and must be spent by March 31, 2024 (three years). These efforts cannot negatively impact current HCBS; but can only add programs, services, and activities that are completed by March 2024 or have an additional plan for funding or sustainability beyond March 2024.

### SAMHSA Block Grants to Address Addiction, Mental Health Crisis

ARP also allocated $71 million of additional SAMHSA Mental Health Block Grant (MHBG) and Substance Abuse Block Grant funding to Arizona. SAMHSA encourages states to consider a focus on support of a behavioral health crisis continuum. Arizona's key planned programs address:[3-13]

- Children Designated with SED
- Adults Designated with SMI
- Crisis System Services
- First Episode Psychosis

### ARP Provider Payment Information

In its ARP Act HCBS spending plan, AHCCCS received federal approval to allocate almost $1.3 billion over three years in one-time provider payments to recruit and retain a knowledgeable and well-trained workforce. This amount is subject to change pending additional modifications made to the HCBS Spending Plan. These time-limited payments were made in SFYs 2022 and 2023, and additional payments are planned for 2024.

The SFY 2023 provider payments totaled more than $500 million and were paid by the AHCCCS Contractors and the FFS administration to providers serving members enrolled in all AHCCCS programs who were active providers in good standing at the time.

- The AHCCCS managed care provider payments, called "directed payments," are computed by applying a flat percentage rate to eligible providers' prior Title XIX Medicaid payments from a specified time period for select ARP qualifying codes.[3-14]

## *Arizona Olmstead Plan*

In CYE 2023, AHCCCS was working on the development of a new Arizona Olmstead Plan (the Plan) designed to enhance the service delivery system through integrated care and further ensure members live and receive services in the most appropriate integrated setting in their community. Development of the

[3-13] Arizona Health Care Cost Containment System. Spending Plan Proposal for the Implementation of the American Rescue Plan Act of 2021, Mental Health Block Grant (MHBG); July 30, 2021. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/Initiatives/ARPA/MHBG_ARPA_Plan.pdf. Accessed on: Jan 10, 2024.

[3-14] Arizona Health Care Cost Containment System. ARP Provider Payment Information 2023 (Updated 12/21/2023). Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/ARPA/providerPayment.html. Accessed on: Jan 10, 2024.

Plan included working with different external stakeholders, such as members/peers and advocates, as well as providing education to and soliciting input/feedback from the community through a survey, four community forums, and a public comment period. Olmstead is a 1999 United States Supreme Court decision that provided a legal framework for the efforts of federal and state governments to integrate persons with disabilities into the communities in which they live. The population targeted to benefit from the Plan consists of individuals who may be at risk of institutionalization, including individuals with behavioral health needs and members of the ALTCS program, collectively referred to as "members" throughout the Plan. Olmstead is intended to remove unnecessary segregation of members from the broader community and to ensure that members receive services in the most integrated setting appropriate to their needs. For additional information, see the AHCCCS website.[3-15]

## *Building an Integrated Health Care System and Improving Care Coordination*

Today's health care system is a series of parts not yet connected to each other. Improving care coordination and communication, while reducing fragmentation, can weave these parts together to create a health care system with more effective outcomes. AHCCCS continues to integrate the care delivery systems and align incentives that are designed to transform the structure of the Medicaid program, improve health outcomes, and better manage limited resources.[3-16]

### Improving Behavioral Health and Physical Health Care Coordination for Individuals with a Serious Mental Illness Designation

On October 1, 2022, AHCCCS updated its contracts with health plans for health insurance coverage for individuals with an SMI designation. The contracts expanded ACC Contractor responsibilities and designated these Contractors as ACC-RBHA Contractors. The contracts also include the provision of integrated care addressing physical health and behavioral health and the first 24 hours of crisis services for members with an SMI designation. AHCCCS will continue to work collaboratively with the ACC-RBHAs to evaluate methods to reduce program complexity, administrative burden, and unnecessary administrative and medical costs; and to improve care coordination and disease/chronic care management.[3-17]

### Medicare and Medicaid Alignment Makes a Difference

Medicare presents one of the greatest challenges to states serving individuals dually eligible for Medicaid and Medicare. Medicare is its own distinct, complex system of care operated by the federal

[3-15] Arizona Health Care Cost Containment System. Arizona Olmstead Plan. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/ArizonaOlmsteadPlan/ArizonaOlmsteadPlan-2023.pdf. Accessed on: Jan 10, 2024.

[3-16] Arizona Health Care Cost Containment System. Building an Integrated Health Care System and Improving Care Coordination. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/. Accessed on: Jan 10, 2024. (azahcccs.gov)

[3-17] Arizona Health Care Cost Containment System. Behavioral Health Contracts. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/behavioralhealth.html. Accessed on: Jan 10, 2024.

government with little to no interface with state Medicaid programs. For the over 180,000 Arizonans that are eligible for both Medicare and Medicaid, navigating these two separate systems of care can be overwhelming. Under these circumstances, it is more likely for people to be overlooked or forgotten, receive inefficient care, and not achieve optimal health outcomes.

AHCCCS continues developing integration initiatives to increase alignment and improve service delivery for individuals covered by both Medicare and Medicaid. This health system fragmentation often results in poor communication, uncoordinated health care decisions and a lack of a patient-centered perspective. AHCCCS has moved toward increasing the coordination of health service delivery between these two health programs by contracting with Medicare Advantage Dual Special Needs Plans (D-SNPs) that are each affiliated with its ACC Medicaid Contractors. Requiring each ACC Medicaid Contractor to offer a partner Medicare D-SNP promotes the enrollment or alignment of dual eligible members with the same Contractor for both Medicare and Medicaid services to the greatest possible extent. Enrolling in specialized Medicare plans allows dual eligible members to receive all of their health care services, including prescription drug benefits, from a single, integrated Contractor.[3-18]

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

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

On October 1, 2013, AHCCCS integrated all services for most children enrolled in the acute care program with CRS qualifying conditions through one CRS contractor with the goals of improved member outcomes and satisfaction, reduced member confusion, improved care coordination, and streamlined administration.

Beginning October 1, 2019, members enrolled with DES/DDD began to use their assigned DES/DDD subcontracted health plan for all of their CRS services. DES/DDD continues to provide long-term care services for these members. Members who qualify for a CRS designation and are not enrolled with DES/DDD have a choice of ACC Contractors in their service area for provision of CRS services.[3-19]

[3-18] Arizona Health Care Cost Containment System. Individuals Covered By Both Medicare and Medicaid (Dual Eligible Members). Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/duals.html. Accessed on: Jan 10, 2024.

[3-19] Arizona Health Care Cost Containment System. What is a Children's Rehabilitative Services (CRS) Designation? Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/CRS.html. Accessed on: Jan 10, 2024.

### Support for Individuals Involved in the Justice System

AHCCCS has developed collaborative partnerships with a growing number of Arizona's justice system stakeholders. Shared goals are to divert individuals from entering the justice system when appropriate and to provide efficient and cost effective health care resources in support of men, women, and children attempting to successfully transition out of the justice system.

A significant number of justice-involved individuals are in critical need of health care services and supports and may be eligible for assistance through AHCCCS. Available services may include help with physical health, behavioral health (e.g., mental health or substance use treatment), housing assistance, employment assistance, crisis services, and other supportive services.[3-20]

## *Electronic Visit Verification*

AHCCCS uses electronic visit verification (EVV) to help ensure, track, and monitor timely service delivery and access to care for members. In addition, EVV reduces provider administrative burden associated with scheduling and hard copy timesheet processing, as well as prevent, detect, and recover improper payments due to fraud, waste, and abuse.

Members and family members have the opportunity to choose which device is used to verify whether a service was received. Services subject to EVV include Attendant, Personal, and Companion Care; Homemaker; Home Health Services; Habilitation and Respite.[3-21]

## *AHCCCS Housing Programs*

AHCCCS provides several permanent supportive housing programs throughout Arizona alongside supportive health services to help members in need. Housing programs are provided to members with an SMI designation, and some services are provided for members with a General Mental Health/Substance Use Disorder (GMH/SUD). Providing supportive housing services not only helps members gain and maintain housing, it also helps lower utilization of emergency and crisis services. AHCCCS provides supportive housing services to approximately 3,000 members across the State.[3-22]

[3-20] Arizona Health Care Cost Containment System. Support for Individuals Involved in the Justice System. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/justiceinitiatives.html. Accessed on: Jan 10, 2024.
[3-21] Arizona Health Care Cost Containment System. Electronic Visit Verification. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/EVV/. Accessed on: Jan 10, 2024.
[3-22] Arizona Health Care Cost Containment System. AHCCCS Housing Programs. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/AHP/. Accessed on: Jan 10, 2024.

## AHCCCS Payment Modernization

Today's reimbursement structure is based on higher production numbers; i.e., performing more services results in higher pay without regard to outcomes for the patient. To bend the cost curve, there must be a paradigm shift such that reimbursement favors the provider who achieves a quality health outcome. That is why payment modernization is a critical policy strategy for moving to a financially sustainable and value-based healthcare delivery system.

AHCCCS is continuing its pursuit to implement long-term strategies that bend the cost curve while improving member health outcomes. The overall mission is to leverage the AHCCCS managed care model toward value-based healthcare systems where patients' experiences and population health are improved through aligned incentives with Contractors and provider partners, and when there is a commitment to continuous quality improvement and learning.[3-23]

## Transforming Health Care Delivery: Targeted Investments Program

TI 2.0 aligns with AHCCCS' strategic plan and Arizona's Section 1115 Waiver to support and incentivize providers to develop and enhance comprehensive whole-person care systems that effectively address the social risk factors that adversely affect health. Eligible Medicaid provider organizations that meet certain benchmarks will receive financial incentives through managed care plans for developing infrastructure and protocols to optimize coordination of services designed to meet the member's acute, behavioral, and HRSN and address identified health inequities among their patient population.[3-24]

## Telehealth Services

Telehealth is the use of digital technology, like computers, telephones, smartphones, and tablets, to access healthcare services remotely. AHCCCS members who cannot travel to an office can use these devices from their homes to attend healthcare appointments with their providers. Telehealth can make access to health care more convenient, saving time and transportation costs.

AHCCCS covers all major forms of telehealth services. Asynchronous (also called "store and forward") occurs when services are not delivered in real-time, but are uploaded by providers and retrieved, perhaps to an online portal. Telephonic services (audio-only) use a traditional telephone to conduct healthcare appointments. Telemedicine involves interactive audio and video, in a real-time, synchronous conversation. AHCCCS also covers telehealth for remote patient monitoring and teledentistry.[3-25]

[3-23] Arizona Health Care Cost Containment System. AHCCCS Payment Modernization. Available at: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/PaymentModernization/. Accessed on: Jan 10, 2024.
[3-24] Arizona Health Care Cost Containment System. Targeted Investments 2.0 Program Overview. Available at: https://www.azahcccs.gov/PlansProviders/TargetedInvestments/. Accessed on: Jan 10, 2024.
[3-25] Arizona Health Care Cost Containment System. Telehealth Services. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/Telehealth/. Accessed on: Jan 10, 2024.

## Using Technology to Improve Patient Care

AHCCCS envisions a whole-person integrated healthcare system in which HIT and HIE improve population health, enhance the patient experience, and lower costs. AHCCCS encourages all eligible laboratories, physical health and behavioral health providers, State/local government agencies, and Contractors to adopt HIT resources that securely store and share EHRs, streamline the delivery of healthcare services, and improve member health outcomes.[3-26]

## Whole Person Care Initiative

The AHCCCS Whole Person Care Initiative is focused on improving essential HRSN of enrolled members. HRSN, also known as social determinants of health (SDOH), have a direct impact on members' physical and mental health outcomes. HRSN include:

- Homelessness and Housing Instability
- Food Insecurity
- Need for Transportation Assistance
- Employment Instability
- Need for Utility Assistance
- Social Isolation and Social Support
- Interpersonal Safety
- Environmental Safety
- Justice or Legal Involvement
- Education and Childhood Development
- Access to Outdoor Spaces and Parks

Research shows that HRSN contribute to 80 percent of health outcomes, while only 20 percent of health outcomes are from direct healthcare services. Across the Medicaid delivery system, AHCCCS is working to improve members' access to resources that can address their HRSN, and therefore improve health equity in Arizona. For additional information about how AHCCCS is addressing HRSN, see the AHCCCS website.[3-27]

[3-26] Arizona Health Care Cost Containment System. Using Technology to Improve Patient Care. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/HIT/. Accessed on: Jan 10, 2024.
[3-27] Arizona Health Care Cost Containment System. AHCCCS Whole Person Care Initiative (WPCI). Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/AHCCCSWPCI/. Accessed on: Jan 10, 2024.

## Awards, Studies, and Highlights

The Direct Service Workforce (DSW) Learning Collaborative, created by CMS, facilitates the development, implementation, and expansion of innovative strategies for strengthening the DSW, and addresses specific challenges among state Medicaid agencies. Arizona was highlighted for its successful training and recruitment strategies.[3-28] Additional information on Arizona's participation and the following two highlights can be found on the CMS website.[3-29]

### Home Health Aide/Direct Care Worker Training Program

Arizona's Home Health Aide/Direct Care Worker Training Program was highlighted as a successful training strategy to address the direct care worker training need. This high school-based program qualifies graduates to work as direct care workers in Arizona's networks of long-term care service providers. [3-30]

## 2023 AHCCCS Year in Review

2023 was a year of extraordinary change for AHCCCS. The agency welcomed a new Cabinet Executive Officer and restructured to better focus on systems and operational enhancements. AHCCCS addressed an unprecedented fraudulent billing scheme that jeopardized member safety and, as the pandemic ended, AHCCCS returned to regular renewals and began the 12-month process to determine eligibility for all 2.5 million AHCCCS members.[3-31]

### Unwinding From the Pandemic and Return to Regular Renewals

- **Renewed eligibility for more than 1.2 million AHCCCS members,** maintained a monthly dashboard of renewal progress, and built an interactive ZIP Code map of areas most at risk of procedural disenrollment.
- Launched **AHCCCS Connect**, a text/email/phone communication tool that follows applicants through their Medicaid lifecycle and alerts them of decisions and responses needed.
- Deployed Arizona's **12-month strategic plan** to ensure a smooth return to a regular renewal process, aligning more than 2.5 million member households with SNAP benefit renewals when possible and initiating more than 1 million member contact touchpoints.

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[3-28] Arizona Health Care Cost Containment System. Awards, Studies, and Highlights. Available at: https://www.azahcccs.gov/AHCCCS/AboutUs/awardsandstudies.html. Accessed on: Jan 10, 2024.
[3-29] Medicaid.gov. Direct Service Workforce Learning Collaborative Summary Report. Available at: https://www.medicaid.gov/sites/default/files/2023-01/hcbs-learning-collaborative-summary.pdf. Accessed on: Jan 10, 2024.
[3-30] AHCCCS News & Updates (azahcccs.gov)
[3-31] Arizona Health Care Cost Containment System. 2023 Year in Review. Available at: 2023YearInReview.pdf (azahcccs.gov). Accessed on: Jan 24, 2024.

- To unwind pandemic flexibilities for providers, AHCCCS initiated **re-registration of more than 52,000 providers** in the AHCCCS Provider Enrollment Portal (APEP).
- **Launched SAM**, a chatbot found at www.healthearizonaplus.gov that can answer more than 80 renewal questions in English and Spanish, update a member's contact information, and transfer a chat to a live agent during business hours.

### Member and Provider Services

- Launched the **Arizona Perinatal Access Line** to provide real time perinatal psychiatric consultation to primary care practitioners serving pregnant and postpartum members.
- Launched the **Targeted Investments 2.0 program** to incentivize providers to develop and enhance comprehensive whole person care systems that address health-related social needs; partners at Arizona State University Targeted Investments Program Quality Improvement Collaborative (TIPQIC) received the ASU President's Social Embeddedness Award.
- Addressed **organized, fraudulent Medicaid behavioral health billing** with numerous operational and administrative system changes to strengthen program security; suspended more than 300 providers for credible allegations of fraud and launched a member assistance hotline that served more than 7,000 individuals.
- Designed and implemented the **Free and Reduced School Lunch data match** with the Arizona Department of Education to facilitate automatically enrolling students in free and reduced-price lunch plans without requiring an application.
- Created the Direct Service Workforce (DSW) Learning Collaborative and partnered with Arizona's community colleges, Association of Training & Development, Pipeline AZ, Arizona Board of Nursing, and Arizona Hospital and Healthcare Association to **launch workforce development programs** to address future healthcare worker needs.
- Provided free Early Childhood Service Intensity Instrument (**ECSII) training and access** for providers, case managers, and support staff to support healthy early childhood development.
- Provided **permanent supportive housing to more than 2,300 Arizonans** with Serious Mental Illness (SMI) and General Mental Health and/or Substance Use Disorder designations.
- Created a new **Olmstead Plan** outlining the agency's priorities regarding members at risk of institutionalization.
- Aligned the **Serious Emotional Disturbance (SED) determination** process for children with the SMI determination process for adults.
- Reformed the **Tribal Consultation process** to allow for greater input from tribal leaders and governments.
- Reformed **Peer Support Training Programs** to incorporate national standards.
- Successfully procured and implemented a **Third Party Liability (TPL) vendor**.
- Conducted multiple rate studies, **rebased rates** for Federally Qualified Health Centers, and established set FFS rates for specific services that historically had paid a percentage of the billed amount.

- Created the **AHCCCS Block Grant Manual** which provides a clear explanation of grants and their requirements.
- Office of Human Rights created a **monthly community stakeholder training series** on advocacy topics related to rights for individuals with a SMI designation.
- **Awarded $17 million** to more than 60 HCBS providers and opened a second round of grants to award another $47.5 million in 2024.
- Disseminated **$368.23 million of American Rescue Plan funding** through Contractors to 3,930 HCBS organizations.

### Waiver, Policy, and Covered Service Enhancements

- Extended coverage to women for up to **12 months postpartum** and added **Rapid Whole Genome Sequencing** for children as a covered service.
- Compiled the agency's **largest-ever stakeholder response** in support of 1115 Waiver submittal to pay parents for the services they provide to their minor children with disabilities, and to expand the upper income limit of KidsCare.
- Awarded **new contracts to two new health plans** to serve members enrolled in the ALTCS-EPD who are elderly or living with disabilities. Beginning October 1, 2024, for the first time in the ALTCS-EPD program, all enrolled members will have a choice of health plans.
- Completed the **Auditor General's Sunset Review** and received legislative authority to continue the agency.
- Allowed **Certified Community Health Workers and Community Health Representatives** to be reimbursed for AHCCCS covered services.

### Technology Enhancements

- Released the **strategic roadmap to modernize the Medicaid Enterprise System**; began implementation of a system integrator environment and of ServiceNow, an agency-wide helpdesk ticketing system.
- Updated the **Quality Management Special Assistance Portal** to ensure healthcare decision makers receive the information and resources they need.

### Administrative Improvements, Employee Development Retention, and Support

- Received the **Healthy Arizona Workplace designation** for the fifth consecutive year.
- Offered numerous **employee development training programs** in conflict of interest training, compassion fatigue, Diversity, Inclusion & Belonging, three-tiered coaching approaches, and virtual leadership.
- Developed and published a **Provider Enrollment manual** to provide consistent support and guidance to staff making provider enrollment determinations.

- **Restructured Office of the General Counsel Legal Services** to align with the AHCCCS: Growing Together reorganization.
- Improved an agency process to determine **Good Cause exceptions** to Credible Allegation of Fraud (CAF) payment suspensions.
- Issued approximately five times the number of **final agency action decisions** over the previous year.

## AHCCCS' Medicaid and CHIP Quality Strategy

In accordance with 42 CFR §438.340 and 42 CFR §457.1240(e), AHCCCS created the AHCCCS Quality Strategy and Quality Strategy Evaluation. The Quality Strategy provides a framework for improving and/or maintaining members' health status as well as fostering the increased resilience and functional health status of members with chronic conditions.

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

The AHCCCS Quality Strategy Evaluation is a companion document to the AHCCCS Quality Strategy that is used to evaluate the effectiveness of the AHCCCS Quality Strategy. AHCCCS' enhanced Quality Strategy and Quality Strategy Evaluation were submitted to CMS in July 2021 and posted to AHCCCS' website. AHCCCS began conducting its Quality Strategy Evaluation in 2023 in preparation for revising the Quality Strategy and submitting the documents to CMS by July 2024.

### *Quality Strategy Goals and Objectives*

The AHCCCS Quality Strategy identifies goals and objectives for improving health outcomes of Arizona's Medicaid and CHIP members and maintaining and improving the managed care delivery system. The goals and supporting objectives take into consideration all populations served by AHCCCS.

AHCCCS' Quality Strategy identifies the following four goals and associated objectives:

**Table 3-1—Quality Strategy Goals and Objectives**

| Goals | Objectives |
|---|---|
| **Goal 1:** Improve the member's experience of care, including quality and satisfaction | Enrich the member experience through an integrated approach to service delivery |
| | Improve information retrieval and reporting capability by establishing new, and upgrading existing, |

| Goals | Objectives |
|---|---|
| | information technologies, thereby increasing responsiveness and productivity |
| | Enhance current performance measures, PIPs, and best practice activities by creating a comprehensive quality of care assessment and improvement plan across AHCCCS programs |
| | Drive the improvement of member-centered outcomes using nationally recognized protocols, standards of care, and benchmarks, as well as the practice of collaborating with MCOs to reward providers based on clinical best practices and outcomes (as funding allows) |
| **Goal 2:** Improve the health of AHCCCS populations | Increase member access to integrated care that meets the member's individual needs within their local community |
| | Support innovative reimbursement models, such as Alternative Payment Models (APMs), while promoting increased quality of care and services |
| | Build upon prevention and health maintenance efforts through targeted medical management:<br>• Emphasizing disease and chronic care management<br>• Improving functionality in activities of daily living<br>• Planning patient care for special needs populations<br>• Identifying and sharing best practices<br>• Expanding provider development of Centers of Excellence (COEs) |
| **Goal 3:** Reduce the growth in healthcare costs and lower costs per person | Increase analytical capacity to make more informed clinical and policy-making decisions |
| | Develop collaborative strategies and initiatives with state agencies and other external partners, such as:<br>• Strategic partnerships to improve access to healthcare services and affordable healthcare coverage<br>• Partnerships with sister government agencies, Contractors, and providers to educate Arizonans on health issues<br>• Effective medical management for at-risk and vulnerable populations |

| Goals | Objectives |
|---|---|
| | • Capacity building in rural and underserved areas to address both professional and paraprofessional shortages |
| **Goal 4:** Enhance data system and performance measure reporting capabilities | Evaluate current data system infrastructure |
| | Identify system and process limitations impacting performance measure reporting and analysis |
| | Leverage various data sources to produce comprehensive reliable data:<br>• Collaborate with external stakeholders to facilitate access to supplemental data sources<br>• Explore means for collecting and reporting performance measure data utilizing EHR methodologies |
| | Drive continuous delivery system performance through advanced data analytics and disparity analyses |

## Recommendations

- HSAG recommends that AHCCCS engage with its Contractors to target lower-scoring behavioral health-related measures. Based on performance measure rate comparisons to national benchmarks, all programs could benefit from quality improvement activities to target *Use of Opioids at High Dosage.* Additionally, the ACC and ACC-RBHA programs could benefit from quality improvement activities to target *Antidepressant Medication Management*.
- As the ACC-RBHA Contractors are responsible for providing services to the SMI-Designated population, HSAG recommends that AHCCCS consider requiring ACC-RBHA Contractors to conduct a behavioral health-specific PIP or other quality improvement initiative that targets specific behavioral health performance measures for the SMI-Designated population. Potential topics may include appropriate utilization of services (e.g., ED visits) and psychotropic medication adherence.
- Network adequacy activities revealed gaps in access to pediatric dentists. HSAG recommends that AHCCCS engage with its Contractors to brainstorm ideas for increasing recruitment and contracting with pediatric dentists.

# 4. ACC (Non-SMI-Designated Population) Program-Level Comparative Results

The ACC Program provides integrated care addressing the physical and behavioral health needs for the majority of Medicaid (Title XIX) eligible children and adults as well as addressing the physical and behavioral health needs for the majority of CHIP KidsCare (Title XXI) eligible children (under age 19).

This section includes ACC program-level comparative results organized by EQR-related activity, strengths, opportunities for improvement, and recommendations for program-level performance improvement. This section also includes aggregate CAHPS survey results for the KidsCare and ACC (Non-SMI-Designated) populations.

## Validation of Performance Measures

### *Results for Information Systems Standards Review*

During CYE 2023, HSAG evaluated each ACC Program Contractor's data system for processing of each data type used for reporting the Contractor's CY 2022 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements.[4-1] A summary of these findings by ACC Program Contractor is provided in Table 4-1. Table 4-1 also displays whether or not each ACC Program Contractor met the assessed Information Systems (IS) standards, which demonstrates whether or not the Contractor has effective IS practices and control procedures for data reporting. Additional information about each ACC Program Contractor's general findings for each data type reviewed can be found in Section 5. ACC Program Contractor-Specific Results. Additional information regarding the CMS EQR Protocol 2 audit requirements, including more information about the levels of scoring, can be found in the Validation of Performance Measures section of Appendix A. Methodology.

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

| Data Type | AzCH–CCP ACC-RBHA | BUFC ACC | Care 1st ACC-RBHA | HCA ACC | Mercy Care ACC-RBHA | Molina ACC | UHCCP ACC |
|---|---|---|---|---|---|---|---|
| **Medical Services Data** | *Met* | *Met* | *Met* | *Met* | *Met* | *Met* | *Met* |
| **Enrollment Data** | *Met* | *Met* | *Met* | *Met* | *Met* | *Met* | *Met* |
| **Provider Data** | *Met* | *Met* | *Met* | *Met* | *Met* | *Met* | *Met* |

[4-1] The Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: January 26, 2024.

| Data Type | AzCH–CCP ACC-RBHA | BUFC ACC | Care 1st ACC-RBHA | HCA ACC | Mercy Care ACC-RBHA | Molina ACC | UHCCP ACC |
|---|---|---|---|---|---|---|---|
| **Medical Record Review Processes** | *Met* | *Met* | *Met* | *Met* | *Met* | *Met* | *Met* |
| **Supplemental Data** | *Met* | *Met* | *Met* | *Met* | *Met* | *Met* | *Met* |
| **Data Preproduction Processing** | *Met* | *Met* | *Met* | *Met* | *Met* | *Met* | *Met* |
| **Data Integration and Reporting** | *Met* | *Met* | *Met* | *Met* | *Met* | *Met* | *Met* |

## ACC Program-Level Results

### Performance Measure Results

Table 4-2 presents the CY 2022 performance measure rates for each ACC Program Contractor and the ACC Program Aggregate for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. Performance measure rate cells shaded green indicate that the Contractor met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the national Medicaid mean are shaded green. Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

**Table 4-2—CY 2022 Performance Measure Results for ACC Program Contractors**

| Measure | AzCH–CCP ACC-RBHA | BUFC ACC | Care 1st ACC-RBHA | HCA ACC | Mercy Care ACC-RBHA | Molina ACC | UHCCP ACC | Aggregate |
|---|---|---|---|---|---|---|---|---|
| ***Maternal and Perinatal Care*** | | | | | | | | |
| ***Prenatal and Postpartum Care*** | | | | | | | | |
| *Timeliness of Prenatal Care*[#] | 82.7%+ | 81.5%+ | 75.4%+ | 86.8%+ | 84.9%+ | 83.7%+ | 82.5%+ | 83.2%+ |
| *Postpartum Care* | 66.4%+ | 69.8%+ | 68.4%+ | 65.3%+ | 78.1%+ | 64.2%+ | 67.6%+ | 69.8%+ |
| ***Behavioral Health*** | | | | | | | | |
| ***Antidepressant Medication Management*** | | | | | | | | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | 60.5% | 58.9% | 60.5% | 60.2% | 53.8% | 63.7% | 61.0% | 59.0% |
| *Effective Continuation Phase* | 41.4% | 40.6% | 42.3% | 43.1% | 35.2% | 48.1% | 42.0% | 40.5% |

| Measure | AzCH–CCP ACC-RBHA | BUFC ACC | Care 1st ACC-RBHA | HCA ACC | Mercy Care ACC-RBHA | Molina ACC | UHCCP ACC | Aggregate |
|---|---|---|---|---|---|---|---|---|
| *Treatment—Total (18+ Years)* | | | | | | | | |
| ***Follow-Up After ED Visit for Substance Use*** | | | | | | | | |
| *7-Day Follow-Up—Total* | 30.6% | 26.5% | 31.8% | 32.7% | 33.1% | 30.8% | 32.5% | 31.2% |
| *30-Day Follow-Up—Total* | 39.7% | 35.4% | 44.2% | 42.9% | 42.9% | 40.5% | 41.9% | 40.9% |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 44.5% | 35.6% | 54.7% | 54.4% | 48.2% | 34.3% | 48.0% | 46.5% |
| *30-Day Follow-Up—Total (6+ Years)* | 61.3% | 50.7% | 69.8% | 71.7% | 65.5% | 54.2% | 64.5% | 63.2% |
| ***Follow-Up After ED Visit for Mental Illness*** | | | | | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 50.8% | 40.3% | 41.9% | 43.6% | 52.1% | 46.3% | 45.4% | 46.4% |
| *30-Day Follow-Up—Total (6+ Years)* | 60.0% | 50.2% | 54.8% | 52.0% | 63.0% | 56.3% | 56.9% | 56.6% |
| ***Use of Opioids at High Dosage*** | | | | | | | | |
| *18+ Years** | 6.8% | 11.6% | 3.6% | 4.4% | 9.1% | 1.6% | 11.0% | 8.7% |
| ***Initiation and Engagement of Substance Use Disorder (SUD) Treatment*** | | | | | | | | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | 52.3% | 51.0% | 41.8% | 48.3% | 54.5% | 56.6% | 53.3% | 51.8% |
| *Engagement of SUD Treatment—Total—Total (13+ Years)* | 21.2% | 19.8% | 13.4% | 18.3% | 20.7% | 21.8% | 20.6% | 19.9% |
| ***Adherence to Antipsychotic Medications for Individuals with Schizophrenia*** | | | | | | | | |
| *18+ Years* | 43.5% | 55.2% | 40.7% | 51.6% | 57.7% | 31.3% | 47.3% | 50.5% |
| ***Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*** | | | | | | | | |
| *18–64 Years* | 78.2% | 79.4% | 78.5% | 77.2% | 81.1% | 75.3% | 77.4% | 78.7% |
| ***Care of Acute and Chronic Conditions*** | | | | | | | | |
| ***Controlling High Blood Pressure*** | | | | | | | | |
| *18–85 Years* | 50.6%+ | 60.1%+ | 43.1%+ | 62.0%+ | 59.9%+ | 39.7%+ | 65.2%+ | 58.7%+ |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | | | | | | | | |
| *HbA1c Control (<8.0 %)—Total (18–75 Years)* | 51.6%+ | 63.0%+ | 38.0%+ | 50.1%+ | 58.4%+ | 44.3%+ | 54.5%+ | 55.0%+ |

| Measure | AzCH–CCP ACC-RBHA | BUFC ACC | Care 1st ACC-RBHA | HCA ACC | Mercy Care ACC-RBHA | Molina ACC | UHCCP ACC | Aggregate |
|---|---|---|---|---|---|---|---|---|
| *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)** | 36.3%+ | 37.0%+ | 55.2%+ | 38.9%+ | 34.8%+ | 49.1%+ | 33.3%+ | 36.5%+ |
| ***Pediatric Health*** | | | | | | | | |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotics*** | | | | | | | | |
| *Blood Glucose Testing—Total (1–17 Years)* | 62.5% | 62.1% | 58.5% | 57.9% | 65.1% | 53.8% | 59.1% | 61.3% |
| *Cholesterol Testing—Total (1–17 Years)* | 54.7% | 49.4% | 36.1% | 40.5% | 53.8% | 43.2% | 50.6% | 49.7% |
| *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* | 52.7% | 48.4% | 35.1% | 38.9% | 52.9% | 40.9% | 48.2% | 48.1% |
| ***Childhood Immunization Status*** | | | | | | | | |
| *Combination 3* | 64.0%+ | 61.8%+ | 47.2%+ | 52.8%+ | 56.9%+ | 61.1%+ | 62.0%+ | 59.5%+ |
| *Combination 7* | 56.2%+ | 56.7%+ | 42.3%+ | 46.5%+ | 52.8%+ | 55.2%+ | 55.0%+ | 53.5%+ |
| *Combination 10* | 28.5%+ | 30.9%+ | 20.7%+ | 20.2%+ | 23.1%+ | 26.3%+ | 28.2%+ | 26.2%+ |
| ***Developmental Screening in the First Three Years of Life*** | | | | | | | | |
| *Total (0–3 Years)* [N] | 45.3%+ | 41.6%+ | 17.0%+ | 41.1%+ | 51.8%+ | 48.4%+ | 48.9%+ | 45.8%+ |
| ***Immunizations for Adolescents*** | | | | | | | | |
| *Combination 1 (Meningococcal, Tdap)* | 84.9%+ | 88.1%+ | 74.2%+ | 82.7%+ | 89.1%+ | 78.6%+ | 87.8%+ | 86.4%+ |
| *Combination 2 (Meningococcal, Tdap, HPV)* | 46.0%+ | 42.3%+ | 32.6%+ | 31.9%+ | 40.1%+ | 31.4%+ | 41.4%+ | 40.2%+ |
| ***Oral Evaluation, Dental Services*** | | | | | | | | |
| *Total (0–20 Years)* [N] | 46.2% | 35.3% | 45.1% | 46.6% | 52.2% | 6.4% | 48.2% | 45.7% |
| ***Well-Child Visits in the First 30 Months of Life*** | | | | | | | | |
| *Six or More Well-Child Visits* | 60.7% | 58.1% | 53.5% | 56.1% | 65.1% | 56.0% | 61.8% | 60.8% |
| *15 Months–30 Months—Two or More Well-Child Visits* | 58.1% | 55.6% | 53.5% | 54.7% | 63.1% | 54.6% | 63.6% | 59.6% |
| ***Child and Adolescent Well-Care Visits*** | | | | | | | | |
| *Total (3–21 Years)* | 46.4% | 39.6% | 33.7% | 39.8% | 49.6% | 39.6% | 47.4% | 45.0% |

| Measure | AzCH–CCP ACC-RBHA | BUFC ACC | Care 1st ACC-RBHA | HCA ACC | Mercy Care ACC-RBHA | Molina ACC | UHCCP ACC | Aggregate |
|---|---|---|---|---|---|---|---|---|
| ***Preventive Screening*** | | | | | | | | |
| ***Breast Cancer Screening*** | | | | | | | | |
| *Total (50–74 Years)* | 53.9% | 51.0% | 32.3% | 40.9% | 54.3% | 47.3% | 55.8% | 50.9% |
| ***Cervical Cancer Screening*** | | | | | | | | |
| *21–64 Years* | 53.3%+ | 44.8%+ | 39.2%+ | 47.4%+ | 60.1%+ | 37.7%+ | 58.9%+ | 53.1%+ |
| ***Appropriate Utilization of Services*** | | | | | | | | |
| ***Ambulatory Care*** | | | | | | | | |
| *Emergency Department (ED) Visits—Total (0–85+ Years)* F | 482.7 | 445.8 | 448.1 | 514.8 | 519.6 | 544.2 | 478.8 | 487.8 |
| ***Plan All-Cause Readmissions*** | | | | | | | | |
| *Observed Readmissions—Total (18–64 Years)* | 12.4% | 9.4% | 9.3% | 8.8% | 9.7% | 11.7% | 8.7% | 9.8% |
| *Expected Readmissions—Total (18–64 Years)* | 11.0% | 8.8% | 9.6% | 9.4% | 9.6% | 9.3% | 9.5% | 9.7% |
| *Outlier Rate—Total (18-64 Years)* | 55.1 | 44.3 | 85.3 | 45.0 | 59.6 | 72.1 | 56.0 | 55.0 |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)** | 1.1185 | 1.0705 | 0.9694 | 0.9296 | 1.0103 | 1.2529 | 0.9117 | 1.0138 |

* A lower rate indicates better performance for this measure.
+ Indicates the measure was reported using hybrid methodology.
# Caution should be considered when comparing CY 2021 to CY 2022 results as changes to the measure specifications occurred.
N Measure has no NCQA Medicaid mean for comparison.
F NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. This measure is not compared to national benchmarks as NCQA does not view higher or lower service counts as indicating better or worse performance.
Cells shaded green indicate that the rate met or exceeded the MY 2022 national Medicaid mean.

Table 4-3 presents the CY 2021 and CY 2022 ACC Program Aggregate results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and MY 2022. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and/or MY 2022. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

**Table 4-3—CY 2021 and CY 2022 Performance Measure Aggregate Results for ACC Program Contractors**

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021-2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| ***Maternal and Perinatal Care*** | | | | |
| ***Prenatal and Postpartum Care*** | | | | |
| *Timeliness of Prenatal Care*[#+] | 79.4% | 83.2% | ↑ | ★★ |
| *Postpartum Care*[+] | 65.2% | 69.8% | ↑ | ★ |
| ***Behavioral Health*** | | | | |
| ***Antidepressant Medication Management*** | | | | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | 59.1% | 59.0% | → | ★★ |
| *Effective Continuation Phase Treatment—Total (18+ Years)* | 41.4% | 40.5% | ↓ | ★★ |
| ***Follow-Up After ED Visit for Substance Use*** | | | | |
| *7-Day Follow-Up—Total* | — | 31.2% | — | ★★★★ |
| *30-Day Follow-Up—Total* | — | 40.9% | — | ★★★ |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 42.5% | 46.5% | ↑ | ★★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 58.8% | 63.2% | ↑ | ★★★ |
| ***Follow-Up After ED Visit for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 45.4% | 46.4% | → | ★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 55.7% | 56.6% | → | ★★★ |
| ***Use of Opioids at High Dosage*** | | | | |
| *18+ Years** | 8.6% | 8.7% | → | ★ |
| ***Initiation and Engagement of Substance Use Disorder (SUD) Treatment*** | | | | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | — | 51.8% | — | ★★★★ |
| *Engagement of SUD Treatment—Total—Total (13+ Years)* | — | 19.9% | — | ★★★★ |
| ***Adherence to Antipsychotic Medications for Individuals with Schizophrenia*** | | | | |
| *18+ Years* | — | 50.5% | — | ★ |
| ***Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication*** | | | | |
| *18–64 Years* | — | 78.7% | — | ★★ |
| ***Care of Acute and Chronic Conditions*** | | | | |
| ***Controlling High Blood Pressure*** | | | | |
| *18–85 Years*[+] | 52.5% | 58.7% | ↑ | ★★ |

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021-2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| ***Hemoglobin A1c Control for Patients With Diabetes*** | | | | |
| *HbA1c Control (<8.0 Percent)—Total (18–75 Years)* [+] | — | 55.0% | — | ★★★ |
| *HbA1c Poor Control (>9.0 Percent)—Total (18–75 Years)** [+] | 42.1% | 36.5% | ↑ | ★★★ |
| ***Pediatric Health*** | | | | |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotics*** | | | | |
| *Blood Glucose Testing—Total (1–17 Years)* | 59.2% | 61.3% | ↑ | ★★★★ |
| *Cholesterol Testing—Total (1–17 Years)* | 46.1% | 49.7% | ↑ | ★★★★ |
| *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* | 44.8% | 48.1% | ↑ | ★★★★ |
| ***Childhood Immunization Status**** | | | | |
| *Combination 3* [+] | 61.2% | 59.5% | → | ★★ |
| *Combination 7* [+] | 55.1% | 53.5% | → | ★★ |
| *Combination 10* [+] | 32.6% | 26.2% | ↓ | ★★ |
| ***Developmental Screening in the First Three Years of Life*** | | | | |
| *Total (0–3 Years)* [+ N] | 39.5% | 45.8% | ↑ | — |
| ***Immunizations for Adolescents*** | | | | |
| *Combination 1 (Meningococcal, Tdap)* [+] | 84.7% | 86.4% | → | ★★★★ |
| *Combination 2 (Meningococcal, Tdap, HPV)* [+] | 39.4% | 40.2% | ↑ | ★★★ |
| ***Oral Evaluation, Dental Services*** | | | | |
| *Total (0–20 Years)* [N] | — | 45.7% | — | — |
| ***Well-Child Visits in the First 30 Months of Life*** | | | | |
| *Six or More Well-Child Visits* | 59.8% | 60.8% | ↑ | ★★★ |
| *15 Months–30 Months—Two or More Well-Child Visits* | 62.5% | 59.6% | ↓ | ★ |
| ***Child and Adolescent Well-Care Visits*** | | | | |
| *Total (3–21 Years)* | 44.9% | 45.0% | → | ★★ |
| ***Preventive Screening*** | | | | |
| ***Breast Cancer Screening*** | | | | |
| *Total (50–74 Years)* | 49.4% | 50.9% | ↑ | ★★ |
| ***Cervical Cancer Screening*** | | | | |
| *Total (21–64 Years)* [+] | 52.4% | 53.1% | ↑ | ★★ |
| ***Appropriate Utilization of Services*** | | | | |
| ***Ambulatory Care*** | | | | |
| *Emergency Department (ED) Visits—Total (0–85+ Years)* [F] | 471.2 | 487.8 | — | — |

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021-2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| ***Plan All-Cause Readmissions*** | | | | |
| *Observed Readmissions—Total (18–64 Years)* | 9.4% | 9.8% | ↓ | — |
| *Expected Readmissions—Total (18–64 Years)* | — | 9.7% | — | — |
| *Outlier Rate—Total (18–64 Years)* | — | 55.0 | — | — |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)** | 0.9985 | 1.0138 | — | ★★ |

* A lower rate indicates better performance for this measure.
**Table A-1 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
+ Indicates the measure was reported using hybrid methodology in CY 2022 and mixed methodology (i.e., combination of administrative and hybrid) in CY 2021.
# Caution should be considered when comparing CY 2021 to CY 2022 results as changes to the measure specifications occurred.
Cells shaded green indicate that the rate met or exceeded the MY 2021 and/or MY 2022 and/or national Medicaid mean.
— Indicates a 2021–2022 comparison is not presented in the CYE 2023 Annual Technical Report because either the CY 2021 rate was not presented in the CYE 2022 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
[1] Aggregated rates were calculated and compared from CY 2021 to CY 2022, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators.
↑ Indicates improvement of measure rates.
↓ Indicates decline of measure rates.
→ Indicates stable measure rates.
[2] Performance Levels for CY 2022 were based on comparisons of the HEDIS MY 2022 measure rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks.
Performance Levels for 2022 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile
[N] Measure has no NCQA Medicaid mean for comparison.
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.

Table 4-4 highlights the ACC Program Contractors' performance for the current year by measure group. The table illustrates the Contractors' CY 2022 measure rates and their performance relative to the NCQA national Medicaid Quality Compass HEDIS MY 2022 percentiles, where applicable. The performance level star ratings are defined as follows:

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

**Table 4-4—CY 2022 National Percentiles Comparison for ACC Program Contractors**

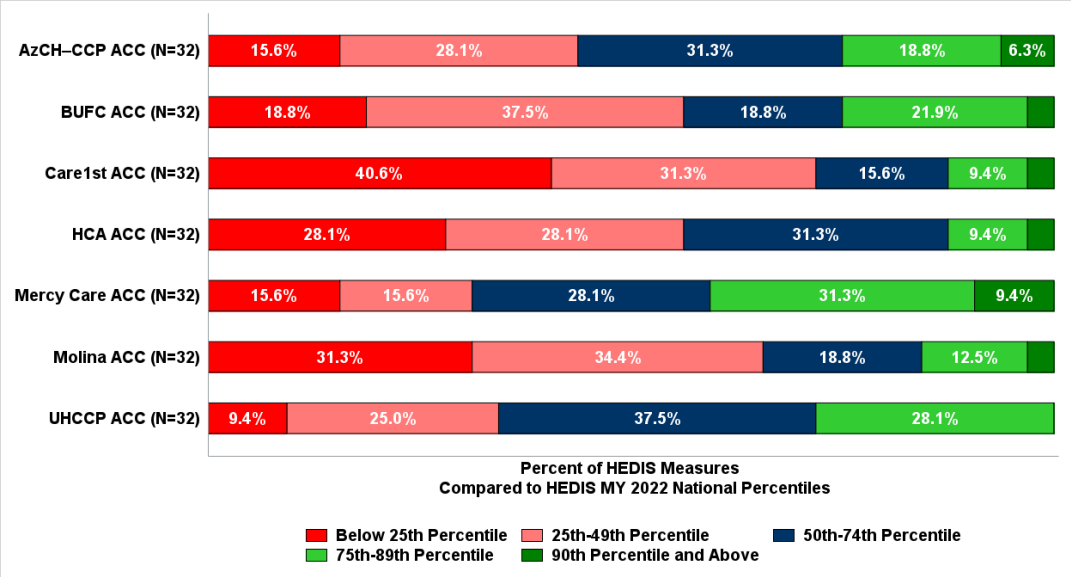
| Measure | AzCH–CCP ACC-RBHA | BUFC ACC | Care 1st ACC-RBHA | HCA ACC | Mercy Care ACC-RBHA | Molina ACC | UHCCP ACC | Aggregate |
|---|---|---|---|---|---|---|---|---|
| ***Maternal and Perinatal Care*** | | | | | | | | |
| ***Prenatal and Postpartum Care*** | | | | | | | | |
| *Timeliness of Prenatal Care* | ★★ | ★★ | ★ | ★★★ | ★★★ | ★★ | ★★ | ★★ |
| *Postpartum Care* | ★ | ★ | ★ | ★ | ★★★ | ★ | ★ | ★ |
| ***Behavioral Health*** | | | | | | | | |
| ***Antidepressant Medication Management*** | | | | | | | | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | ★★ | ★★ | ★★ | ★★ | ★ | ★★★ | ★★★ | ★★ |
| *Effective Continuation Phase Treatment—Total (18+ Years)* | ★★ | ★★ | ★★ | ★★ | ★ | ★★★ | ★★ | ★★ |
| ***Follow-Up After ED Visit for Substance Use*** | | | | | | | | |
| *7-Day Follow-Up—Total* | ★★★★ | ★★★ | ★★★★ | ★★★★ | ★★★★ | ★★★★ | ★★★★ | ★★★★ |
| *30-Day Follow-Up—Total* | ★★★ | ★★ | ★★★★ | ★★★★ | ★★★★ | ★★★ | ★★★ | ★★★ |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | ★★★★ | ★★★ | ★★★★★ | ★★★★★ | ★★★★ | ★★ | ★★★★ | ★★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | ★★★ | ★★ | ★★★★ | ★★★★ | ★★★★ | ★★ | ★★★ | ★★★ |
| ***Follow-Up After ED Visit for Mental Illness*** | | | | | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | ★★★ | ★★ | ★★★ | ★★★ | ★★★★ | ★★★ | ★★★ | ★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | ★★★ | ★★ | ★★ | ★★ | ★★★ | ★★★ | ★★★ | ★★★ |

| Measure | AzCH–CCP ACC-RBHA | BUFC ACC | Care 1st ACC-RBHA | HCA ACC | Mercy Care ACC-RBHA | Molina ACC | UHCCP ACC | Aggregate |
|---|---|---|---|---|---|---|---|---|
| ***Use of Opioids at High Dosage*** | | | | | | | | |
| *18+ Years** | ★★ | ★ | ★★★ | ★★ | ★ | ★★★★ | ★ | ★ |
| ***Initiation and Engagement of Substance Use Disorder (SUD)*** | | | | | | | | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | ★★★★ | ★★★★ | ★★ | ★★★ | ★★★★ | ★★★★★ | ★★★★ | ★★★★ |
| *Engagement of SUD Treatment—Total—Total (13+ Years)* | ★★★★ | ★★★★ | ★★ | ★★★ | ★★★★ | ★★★★ | ★★★★ | ★★★★ |
| ***Adherence to Antipsychotic Medications for Individuals with Schizophrenia*** | | | | | | | | |
| *18+ Years* | ★ | ★★ | ★ | ★ | ★★ | ★ | ★ | ★ |
| ***Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*** | | | | | | | | |
| *18–64 Years* | ★★ | ★★★ | ★★ | ★★ | ★★★ | ★ | ★★ | ★★ |
| ***Care of Acute and Chronic Conditions*** | | | | | | | | |
| ***Controlling High Blood Pressure*** | | | | | | | | |
| *18–85 Years* | ★ | ★★ | ★ | ★★★ | ★★ | ★ | ★★★ | ★★ |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | | | | | | | | |
| *HbA1c Control (<8.0 %)—Total (18–75 Years)* | ★★ | ★★★★★ | ★ | ★★ | ★★★★ | ★ | ★★★ | ★★★ |
| *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)** | ★★★ | ★★★ | ★ | ★★ | ★★★ | ★ | ★★★★ | ★★★ |
| ***Pediatric Health*** | | | | | | | | |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotics*** | | | | | | | | |
| *Blood Glucose Testing—Total (1–17 Years)* | ★★★★ | ★★★★ | ★★★ | ★★★ | ★★★★ | ★★ | ★★★ | ★★★★ |
| *Cholesterol Testing—Total (1–17 Years)* | ★★★★★ | ★★★★ | ★★ | ★★★ | ★★★★★ | ★★★★ | ★★★★ | ★★★★ |

| Measure | AzCH–CCP ACC-RBHA | BUFC ACC | Care 1st ACC-RBHA | HCA ACC | Mercy Care ACC-RBHA | Molina ACC | UHCCP ACC | Aggregate |
|---|---|---|---|---|---|---|---|---|
| *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* | ★★★★★ | ★★★★ | ★★★ | ★★★ | ★★★★★ | ★★★ | ★★★★ | ★★★★ |
| ***Childhood Immunization Status*** | | | | | | | | |
| *Combination 3* | ★★★ | ★★ | ★ | ★ | ★ | ★★ | ★★ | ★★ |
| *Combination 7* | ★★★ | ★★★ | ★ | ★ | ★★ | ★★ | ★★ | ★★ |
| *Combination 10* | ★★ | ★★★ | ★ | ★ | ★ | ★★ | ★★ | ★★ |
| ***Immunizations for Adolescents*** | | | | | | | | |
| *Combination 1 (Meningococcal, Tdap)* | ★★★ | ★★★★ | ★★ | ★★★ | ★★★★★ | ★★ | ★★★★ | ★★★★ |
| *Combination 2 (Meningococcal, Tdap, HPV)* | ★★★★ | ★★★★ | ★★ | ★★ | ★★★ | ★★ | ★★★★ | ★★★ |
| ***Well-Child Visits in the First 30 Months of Life*** | | | | | | | | |
| *Six or More Well-Child Visits* | ★★★ | ★★ | ★★ | ★★ | ★★★★ | ★★ | ★★★ | ★★★ |
| *15 Months–30 Months—Two or More Well-Child Visits* | ★ | ★ | ★ | ★ | ★★ | ★ | ★★ | ★ |
| ***Child and Adolescent Well-Care Visits*** | | | | | | | | |
| *Total (3–21 Years)* | ★★ | ★ | ★ | ★ | ★★★ | ★ | ★★ | ★★ |
| ***Preventive Screening*** | | | | | | | | |
| ***Breast Cancer Screening*** | | | | | | | | |
| *Total (50–74 Years)* | ★★★ | ★★ | ★ | ★ | ★★★ | ★★ | ★★★ | ★★ |
| ***Cervical Cancer Screening*** | | | | | | | | |
| *21–64 Years* | ★★ | ★ | ★ | ★ | ★★★ | ★ | ★★★ | ★★ |
| ***Appropriate Utilization of Services*** | | | | | | | | |
| ***Plan All-Cause Readmissions*** | | | | | | | | |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)** | ★ | ★ | ★★★ | ★★★ | ★★ | ★ | ★★★ | ★★ |

Figure 4-1 displays the ACC Program Contractors' HEDIS MY 2022 performance compared to NCQA MY 2022 National Percentiles. HSAG analyzed results from 19 performance measures for HEDIS MY 2022 for a total of 32 measure rates.

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




## *ACC Program-Level Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measure Validation*

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

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

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| In the Behavioral Health measure group:<br>• The *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total* measure rates for all seven ACC Program Contractors and the ACC Program Aggregate and the *Follow-Up After ED Visit for Substance Use—30-Day Follow-Up—Total* measure rates for six out of seven ACC Program Contractors and the ACC Program Aggregate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. In 2016, 20.1 million Americans over 12 years of age (about 7.5 percent of the population) were classified as having a SUD |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| involving alcohol or other substances. High ED use for individuals with substance use may signal a lack of access to care or issues with continuity of care. Timely follow-up care for individuals with SUD who were seen in the ED is associated with a reduction in substance use, future ED use, hospital admissions, and bed days.[4] **[Quality, Timeliness, Access]**<br>• The *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* measure rate for six of the seven ACC Program Contractors and the ACC Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. These results may indicate that members were receiving important timely follow-up visits for mental illness after an ED visit. Research suggests that follow-up care for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function, and increased compliance with follow-up instructions.[4-2] The CY 2022 results in this measure continued the prior year's high performance related to ensuring timely follow-up for members in accessing care after an ED visit for mental illness. **[Quality, Timeliness, Access]**<br>• The *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* and *Engagement of SUD Treatment—Total—Total (13+ Years)* measure rates for six of the seven ACC Program Contractors and the ACC Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. In 2022, 48.7 million individuals in the United States 12 years of age or older (approximately 17.3 percent of the population) were classified as having had an SUD within the past year. Individuals with SUD are at increased risk of overdose, injury, soft tissue infections and mortality. In 2021, drug overdose accounted for 106,699 deaths, representing a 14 percent increase in overdose deaths compared to 2020. Similarly, over 140,000 people die each year from excessive alcohol use. Early and regular SUD treatment, including medication therapy, has been demonstrated to improve outcomes for individuals with SUD, but less than 20 percent of individuals with a SUD receive this important specialty care. indicating that most members with diagnosed SUD may have initiated SUD treatment and had two or more additional SUD services or MAT within 34 days of the initiation visit, which, in conjunction with counseling or other behavioral therapies, has been shown to reduce SUD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending. [4-3] **[Quality, Timeliness, Access]** |
| In the Pediatric Health measure group, the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total (1–17 Years), Blood Glucose Testing—Total (1–17 Years),* and *Blood Glucose and Cholesterol Testing—Total (1–17 Years);* and *Immunizations for Adolescents—Combination 1(Meningococcal, Tdap)* measure rates for six out of seven ACC Program |

[4-2] National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Mental Illness. Available at: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/. Accessed on: Jan 25, 2024.

[4-3] National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence. Available at https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-alcohol-and-other-drug-abuse-or-dependence/. Accessed on: Jan 25, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| Contractors and the ACC Program Aggregate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. These results suggest that most children and adolescents with ongoing antipsychotic medication use had appropriate metabolic testing performed, which is consistent with the CY 2021 results as well. Antipsychotic prescribing for children and adolescents has increased rapidly in recent decades. These medications can elevate a child's risk for developing serious metabolic health complications associated with poor cardiometabolic outcomes in adulthood. Metabolic monitoring (blood glucose and cholesterol testing) is an important component of ensuring appropriate management of children and adolescents on antipsychotic medications.[4-4] The results also indicate that adolescents are receiving the recommended Combination 1 vaccination. Receiving recommended vaccinations is the best defense against serious vaccine-preventable diseases. **[Quality]** |
| **Opportunities for Improvement and Recommendations** |
| In the Maternal and Perinatal Care measure group, rates for six out of seven ACC Program Contractors and the ACC Program Aggregate rate for the *Prenatal and Postpartum Care—Postpartum Care* measure indicator fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and fell below the 25th percentile, indicating a continued opportunity to increase access to timely postpartum care. **[Quality, Timeliness, Access]**<br><br>Recommendation: As noted by the American College of Obstetricians (ACOG), all women should have contact with their obstetrician/gynecologist or other obstetric provider within three weeks postpartum, followed by ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth.[4-5] To positively impact women in need of postpartum care, HSAG recommends that the ACC Program Contractors build on the results of their prior year's root cause analysis to determine why some members were not receiving timely postpartum care, and monitor the success of newly implemented interventions to improve performance related to access to postpartum care. Continued monitoring of interventions' success should be conducted, and the ACC Program Contractors should submit results as required by AHCCCS. Of note, the ACC Program Contractors are currently conducting the *Prenatal and Postpartum Care* PIP, which includes a root cause analysis and interventions to address this measure. |
| In the Behavioral Health measure group, the rates for six of the seven ACC Program Contractors and the ACC Program Aggregate rate for the *Antidepressant Medication Management—Effective Continuation Phase Treatment—Total (18+ Years)* measure indicator fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. In addition, the rates for five of the seven ACC Program Contractors and the ACC Program Aggregate rate fell below the NCQA Quality |

[4-4] National Committee for Quality Assurance. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM). Available at: https://www.ncqa.org/hedis/measures/metabolic-monitoring-for-children-and-adolescents-on-antipsychotics/ Accessed on: Jan 25, 2024.

[4-5] National Committee for Quality Assurance. Prenatal and Postpartum Care. Available at: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/ Accessed on: Jan 25, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| Compass national Medicaid HMO mean for HEDIS MY 2022 for *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)*, indicating that some members with a diagnosis of major depression were not receiving continuous medication treatment. Effective medication treatment of major depression can improve a person's daily functioning and well-being, and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated as well.[4-6] **[Quality]**<br><br>Recommendation: HSAG recommends that the ACC Program Contractors conduct a root cause analysis or focus study to determine why some members with a diagnosis of major depression were not receiving continuous medication treatment. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, the ACC Program Contractors should implement appropriate interventions to improve performance related to antidepressant medication management. |
| In the Pediatric Health measure group:<br>• The rates for six of the seven ACC Program Contractors and the ACC Program Aggregate rate for the *Child and Adolescent Well-Care Visits—Total (3–21 Years)* measure fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022, indicating that some children and adolescents were not always receiving well-care visits at the recommended intervals. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[4-7] **[Quality, Access]**<br><br>Recommendation: HSAG recommends that the ACC Program Contractors conduct a root cause analysis to determine why some children and adolescents did not receive well-care visits according to the recommended schedule. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, the ACC Program Contractors should implement appropriate interventions to improve the *Child and Adolescent Well-Care Visits—Total (3–21 Years)* measure. (Of note, the ACC Program Contractors are currently conducting the *Back to Basics* PIP, which includes a root cause analysis and interventions to address this measure.) |
| For CY 2022 performance measure reporting, race and ethnicity stratifications (RES) were required based on NCQA HEDIS specifications. While HSAG did not identify ACC Contractor-specific |

[4-6] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Jan 31, 2024.
[4-7] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/#:~:text=Well%2DChild%20Visits%20in%20the,first%2015%20months%20of%20life. Accessed on: Jan 31, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| opportunities to improve RES, all ACC Contractors could benefit from continuing to focus on refining RES reporting where required per measure specifications. **[Quality]**<br><br>Recommendation: HSAG recommends that the ACC Program Contractors explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratifications related to race and ethnicity. The ACC Program Contractors should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information. |

# Validation of Performance Improvement Projects

## *Back to Basics PIP*

Well-care and annual dental visits for children and adolescents aim to promote optimal health and development.[4-8] Ensuring that children and adolescents receive regular well-care and dental visits is critical in disease prevention, early detection, and treatment. There are many benefits of well-child/well-care visits, including disease prevention, tracking growth and development, raising concerns, and establishing a team approach to assist with the development of optimal physical, mental, and social health of a child.[4-9] Adolescence is a critical stage of development during which physical, intellectual, emotional, and psychological changes occur.[4-10] Adolescent well-care visits assist with promoting healthy choices and behaviors, preventing risky behaviors, and detecting early the conditions that can inhibit an adolescent's development.

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Back to Basics* PIP for the ACC/KidsCare population. The objective of the *Back to Basics* PIP 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. In October 2023, AHCCCS amended the methodology for the *Back to Basics* PIP and removed the *Annual Dental Visit (ADV)* performance measure as NCQA retired this measure. AHCCCS intends to monitor dental services through dental-focused CMS Core Set measures going forward.

[4-8] American Academy of Pediatrics. AAP Schedule of Well-Child Care Visits. Available at: https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx. Accessed on: Feb 6, 2024.
[4-9] Ibid.
[4-10] Centers for Disease Control and Prevention. Adolescence: Preparing for Lifelong Health and Wellness. Available at: https://www.cdc.gov/grand-rounds/pp/2015/20150818-adolescent-wellness.html. Accessed on: Feb 6, 2024.

## ACC Program-Level Validation Results

Table 4-6 presents the ACC program-level overall validation results for each Contractor for the *Back to Basics* PIP. Confidence levels for PIP Methodology and Significant Improvement are described in the PIP section of Appendix A—Methodology.

**Table 4-6—ACC Program *Back to Basics* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| AzCH-CCP ACC-RBHA | *High Confidence* | 100% | 100% | *No Confidence* | 33% | 100% |
| BUFC ACC | *Low Confidence* | 87% | 89% | *No Confidence* | 33% | 100% |
| Care 1st ACC-RBHA | *High Confidence* | 100% | 100% | *No Confidence* | 33% | 100% |
| HCA ACC | *High Confidence* | 100% | 100% | *No Confidence* | 33% | 100% |
| Mercy Care ACC-RBHA | *High Confidence* | 100% | 100% | *Low Confidence* | 33% | 100% |
| Molina ACC | *High Confidence* | 100% | 100% | *High Confidence* | 100% | 100% |
| UHCCP ACC | *High Confidence* | 100% | 100% | *No Confidence* | 33% | 100% |

## ACC Program-Level Measure Results

Table 4-7 and Table 4-8 present indicator rates for each Contractor for the *Back to Basics* PIP during the baseline year, intervention years, and Remeasurement Year 1.

**Table 4-7—ACC Program *Back to Basics* PIP Comparative Rates for Indicator 1**

| Contractor | PIP Indicator 1: *Well-Child Visits in the First 30 Months of Life (W30 Rate 1)* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| AzCH-CCP ACC-RBHA | 63.2% | 60.7% |
| BUFC ACC | 63.5% | 58.1% |
| Care 1st ACC-RBHA | 70.5% | 53.5% |
| HCA ACC | 59.4% | 56.1% |
| Mercy Care ACC-RBHA | 65.0% | 65.1% |
| Molina ACC | Not Reported^ | 56.0% |
| UHCCP ACC | 65.6% | 61.9% |

^In CYE 2019, the Molina ACC performance measure rate for indicator 1 had a small denominator, which did not allow for reporting of the measure. CY 2020 served as baseline for indicator 1 for Molina ACC. Molina ACC's baseline rate for indicator 1, for the purposes of this PIP, was 49.1%

**Table 4-8—ACC Program *Back to Basics* PIP Comparative Rates for Indicator 2**

| Contractor | PIP Indicator 2: *Child and Adolescent Well-Care Visits (WCV)* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| AzCH-CCP ACC-RBHA | 46.9% | 46.4% |
| BUFC ACC | 46.6% | 39.6% |
| Care 1st ACC-RBHA | 51.4% | 33.7% |
| HCA ACC | 43.6% | 39.8% |
| Mercy Care ACC-RBHA | 52.9% | 49.6% |
| Molina ACC | 33.9% | 39.6% |
| UHCCP ACC | 52.7% | 47.4% |

## ACC Program-Level Interventions

For the *Back to Basics* PIP, all Contractors provided lists of interventions that were in place for this validation cycle. These lists detailed the identified population, the intervention(s) in place, and whether or not the intervention(s) will be continued. The most common interventions across Contractors included targeting members and providers for outreach and education related to well-care visits. Outreach methods included interactive voice response (IVR), person-to-person, and automated phone calls; text message campaigns; emails; member events; and mailing materials. Additionally, several Contractors

had physician and/or member incentives in place directly tied to closing gaps in care. Opportunity for Care reports were utilized to inform providers of members in need of well-care visits. These interventions may impact indicator performance, which will be evaluated during the next validation cycle.

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

Table 4-9 presents program-level strengths, opportunities for improvement, and recommendations for the ACC Program related to the *Back to Basics* PIPs.

**Table 4-9—ACC Program Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIPs**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| The ACC Program Contractors were able to measure the effectiveness of interventions and perform accurate statistical testing between the baseline and Remeasurement 1 results. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| Program-level indicator rates demonstrated a decline at Remeasurement 1 compared to baseline rates with few exceptions.<br><br>For indicator 1, five ACC Program Contractors showed a decline in the rates between the baseline year and Remeasurement Year 1, with a decline of approximately 3 percentage points for the ACC Program aggregate rate.<br><br>For indicator 2, six ACC Program Contractors showed a decline in the indicator rates between the baseline year and Remeasurement Year 1, with a decline of approximately 5 percentage points for the ACC Program Aggregate rate.<br><br>Recommendations: To support successful progression of the PIP in the next calendar year, HSAG recommends that the ACC Program Contractors:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

## Prenatal and Postpartum Care PIP

According to the Centers for Disease Control and Prevention (CDC), at least 50,000 women in the United States are affected by severe morbidity due to unexpected pregnancy-related health problems. In addition, more than 700 women die each year from pregnancy-related problems or delivery complications. Racial disparities exist among pregnancy-related deaths, as the CDC reports, "American Indian, Alaska Native, and Black women are two to three times more likely to die of pregnancy-related causes than White women."[4-11] Every death related to pregnancy is a tragedy, especially considering the CDC found that four in five of the deaths are preventable.[4-12]

According to Healthy People 2030, "women's health before, during, and after pregnancy can have a major impact on infants' health and well-being."[4-13] Strategies such as maintaining a healthy lifestyle, receiving proper health care, and adopting healthy habits before and during pregnancy help prevent pregnancy complications and improve health outcomes for women and their babies. In addition, these strategies may assist in promoting infant health, development, and overall well-being.

In CYE 2022 (October 1, 2021, through September 30, 2022), AHCCCS implemented the *Prenatal and Postpartum Care* PIP for the ACC-RBHA population. The objective of the *Prenatal and Postpartum Care* PIP is to improve health outcomes for members and infants. This PIP focuses on increasing the number and percentage of members with live birth deliveries that 1) received a prenatal care visit, and 2) received a postpartum visit.

### ACC Program-Level Validation Results

Table 4-10 presents the ACC program-level overall validation results for each Contractor for the *Prenatal and Postpartum Care* PIP.

[4-11] Centers for Disease Control and Prevention. Hear Her Campaign. Pregnancy-Related Deaths in the United States. Available at: Pregnancy-Related Deaths in the United States | CDC. Accessed on: Feb 7, 2024.
[4-12] Ibid.
[4-13] U.S. Department of Health and Human Services. Healthy People 2030. Pregnancy and Childbirth. Available at: https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth#:~:text=Women's%20health%20before%2C%20during%2C%20and%20after%20pregnancy%20can%20have%20a,and%20to%20have%20healthy%20babies. Accessed on: Feb 7, 2024.

**Table 4-10—ACC Program *Prenatal and Postpartum Care* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| AzCH-CCP ACC-RBHA | *High Confidence* | 100% | 100% | *Not Assessed* | *Not Assessed* | *Not Assessed* |
| BUFC ACC | *High Confidence* | 100% | 100% | *Not Assessed* | *Not Assessed* | *Not Assessed* |
| Care 1st ACC-RBHA | *High Confidence* | 100% | 100% | *Not Assessed* | *Not Assessed* | *Not Assessed* |
| HCA ACC | *High Confidence* | 100% | 100% | *Not Assessed* | *Not Assessed* | *Not Assessed* |
| Mercy Care ACC-RBHA | *High Confidence* | 100% | 100% | *Not Assessed* | *Not Assessed* | *Not Assessed* |
| Molina ACC | *High Confidence* | 100% | 100% | *Not Assessed* | *Not Assessed* | *Not Assessed* |
| UHCCP ACC | *High Confidence* | 100% | 100% | *Not Assessed* | *Not Assessed* | *Not Assessed* |

## ACC Program-Level Measure Results

Table 4-11 and Table 4-12 present indicator rates for each Contractor for the *Prenatal and Postpartum Care* PIP during the baseline year.

**Table 4-11—ACC Program *Prenatal and Postpartum Care* PIP Comparative Rates for Indicator 1**

| Contractor | PIP Indicator 1: *Timeliness of Prenatal Care* |
|---|---|
| | Baseline Year |
| | CY 2022 |
| AzCH-CCP ACC-RBHA | 82.7% |
| BUFC ACC | 81.5% |
| Care 1st ACC-RBHA | 75.4% |
| HCA ACC | 86.9% |
| Mercy Care ACC-RBHA | 84.9% |
| Molina ACC | 83.7% |
| UHCCP ACC | 82.5% |

**Table 4-12—ACC Program *Prenatal and Postpartum Care* PIP Comparative Rates for Indicator 2**

| Contractor | PIP Indicator 2: *Postpartum Care* |
|---|---|
| | Baseline Year |
| | CY 2022 |
| AzCH-CCP ACC-RBHA | 66.4% |
| BUFC ACC | 69.8% |
| Care 1st ACC-RBHA | 68.4% |
| HCA ACC | 65.3% |
| Mercy Care ACC-RBHA | 78.1% |
| Molina ACC | 64.2% |
| UHCCP ACC | 67.6% |

## ACC Program-Level Interventions

For the *Prenatal and Postpartum Care* PIP, all Contractors provided lists of interventions that were in place for this validation cycle. These lists detailed the identified population, the intervention(s) in place, and whether or not the interventions(s) will be continued. The most common interventions across Contractors included targeting members and providers for outreach and education related to prenatal and postpartum care visits. Outreach methods included person-to-person and automated phone calls; text message campaigns; emails; member events; and mailing materials. Additionally, several Contractors had physician and/or member incentives in place directly tied to closing gaps in care. Opportunity for Care reports and Notification of Pregnancy reports through provider portals were utilized to inform providers of members in need of well-care visits. Pregnancy care programs as well as transportation

assistance were offered to pregnant women. These interventions may impact indicator performance, which will be evaluated during the next validation cycle.

For further description of each Contractors' interventions, see Section 5. ACC Program Contractor-Specific Results.

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

Table 4-13 presents program-level strengths, opportunities for improvement, and recommendations for the ACC Program related to the *Prenatal and Postpartum Care* PIP.

**Table 4-13—ACC Program Strengths, Opportunities for Improvement, and Recommendations Related to the *Prenatal and Postpartum Care* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| The ACC Program Contractors developed and implemented measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 1 **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| HSAG identified no opportunities for improvement during the validation.<br><br>Recommendations: Although HSAG identified no opportunities for improvement, to support successful progression of the PIP in the next calendar year, HSAG recommends that the ACC Program Contractors:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement, as necessary.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

## Compliance Reviews

For the ACC Program, AHCCCS includes the following Focus Areas in its compliance review activity. Table 4-14 presents the Focus Areas, including each associated acronym used by AHCCCS during its compliance review.

**Table 4-14—Focus Areas and Associated Acronyms**

| Focus Area | Acronym |
|---|---|
| Corporate Compliance | CC |
| Claims and Information Standards | CIS |
| Delivery Systems | DS |
| General Administration | GA |
| Grievance Systems | GS |
| Adult; EPSDT; and Maternal Child Health | MCH |
| Medical Management | MM |
| Member Information | MI |
| Quality Management | QM |
| Quality Improvement | QI |
| Reinsurance | RI |
| Third-Party Liability | TPL |
| Integrated Systems of Care | ISOC |

For ACC Program Contractor-specific results, see Section 5. ACC Program Contractor-Specific Results.

## ACC Program-Level Results

AHCCCS conducts a full compliance review for each Contractor every three years. This current three-year review cycle spans from CYE 2022 to CYE 2024. In CYE 2022, AHCCCS conducted compliance reviews for BUFC ACC, HCA ACC, Molina ACC, and UHCCP ACC. In CYE 2023, AHCCCS assessed the Contractor's corrective action plans (CAPs) for standards with a total score of less than 95 percent. Results and CAP updates for BUFC ACC, HCA ACC, Molina ACC, and UHCCP ACC are available in Section 5. ACC Program Contractor-Specific Results. In November 2021, AHCCCS awarded ACC-RBHA contracts to AzCH-CCP, Care 1st, and Mercy Care, expanding the current ACC contract. As a result, AHCCCS conducted an extensive readiness review process during CYE 2022. The ACC-RBHA contracts went into effect on October 1, 2022. Compliance reviews will be conducted in CYE 2024 and will therefore be included in the CYE 2024 annual technical report. Table 4-15 presents program-level and comparative results for the ACC Program for compliance reviews based on the review of all Focus Areas conducted in CYE 2022.

**Table 4-15—ACC Program-Level Compliance Review Results**

| Focus Areas | AzCH-CCP ACC-RBHA* | BUFC ACC | Care 1st ACC-RBHA* | HCA ACC | Mercy Care ACC-RBHA* | Molina ACC | UHCCP ACC | Program-Level Average |
|---|---|---|---|---|---|---|---|---|
| Year Reviewed | NA | CYE 2022 | NA | CYE 2022 | NA | CYE 2022 | CYE 2022 | CYE 2022 |
| CC | TBD | 100% | TBD | 100% | TBD | 100% | 93% | 99% |
| CIS | TBD | 97% | TBD | 99% | TBD | 92% | 99% | 96% |
| DS | TBD | 87% | TBD | 98% | TBD | 84% | 98% | 91% |
| GA | TBD | 96% | TBD | 78% | TBD | 93% | 100% | 92% |
| GS | TBD | 99% | TBD | 99% | TBD | 99% | 100% | 99% |
| MCH | TBD | 70% | TBD | 98% | TBD | 76% | 95% | 82% |
| MM | TBD | 90% | TBD | 97% | TBD | 93% | 97% | 94% |
| MI | TBD | 100% | TBD | 94% | TBD | 95% | 95% | 96% |
| QM | TBD | 80% | TBD | 75% | TBD | 69% | 84% | 77% |
| QI | TBD | 96% | TBD | 83% | TBD | 89% | 100% | 92% |
| RI | TBD | 100% | TBD | 100% | TBD | 100% | 100% | 100% |
| TPL | TBD | 100% | TBD | 100% | TBD | 100% | 100% | 100% |
| ISOC | TBD | 100% | TBD | 98% | TBD | 97% | 86% | 96% |

* NA = "not applicable" and TBD = "to be determined." AHCCCS conducted an extensive readiness review for these Contractors during CYE 2022. The compliance reviews for these Contractors will be conducted in CYE 2024.

## *ACC Program-Level Strengths, Opportunities for Improvement, and Recommendations Related to Compliance Review*

Table 4-16 presents program-level strengths, opportunities for improvement, and recommendations for the ACC Program related to compliance.

**Table 4-16—ACC Program Strengths, Opportunities for Improvement, and Recommendations Related to Compliance**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| The ACC Program-level average score was at or above 95 percent in the following Focus Areas:<br>• Corporate Compliance (CC) **[Quality, Access]**<br>• Claims and Information Standards (CIS) **[Access]**<br>• Grievance Systems (GS) **[Timeliness, Access]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| • Member Information (MI) **[Quality]**<br>• Reinsurance (RI) **[Quality]**<br>• Third-Party Liability (TPL) **[Quality, Timeliness, Access]**<br>• Integrated Systems of Care (ISOC) **[Quality, Access]**<br><br>In CYE 2023, AHCCCS approved all ACC Program Contractors' proposed CAPs for all Focus Areas with scores less than 95 percent. |
| **Opportunities for Improvement and Recommendations** |
| The ACC Program-level average score was below 95 percent in the following Focus Areas:<br>• Delivery Systems (DS) **[Timeliness, Access]**<br>• General Administration (GA) **[Timeliness, Access]**<br>• Adult, EPSDT, and Maternal Child Health (MCH) **[Quality, Timeliness, Access]**<br>• Medical Management (MM) **[Timeliness, Access]**<br>• Quality Management (QM) **[Quality]**<br>• Quality Improvement (QI) **[Quality, Access]**<br><br>Recommendation: HSAG recommends that the ACC Program Contractors continue to work on outstanding CAPs related to the DS, GA, MCH, MM, QM, and QI Focus Area requirements. |

# Network Adequacy Validation

## *ACC Program-Level Results*

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

Table 4-17 summarizes HSAG's assessment of each ACC Program Contractor's compliance with AHCCCS' minimum time/distance network standards. A check mark indicates that the ACC Program Contractor met the minimum network standard for each Arizona county during the semiannual assessments, and an "X" indicates that the ACC Program Contractor failed to meet one or more

minimum network standards in any county or quarter. Section 5. ACC Program Contractor-Specific Results contains NAV results specific to each Contractor and semiannual validation period.

**Table 4-17—Summary of CYE 2023 Compliance with Minimum Time/Distance Network Requirements for ACC Program Contractors**

| Minimum Network Requirement | AzCH-CCP ACC-RBHA | BUFC ACC | Care 1st ACC-RBHA | HCA ACC | Molina ACC | Mercy Care ACC-RBHA | UHCCP ACC |
|---|---|---|---|---|---|---|---|
| Behavioral Health Outpatient and Integrated Clinic, Adult | ✓ | ✓ | X | X | ✓ | ✓ | ✓ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | ✓ | ✓ | X | X | ✓ | ✓ | ✓ |
| BHRF (Only Maricopa and Pima Counties) | ✓ | ✓ | NA | ✓ | ✓ | ✓ | ✓ |
| Cardiologist, Adult | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Cardiologist, Pediatric | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Dentist, Pediatric | X | X | X | X | X | ✓ | X |
| Hospital | ✓ | ✓ | X | ✓ | ✓ | ✓ | ✓ |
| OB/GYN | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Pharmacy | X | X | X | ✓ | ✓ | ✓ | ✓ |
| PCP, Adult | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| PCP, Pediatric | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

NA indicates that the time/distance standard does not apply based on the program and county associated with each Contractor.

The ACC Program Contractors consistently met the BHRF; Cardiologist; Adult and Pediatric; OB/GYN; and PCP, Adult and Pediatric standards while not consistently meeting standards for Dentist, Pediatric and Pharmacy.

However, several Contractors demonstrated Provider Affiliation Transmission (PAT) data issues, which impacted HSAG's time/distance results and the validation of Contractors' ACOM 436 results in CYE 2023 Q2 and Q4.

Isolated data issues may have contributed to specific instances affecting ACC Program Contractors' compliance with time/distance standards. Specific examples include the following:

- In CYE 2023 Q2, one ACC Program Contractor's data included decreased numbers of providers used to measure the Behavioral Health Outpatient and Integrated Clinic for Adult and Pediatric standards, as compared to prior submissions. This potentially influenced the validated compliance for this provider type. The Contractor identified the cause and successfully tested the solution.

- In CYE 2023 Q4, one ACC Program Contractor's data included substantially increased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; Cardiologist, Adult and Pediatric; Crisis Stabilization Facility; OB/GYN; and PCP, Adult and Pediatric. This potentially influenced the validated compliance for these provider types. The Contractor reported the increase was due to revisions in its extract file creating the PAT file that included all active provider addresses.

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

Overall, the applicable ACC Program Contractors met all minimum time/distance network standards during both quarters in Cochise, Graham, Maricopa, Mohave, Pima, Pinal, Yavapai and Yuma counties. Based on the semiannual NAV results, Mercy Care ACC was the only ACC Program Contractor that met all requirements for all standards and quarters in its respective counties.

Each ACC Program Contractor should continue to monitor and maintain its existing provider network as of CYE 2023 Q4, with specific attention to ensuring the availability of the following provider types:

- Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric in Apache County.
- Dentist, Pediatric in Apache, Coconino, Gila, Greenlee, La Paz, and Santa Cruz Counties
- Hospitals in Apache County
- Pharmacy in La Paz County

## *ACC Program Conclusions, Opportunities for Improvement, and Recommendations Related to Network Adequacy Validation*

Table 4-18 presents program-level strengths, opportunities for improvement, and recommendations for the ACC Program related to NAV.

**Table 4-18—ACC Program Strengths, Opportunities for Improvement, and Recommendations Related to NAV**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths:<br>• The applicable ACC Program Contractors met all minimum time/distance network standards during both quarters in Cochise, Graham, Maricopa, Mohave, Pima, Pinal, Yavapai, and Yuma counties. **[Access]**<br>• The ACC Program Contractors consistently met the BHRF; Cardiologist, Adult and Pediatric; OB/GYN; and PCP, Adult and Pediatric standards. **[Access]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Opportunities for Improvement and Recommendations** |
| HSAG identified the following opportunities for improvement:<br>• Isolated data issues may have contributed to specific instances affecting ACC Program Contractors' compliance with time/distance standards. **[Access]**<br>• Based on the semiannual NAV results, ACC Program Contractors did not consistently meet the standards for Dentist, Pediatric and Pharmacy in Apache, Coconino, Greenlee, and La Paz counties. **[Access]**<br><br>Recommendations:<br>• HSAG recommends that AHCCCS support the ACC Program Contractors in continuing to monitor their processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.<br>• HSAG recommends that AHCCCS support each ACC Program Contractor in continuing to monitor and maintain its existing provider network coverage as of CYE 2023 Q4, with specific attention to ensuring the availability of the following provider types among the applicable ACC Program Contractors:<br>– Pediatric dentists in Apache, Coconino, Greenlee, and La Paz counties<br>– Pharmacies in La Paz County |

# Consumer Assessment of Healthcare Providers and Systems Results

## *ACC (Non-SMI-Designated Population) Results*

HSAG administered member experience surveys on AHCCCS' behalf to adult members enrolled with an ACC Contractor from the statewide sample and the ACC oversample provided by AHCCCS. AHCCCS contracted with HSAG to administer and report results of the CAHPS Health Plan Survey for adult members enrolled with an ACC Contractor.

HSAG calculated results for four global rating questions, four composite measures, one individual item measure, and three medical assistance with smoking and tobacco use cessation items.

Table 4-19 shows the 2023 scores and overall member experience ratings on each CAHPS measure for the adult Medicaid population.

**Table 4-19—NCQA Comparisons**

| Measures | 2023 Adult Medicaid |
|---|---|
| **Global Ratings** | |
| *Rating of Health Plan* | ★★★★ 68.0% |
| *Rating of All Health Care* | ★★★ 56.9% |
| *Rating of Personal Doctor* | ★★★ 70.1% |
| *Rating of Specialist Seen Most Often* | ★★ 67.3% |
| **Composite Measures** | |
| *Getting Needed Care* | ★★ 81.3% |
| *Getting Care Quickly* | ★ 76.1%+ |
| *How Well Doctors Communicate* | ★★ 92.0% |
| *Customer Service* | ★ 84.1% |
| **Individual Item Measure** | |
| *Coordination of Care* | ★ 81.0%+ |
| **Medical Assistance With Smoking and Tobacco Use Cessation Items** | |
| *Advising Smokers and Tobacco Users to Quit* | ★ 61.4%+ |
| *Discussing Cessation Medications* | ★★ 47.7%+ |
| *Discussing Cessation Strategies* | ★ 38.6%+ |

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
Star Assignments Based on Percentiles:
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

## ACC (Non-SMI-Designated Population) Strengths, Opportunities for Improvement, and Recommendations Related to Consumer Assessment of Healthcare Providers and Systems Results

Table 4-20 presents program-level strengths, opportunities for improvement, and recommendations for the ACC (Non-SMI-Designated Population) Program related to the 2023 ACC program-level CAHPS results for the adult Medicaid (Non-SMI-Designated) population.

**Table 4-20—ACC Program Strengths, Opportunities for Improvement, and Recommendations Related to CAHPS**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths for the ACC Program:<br>• The ACC Program's member experience rating for *Rating of Health Plan* met or exceeded the 75th percentile for the adult Medicaid population. **[Quality]** |
| **Opportunities for Improvement and Recommendations** |
| HSAG identified the following opportunities for improvement for the ACC Program:<br>• The ACC Program's member experience rating for *Getting Care Quickly*, *Customer Service*, *Coordination of Care*, *Advising Smokers and Tobacco Users to Quit*, and *Discussing Cessation Strategies* were below the 25th percentiles for the adult Medicaid population. **[Quality, Timeliness]**<br>• The ACC Program's member experience rating for *Rating of Specialist Seen Most Often, Getting Needed Care, How Well Doctors Communicate,* and *Discussing Cessation Medications* were between the 25th and 49th percentiles for the adult Medicaid population. **[Quality, Access]**<br><br>Recommendation: HSAG recommends that the ACC Program Contractors explore what may be driving lower experience scores and develop initiatives designed to improve quality and access to care, including a focus on improving adult members' overall experiences with their coordination of care, customer service, and medical assistance with smoking and tobacco use. |

## KidsCare Results

HSAG administered member experience surveys on AHCCCS' behalf to members enrolled in the AHCCCS' KidsCare Program. KidsCare is Arizona's CHIP for eligible children (under age 19) who do not qualify for other AHCCCS health insurance. AHCCCS contracted with HSAG to administer and report the results of the CAHPS Health Plan Survey for the KidsCare Program. The goal of the CAHPS Health Plan Survey is to provide performance feedback that is actionable and will aid in improving overall member experience.

HSAG calculated results for four global ratings, four composite measures, one individual item measure, three CCC composite measures (CCC population only), and two CCC individual item measures (CCC population only).

Table 4-21 shows the 2023 scores and overall member experience ratings on each CAHPS measure for both the general child and CCC populations.

**Table 4-21—NCQA Comparisons**

| Measure | 2023 General Child | 2023 CCC Medicaid |
|---|---|---|
| **Global Ratings** | | |
| *Rating of Health Plan* | ★<br>68.5% | ★★<br>67.8% |
| *Rating of All Health Care* | ★<br>63.5% | ★<br>61.5% |
| *Rating of Personal Doctor* | ★<br>73.7% | ★★<br>74.3% |
| *Rating of Specialist Seen Most Often* | ★★★<br>76.0%+ | ★<br>67.1%+ |
| **Composite Measures** | | |
| *Getting Needed Care* | ★★★★<br>87.5%+ | ★★<br>84.3%+ |
| *Getting Care Quickly* | ★<br>83.7%+ | ★★★★<br>94.3%+ |
| *How Well Doctors Communicate* | ★★★<br>94.9% | ★★★<br>95.3% |
| *Customer Service* | ★★<br>86.7%+ | NA<br>86.1%+ |

| Measure | 2023 General Child | 2023 CCC Medicaid |
|---|---|---|
| **Individual Item Measure** | | |
| *Coordination of Care* | ★ 75.4%+ | ★ 76.3%+ |
| **CCC Composite Measures and Items** | | |
| *Access to Specialized Services* | NA | ★★★★ 72.9%+ |
| *FCC: Personal Doctor Who Knows Child* | NA | ★ 85.2%+ |
| *Coordination of Care for Children with Chronic Conditions* | NA | ★★★ 78.0%+ |
| *Access to Prescription Medicines* | NA | ★★ 90.6% |
| *FCC: Getting Needed Information* | NA | ★★★★ 94.3% |

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

NA indicates that this measure is not applicable for the population or the benchmark is not available.

Star Assignments Based on Percentiles:

★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

Table 4-22 shows the results of the trend analysis where the 2023 CAHPS results were compared to their corresponding 2023 CAHPS results on each CAHPS measure for both the general child and CCC populations.

**Table 4-22—Trend Analysis**

| Measure | General Child | | | CCC | | |
|---|---|---|---|---|---|---|
| | 2022 | 2023 | Trend Results (2022–2023) | 2022 | 2023 | Trend Results (2022–2023) |
| **Global Ratings** | | | | | | |
| *Rating of Health Plan* | 77.0% | 68.5% | ▼ | 75.0% | 67.8% | — |
| *Rating of All Health Care* | 72.7% | 63.5% | — | 63.8% | 61.5% | — |
| *Rating of Personal Doctor* | 78.5% | 73.7% | — | 76.0% | 74.3% | — |
| *Rating of Specialist Seen Most Often* | 76.0%+ | 76.0%+ | — | 76.6%+ | 67.1%+ | — |
| **Composite Measures** | | | | | | |
| *Getting Needed Care* | 89.1% | 87.5%+ | — | 91.0% | 84.3%+ | — |
| *Getting Care Quickly* | 89.2% | 83.7%+ | — | 93.9%+ | 94.3%+ | — |

| Measure | General Child | | | CCC | | |
|---|---|---|---|---|---|---|
| | 2022 | 2023 | Trend Results (2022–2023) | 2022 | 2023 | Trend Results (2022–2023) |
| *How Well Doctors Communicate* | 94.7% | 94.9% | — | 95.3% | 95.3% | — |
| *Customer Service* | 89.8%+ | 86.7%+ | — | 89.4%+ | 86.1%+ | — |
| **Individual Item Measure** | | | | | | |
| *Coordination of Care* | 88.9%+ | 75.4%+ | ▼ | 81.8%+ | 76.3%+ | — |
| **CCC Composite Measures and Items** | | | | | | |
| *Access to Specialized Services* | NA | NA | NA | 75.4%+ | 72.9%+ | — |
| *FCC: Personal Doctor Who Knows Child* | NA | NA | NA | 90.4% | 85.2%+ | — |
| *Coordination of Care for Children with Chronic Conditions* | NA | NA | NA | 77.2%+ | 78.0%+ | — |
| *Access to Prescription Medicines* | NA | NA | NA | 89.8% | 90.6% | — |
| *FCC: Getting Needed Information* | NA | NA | NA | 96.9% | 94.3% | — |

▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
— Indicates the 2023 score is not statistically significantly higher or lower than the 2022 score.
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
NA indicates that this measure is not applicable for the population.

## KidsCare Strengths, Opportunities for Improvement, and Recommendations Related to Consumer Assessment of Healthcare Providers and Systems Results

Table 4-23 presents program-level strengths, opportunities for improvement, and recommendations for the ACC Program related to the 2023 KidsCare Program-Level CAHPS results.

**Table 4-23—ACC KidsCare Program Strengths, Opportunities for Improvement, and Recommendations Related to CAHPS**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths for the KidsCare Program:<br>• The KidsCare Program's member experience rating for *Getting Needed Care* met or exceeded the 75th percentile for the general child population. **[Quality, Access]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| • The KidsCare Program's member experience ratings for *Getting Care Quickly*, *Access to Specialized Services,* and *FCC: Getting Needed Information* met or exceeded the 75th percentiles for the CCC population. **[Quality, Timeliness, Access]**<br>• The KidsCare Program's 2023 scores were not statistically significantly higher than the 2022 scores; therefore, no substantial strengths were identified for trend results. |
| **Opportunities for Improvement and Recommendations** |
| HSAG identified the following opportunities for improvement for the KidsCare Program:<br>• The KidsCare Program's member experience rating for *Rating of Health Plan*, *Rating of All Health Care, Rating of Personal Doctor*, *Getting Care Quickly*, and *Coordination of Care* were below the 25th percentiles for the general child population. **[Quality, Timeliness]**<br>• The KidsCare Program's member experience rating for *Rating of All Health Care, Rating of Specialist Seen Most Often*, *Coordination of Care*, and *FCC: Personal Doctor Who Knows Child* were below the 25th percentiles for the CCC population. **[Quality]**<br>• The KidsCare Program's member experience rating for *Customer Service* was between the 25th and 49th percentiles for the general child population. **[Quality]**<br>• The KidsCare Program's member experience rating for *Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Needed Care*, and *Access to Prescription Medicines* were between the 25th and 49th percentiles for the CCC population. **[Quality, Access]**<br>• The KidsCare Program's 2023 scores for *Rating of Health Plan* and *Coordination of Care* were statistically significantly lower than the 2022 scores for the general child population. **[Quality]**<br><br>Recommendation: HSAG recommends that the KidsCare Program Contractors explore what may be driving lower experience scores and develop initiatives designed to improve quality and access to care, including a focus on improving parents'/caretakers' overall experiences with the health plan, healthcare, personal doctor, access to care in a timely manner, access to prescription medicines, coordination of care, and customer service for child members. |

# 5. ACC Program Contractor-Specific Results

ACC and ACC-Regional Behavioral Health Agreement (ACC-RBHA) Contractors are responsible for the provision of services under the ACC Program.

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

## AzCH-CCP ACC-RBHA

### *Validation of Performance Measures*

#### Results for Information Systems Standards Review

During CYE 2023, HSAG evaluated AzCH-CCP ACC-RBHA's data system for processing of each data type used for reporting the Contractor's CY 2022 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that AzCH-CCP ACC-RBHA followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-1 displays HSAG's PMV findings for each data type reviewed during CYE 2023 in alignment with the CMS EQR Protocol 2 audit requirements.

**Table 5-1—CYE 2023 PMV Findings**

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

#### Results for Performance Measures

Table 5-2 presents the CY 2021 and CY 2022 AzCH-CCP ACC-RBHA performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for

HEDIS MY 2021 and MY 2022. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and/or MY 2022. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

**Table 5-2—CY 2021 and CY 2022 AzCH-CCP ACC-RBHA Performance Measure Results**

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| ***Maternal and Perinatal Care*** | | | | |
| ***Prenatal and Postpartum Care*** | | | | |
| *Timeliness of Prenatal Care#+* | 77.9%+ | 82.7%+ | → | ★★ |
| *Postpartum Care+* | 67.9%+ | 66.4%+ | → | ★ |
| ***Behavioral Health*** | | | | |
| ***Antidepressant Medication Management*** | | | | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | 60.6% | 60.5% | → | ★★ |
| *Effective Continuation Phase Treatment—Total (18+ Years)* | 42.7% | 41.4% | → | ★★ |
| ***Follow-Up After ED Visit for Substance Use*** | | | | |
| *7-Day Follow-Up—Total* | — | 30.6% | — | ★★★★ |
| *30-Day Follow-Up—Total* | — | 39.7% | — | ★★★ |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 41.1% | 44.5% | ↑ | ★★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 60.5% | 61.3% | → | ★★★ |
| ***Follow-Up After ED Visit for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 47.7% | 50.8% | → | ★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 57.8% | 60.0% | → | ★★★ |
| ***Use of Opioids at High Dosage*** | | | | |
| *18+ Years** | 8.3% | 6.8% | ↑ | ★★ |
| ***Initiation and Engagement of Substance Use Disorder (SUD) Treatment*** | | | | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | — | 52.3% | — | ★★★★ |
| *Engagement of SUD Treatment—Total—Total (13+ Years)* | — | 21.2% | — | ★★★★ |
| ***Adherence to Antipsychotic Medications for Individuals with Schizophrenia*** | | | | |
| *18+ Years* | — | 43.5% | — | ★ |

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| ***Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication*** | | | | |
| *18–64 Years* | — | 78.2% | — | ★★ |
| ***Care of Acute and Chronic Conditions*** | | | | |
| ***Controlling High Blood Pressure*** | | | | |
| *18–85 Years*+ | 51.1%+ | 50.6%+ | → | ★ |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | | | | |
| *HbA1c Control (<8.0 Percent)—Total (18–75 Years)* + | — | 51.6%+ | — | ★★ |
| *HbA1c Poor Control (>9.0 Percent)—Total (18–75 Years)*+* | 39.4%+ | 36.3%+ | → | ★★★ |
| ***Pediatric Health*** | | | | |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotics*** | | | | |
| *Blood Glucose Testing—Total (1–17 Years)* | 63.4% | 62.5% | → | ★★★★ |
| *Cholesterol Testing—Total (1–17 Years)* | 52.4% | 54.7% | → | ★★★★★ |
| *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* | 51.8% | 52.7% | → | ★★★★★ |
| ***Childhood Immunization Status***** | | | | |
| *Combination 3*+ | 65.7% | 64.0% | → | ★★★ |
| *Combination 7*+ | 59.4% | 56.2% | → | ★★★ |
| *Combination 10*+ | 38.2% | 28.5% | ↓ | ★★ |
| ***Developmental Screening in the First Three Years of Life*** | | | | |
| *Total (0–3 Years)* +N | — | 45.3% | — | — |
| ***Immunizations for Adolescents*** | | | | |
| *Combination 1 (Meningococcal, Tdap)* + | 89.3% | 84.9% | → | ★★★ |
| *Combination 2 (Meningococcal, Tdap, HPV)* + | 41.1% | 46.0% | → | ★★★★ |
| ***Oral Evaluation, Dental Services*** | | | | |
| *Total (0–20 Years)* N | — | 46.2% | — | — |
| ***Well-Child Visits in the First 30 Months of Life*** | | | | |
| *Six or More Well-Child Visits* | 60.6% | 60.7% | → | ★★★ |
| *15 Months–30 Months—Two or More Well-Child Visits* | — | 58.1% | — | ★ |

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| ***Child and Adolescent Well-Care Visits*** | | | | |
| *Total (3–21 Years)* | 41.5% | 46.4% | ↑ | ★★ |
| ***Preventive Screening*** | | | | |
| ***Breast Cancer Screening*** | | | | |
| *Total (50–74 Years)* | 51.5% | 53.9% | ↑ | ★★★ |
| ***Cervical Cancer Screening*** | | | | |
| *21–64 Years*+ | 55.5%+ | 53.3%+ | → | ★★ |
| ***Appropriate Utilization of Services*** | | | | |
| ***Ambulatory Care*** | | | | |
| *Emergency Department (ED) Visits—Total (0–85+ Years)* F | 467.2 | 482.7 | — | — |
| ***Plan All-Cause Readmissions*** | | | | |
| *Observed Readmissions—Total (18–64 Years)* | 9.3% | 12.4% | ↓ | — |
| *Expected Readmissions—Total (18–64 Years)* | — | 11.0% | — | — |
| *Outlier Rate—Total (18–64 Years)* | — | 55.1 | — | — |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)** | 0.9960 | 1.1185 | — | ★ |

* A lower rate indicates better performance for this measure.
**Table A-1 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
+ Indicates the measure was reported using hybrid methodology.
# Caution should be considered when comparing CY 2021 to CY 2022 results as changes to the measure specifications occurred.
Cells shaded green indicate that the rate met or exceeded the MY 2021 and/or MY 2022 national Medicaid mean.
— Indicates a 2021–2022 comparison is not presented in the CYE 2023 Annual Technical Report because either the CY 2021 rate was not presented in the CYE 2022 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
↑ Indicates improvement of measure rates.
↓ Indicates decline of measure rates.
→ Indicates stable measure rates.
[2] Performance Levels for CY 2022 were based on comparisons of the HEDIS MY 2022 measure rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks.
Performance Levels for 2022 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile
N Measure has no NCQA Medicaid mean for comparison.
F NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.

## Strengths, Opportunities for Improvement, and Recommendations

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

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

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| In the Behavioral Health measure group:<br>• Eight of 13 (61.5 percent) AzCH-CCP ACC-RBHA measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 **[Quality, Timeliness, Access]**<br>– *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total and 30-Day Follow-Up—Total*<br>– *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)*<br>– *Follow-Up After ED for Mental Illness—7-Day Follow-Up—Total (6+ Years) and 30-Day Follow-Up—Total (6+ Years)*<br>– *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years) and Engagement of SUD Treatment—Total—Total (13+ Years)*<br>• AzCH-CCP ACC-RBHA's performance measure rates for *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years*) and *Engagement of SUD Treatment—Total—Total (13+ Years*) *were* at or above the 75th percentile, indicating that most members with diagnosed SUD initiated treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth treatment, or MAT within 14 days of diagnosis and had two more or more additional SUD services or medications within 34 days of the initiation visit.[5-1] **[Quality, Timeliness, Access]** |
| In the Pediatric Health measure group:<br>• Eight of 13 (61.5 percent) AzCH-CCP ACC-RBHA measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 **[Quality, Timeliness, Access]**<br>– *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total (1–17 Years), Cholesterol Testing—Total (1–17 Years),* and *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* |

[5-1] National Committee for Quality Assurance. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment. Available at https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/. Accessed on: Jan 25, 2024

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| – *Childhood Immunization Status—Combination 3 and Combination 7*<br>– *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*<br>– *Well-Child Visits in the First 30 Months of Life—Six or More Well-Child Visits*<br>• AzCH-CCP ACC-RBHA's performance measure rate for *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* was at or above the 75th percentile, indicating that most adolescents were receiving one dose of meningococcal vaccine, one Tdap [tetanus, diphtheria, pertussis] vaccine, and the complete HPV vaccine series by their 13th birthday. Receiving recommended vaccinations is the best defense against serious vaccine-preventable diseases, including meningococcal meningitis, tetanus, diphtheria, pertussis (whooping cough), and HPV.[5-2] [**Quality, Access**]<br>• AzCH-CCP ACC-RBHA's performance measure rates for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total (1–17 Years), Cholesterol Testing—Total (1–17 Years),* and *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* were at or above the 75th percentile, indicating that most children and adolescents with ongoing antipsychotic medication use had metabolic testing performed. Metabolic monitoring (blood glucose and cholesterol testing) is an important component of ensuring appropriate management of children and adolescents on antipsychotic medications.[5-3] [**Quality**] |
| **Opportunities for Improvement and Recommendations** |
| While AzCH-CCP ACC-RBHA was successful in reporting valid rates for all AHCCCS-required performance measures for its ACC population, the audit identified some considerations and recommendations for future years' reporting. **[Quality]**<br><br>Recommendations: HSAG recommends that AzCH-CCP ACC-RBHA continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. Additionally, HSAG recommends that AzCH-CCP ACC-RBHA continue to conduct a formal review of its source code followed by a complete test plan, including live system validation of data, prior to reporting any performance measure data. |
| In the Maternal and Perinatal Care measure group, AzCH-CCP ACC-RBHA's performance measure rate for *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, indicating an opportunity to increase access to timely postpartum care. **[Quality, Timeliness, Access]**<br><br>Recommendations: While AzCH-CCP ACC-RBHA conducted a root cause analysis and implemented targeted interventions specific to the CY 2021 *Prenatal and Postpartum Care—* |

[5-2] National Committee for Quality Assurance. Immunizations for Adolescents. Available at: https://www.ncqa.org/hedis/measures/immunizations-for-adolescents/. Accessed on: Feb 15, 2024.
[5-3] National Committee for Quality Assurance. Metabolic Monitoring for Children and Adolescents on Antipsychotics. Available at: https://www.ncqa.org/hedis/measures/metabolic-monitoring-for-children-and-adolescents-on-antipsychotics/. Accessed on: Feb 15, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
| --- |
| Recommendations: While AzCH-CCP ACC-RBHA conducted a root cause analysis and implemented targeted interventions specific to the CY 2021 *Prenatal and Postpartum Care—Timeliness of Postpartum Care* rate, this rate remained low in CY 2022; therefore, HSAG recommends that AzCH-CCP ACC-RBHA continue to implement appropriate interventions to improve performance relative to prenatal and postpartum care. HSAG also recommends that AzCH-CCP ACC-RBHA monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Postpartum Care* measure indicators. |
| In the Care of Acute and Chronic Conditions measure group, AzCH-CCP ACC-RBHA's performance measure rate for *Controlling High Blood Pressure—18–85 Years* fell below the 25th percentile, indicating that some adult members with hypertension did not have adequately controlled blood pressure. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[5-4] **[Quality]** |
| Recommendations: HSAG recommends that AzCH-CCP ACC-RBHA monitor and expand on its previously implemented interventions to members optimally managing their high blood pressure. AzCH-CCP ACC-RBHA should continue to assess new barriers that members experience related to controlling high blood pressure and submit the results of its continuous barrier assessments and implemented interventions as required by AHCCCS. |

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

Table 5-4 presents performance measure recommendations made to AzCH-CCP ACC in the CYE 2022 Annual Technical Report[5-5] and AzCH-CCP ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which AzCH-CCP ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

[5-4] National Committee for Quality Assurance. Controlling High Blood Pressure. Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Jan 31, 2024.

[5-5] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP) Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 1, 2024

**Table 5-4—AzCH-CCP ACC-RBHA Follow-Up to CYE 2022 Performance Measure Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| **Recommendation 1:** |
| HSAG recommended that AzCH-CCP ACC continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. Additionally, HSAG recommended that AzCH-CCP ACC continue to conduct a formal review of its source code followed by a complete test plan, including live system validation of data, prior to reporting any performance measure data. |
| **AzCH-CCP ACC-RBHA's Response:** |
| AzCH-CCP ACC is continuing to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV Reporting.<br><br>AzCH-CCP ACC is continuing to conduct and complete formal reviews of the source code, including a complete test plan and live system validation of data, and will correct any discrepancies identified. |
| **HSAG's Assessment:** |
| HSAG determined that AzCH-CCP ACC-RBHA satisfactorily addressed these prior year's recommendations. |
| **Recommendation 2:** |
| HSAG recommended that AzCH-CCP ACC explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratifications related to race and ethnicity. AzCH-CCP ACC should continue working with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information. |
| **AzCH-CCP ACC-RBHA's Response:** |
| AzCH-CCP ACC's corporate partner has implemented software which predicts indirect cultural data for adult members with 99% accuracy. This assists AzCH-CCP ACC in providing additional data sources for the capture of race and ethnicity data.<br><br>AzCH-CCP ACC participates in the AZHIP Data Advisory Committee where one of the focuses is gathering cultural data and identifying additional sources and opportunities. AzCH-CCP ACC also participates in the AHCCCS TI 2.0 Workgroup whose current focus is on health equity. |
| **HSAG's Assessment:** |
| HSAG determined that AzCH-CCP ACC-RBHA satisfactorily addressed these prior year's recommendations. |
| **Recommendation 3:** |
| While AzCH-CCP ACC conducted a root cause analysis and implemented targeted interventions specific to its CY 2020 *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* rates, these rates remained low in CY 2021; therefore, HSAG recommended that AzCH-CCP ACC continue to implement appropriate interventions to improve performance relative to prenatal and |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| postpartum care. HSAG also recommends that AzCH-CCP ACC monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators. |
| **AzCH-CCP ACC-RBHA's Response:**<br>The performance measure rate for *Prenatal and Postpartum Care—Postpartum Care (PPC)* fell below the 25th percentile, indicating an opportunity to increase access to timely postpartum care. AzCH-CCP ACC performed a root cause analysis that focused on increasing access to postpartum care by identifying those barriers, such as collaboration with providers and the health plan, successful communication with members, and effective gap lists. Interventions in place include:<br>• Start Smart for Your Baby effectively educates and encourages members via text messaging and emails. In CY 2022 a total of 3,555 members were enrolled.<br>• The PPC Provider Forum supplies providers with materials and engages providers with education, technical assistance, and performance improvement.<br>• Implementation of a mobile application that provides a specialized care plan for members with tailored daily health check lists, provides alerts, care gaps, progress tracking to CMS benchmarks, and allows for two-way video/text communication with care management.<br>• Implementation of a new NCQA accredited self-management tool on the member portal in Q1 2023 to increase members' confidence and positive improvement in members' health.<br>• Weekly Newborn Calls outreach to birthing parents and educate and assist with scheduling postpartum appointments. In CY 2022, 6,128 calls were attempted with 1,369 members reached at a 22.3% reach rate.<br>• Weekly Notice of Pregnancy reports are sent to strategic partners and provider groups for member outreach. The goal of this report is to create a proactive outreach list so members can be engaged early with prenatal care and educated about the importance of postpartum care, available resources, and community supports.<br>• In addition, in CY 2023 AzCH-CCP ACC implemented an internal workgroup to identify additional opportunities for interventions to increase performance. |
| **HSAG's Assessment:**<br>AzCH-CCP ACC-RBHA identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that AzCH-CCP ACC-RBHA satisfactorily addressed these prior year's recommendations. |
| **Recommendation 4:** |
| HSAG recommended that AzCH-CCP ACC identify best practices to support children in receiving well-care visits. HSAG also recommended that AzCH-CCP ACC consider conducting a root cause analysis to identify barriers that members are experiencing in accessing care and services in order to implement appropriate interventions to improve performance related to timely well-care visits. |
| **AzCH-CCP ACC-RBHA's Response:**<br>AzCH-CCP ACC's performance measure rate for *Child and Adolescent Well-Care Visits (WCV)—Total* fell below the 25th percentile, indicating that children and adolescents were not always |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| accessing well-child visits. AzCH-CCP ACC performed a root cause analysis that focused on improving access to care. The barriers identified were lack of encouragement and a need to increase collaboration with providers and the health plan. In response to identified barriers, the following interventions were implemented:<br>• Utilization of a member rewards program to incentivize members for completing annual well visits; in CY 2022 the WCV reward was the highest obtained with a total of 53,838 rewards provided.<br>• Blitz Call Campaign to educate on the importance of annual wellness visits and assist members with scheduling appointments.<br>• Deployment of an updated EPSDT Provider Quick Reference Guide that allows for collaboration with providers and the health plan, providing educational material regarding how to reduce no shows and missed appointments and scheduling follow-up appointments before the member leaves the office.<br>• Outreach members to encourage them to attend community events that provided annual checkups and complete needed screenings. During CY 2022 the health plan outreached over 7,500 members/healthcare decision makers via email.<br>• Milestone text messaging to the member or the member's healthcare decision maker to encourage attendance for the annual well visits; in CY 2022 AzCH-CCP ACC deployed a total of 317,548 outreach attempts with an engagement rate of 75.2%.<br>• In addition, in CY 2023 AzCH-CCP ACC implemented a collaborative project with specific strategic partners to outreach historically difficult-to-engage members and offer in-home or telehealth visits to increase access and availability of care. |
| **HSAG's Assessment:**<br>AzCH-CCP ACC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that AzCH-CCP ACC-RBHA satisfactorily addressed these prior year's recommendations. |
| **Recommendation 5:** |
| HSAG recommended that AzCH-CCP ACC conduct a root cause analysis to determine why some members were not managing their high blood pressure optimally. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. AzCH-CCP ACC should consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). Additionally, AzCH-CCP ACC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, HSAG recommended that AzCH-CCP ACC implement appropriate interventions to improve performance related to this chronic condition. |
| **AzCH-CCP ACC-RBHA's Response:**<br>AzCH-CCP ACC's performance measure rates for *Controlling High Blood Pressure* fell below the 25th percentile, indicating that most members were not managing their high blood pressure properly. AzCH-CCP ACC performed a root cause analysis that focused on assisting members in maintaining |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| their chronic health conditions at optimal levels. The barriers identified were minimal member-focused interventions, lack of provider utilization of supplemental feeds, and lack of CPT Category II code utilization to close care gaps. In response to identified barriers, the following interventions were implemented:<br>• Supplemental data feeds have been effective in providing additional clinical data about a member beyond claims data. Supplemental data feeds may include the use of CPT Category II codes for reporting a clinical result, such as blood pressure.<br>• A Coding for Quality Reference Guide is distributed to providers during provider meetings.<br>• Identified opportunity to increase education to providers by incorporating Path to 5 to target larger audiences.<br>• Implementation of member-facing educational materials to educate on the importance of members engaging with their provider and having their blood pressure checked regularly. |
| **HSAG's Assessment:**<br>AzCH-CCP ACC-RBHA identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that AzCH-CCP ACC-RBHA satisfactorily addressed these prior year's recommendations. |

## *Validation of Performance Improvement Projects*

### Back to Basics PIP

In CYE 2023, AzCH-CCP ACC-RBHA continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 1, PIP validation activities focused on improvement from the baseline results. AzCH-CCP ACC-RBHA submitted Remeasurement 1 performance indicator results and interventions implemented during CY 2022 along with the status of interventions, focus, and rationale for changes or discontinuation of the interventions.

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

### *Validation Results*

Table 5-5 displays the overall confidence levels for the AzCH-CCP ACC-RBHA *Back to Basics* PIP.

**Table 5-5—AzCH-CCP ACC-RBHA *Back to Basics* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| AzCH-CCP ACC-RBHA | *High Confidence* | 100% | 100% | *No Confidence* | 33% | 100% |

### *Measure Results*

Table 5-6 and Table 5-7 provide the *Back to Basics* PIP baseline, intervention, and Remeasurement Year 1 rates for each indicator for AzCH-CCP ACC-RBHA.

**Table 5-6—AzCH-CCP ACC-RBHA *Back to Basics* PIP Rates for PIP Indicator 1**

| Contractor | PIP Indicator 1: *W30 Rate 1* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| AzCH-CCP ACC-RBHA | 63.2% | 60.7% |

**Table 5-7—AzCH-CCP ACC-RBHA *Back to Basics* PIP Rates for PIP Indicator 2**

| Contractor | PIP Indicator 2: *WCV* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| AzCH-CCP ACC-RBHA | 46.9% | 46.4% |

### *Interventions*

Table 5-8 presents PIP interventions for AzCH-CCP ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 5-8—AzCH-CCP ACC-RBHA *Back to Basics* PIP Interventions**

| Contractor | Interventions |
|---|---|
| AzCH-CCP ACC-RBHA | • AzCH-CCP ACC Data Analytics will provide a report indicating all children and adolescents who need to complete their well visits and dental visits, and the percentage of children who completed their well visits and dental visits. The EPSDT team and the Quality Improvement team will analyze the data quarterly.<br>• Revamp the EPSDT first and second reminder and change it from a letter to an age-specific postcard, adding developmental screenings at appropriate periodicity.<br>• The outreach call spreadsheet will now include a reminder task for the EPSDT coordinator to remind the parent of a developmental screening.<br>• The EPSDT coordinator will conduct 20 provider site visits per month. These visits educate providers about scheduling well visits, completing developmental screenings, and referring children to the dentists for their assigned members. During the site visit, the EPSDT coordinator gives the PCP a list of their members with a periodicity schedule and EPSDT materials.<br>• The EPSDT team will present about completing well visits, referring to the dentist, and completing a developmental tool at the provider forums.<br>• Retrain the EPSDT staff to engage the member by conducting a three-way call to the doctor's office.<br>• Address barriers when a member does not show up to a scheduled appointment, including transportation.<br>• Promote the AzCH My Health Pays Rewards (MHP) program.<br>• Conduct provider fax blast communications which will educate providers about the available developmental screening tools.<br>• Utilize community outreach workers to engage members in the community.<br>• Path to 5 is distributed to providers to educate on quality and performance measures.<br>• Outreach members via Short Message Service (SMS) text messaging.<br>• Conduct dental workgroups which review ongoing provider performance.<br>• Back to School event outreaches members to encourage them to attend events to help complete needed screenings.<br>Planned Interventions:<br>• The health plan will maintain a report gap analysis on KidsCare versus ACC to complete specific outreach to KidsCare members with open care gaps.<br>• Collaborate with providers through Provider Office Outreach and look closely at KidsCare engagement around annual visits.<br>• Through member outreach (e.g., SMS texts, emails, postcards, and telephone) identify KidsCare members and encourage and educate on the importance of annual visits. |

### *Strengths, Opportunities for Improvement, and Recommendations*

Table 5-9 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC-RBHA related to the *Back to Basics* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-9—AzCH-CCP ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG noted that AzCH-CCP ACC-RBHA performed accurate statistical testing between the baseline and Remeasurement 1 results. **[Quality, Access]**<br><br>AzCH-CCP ACC-RBHA developed and implemented measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 2. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| For indicator 1, AzCH-CCP ACC-RBHA had a decline of 2.46 percentage points in the indicator rate between the baseline year and Remeasurement Year 1. AzCH-CCP ACC-RBHA had a decline of 0.51 percentage point in the indicator rate between the baseline year and Remeasurement Year 1 for indicator 2. **[Quality, Access]**<br><br>Recommendations: As the PIP progresses, HSAG recommends that AzCH-CCP ACC-RBHA:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

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

Table 5-10 presents PIP recommendations made to AzCH-CCP ACC in the CYE 2022 Annual Technical Report[5-6] and AzCH-CCP ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which AzCH-CCP ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language

[5-6] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP) Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 8, 2024.

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

**Table 5-10—AzCH-CCP ACC-RBHA Follow-Up to CYE 2022 PIP Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| HSAG recommended that AzCH-CCP ACC:<br>• Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary.<br>• Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available.<br>• Develop and document a plan for sustaining the improvement for any demonstrated improvement in indicator rates. |
| **AzCH-CCP ACC-RBHA's Response:**<br>AzCH-CCP ACC identified the following barriers to aid in focusing interventions to better engage members in care:<br>• Ineffective tracking of healthcare gaps.<br>• Lack of education on the importance of annual visits.<br>• Lack of encouragement.<br>• Need to increase collaboration with providers and the health plan.<br><br>AzCH-CCP ACC has assessed the impact and effectiveness of the following interventions during the first remeasurement year: |

| Interventions Assessment | |
|---|---|
| **Interventions** | **Impact/Effectiveness** |
| AzCH-ACC Data Analytics will provide a report indicating all children and adolescents who need to complete their well visits and dental visits, and the percentage of children who completed their well visits and dental visits. The EPSDT team and the Quality Improvement team will analyze the data quarterly. | This intervention's expected impact is to improve tracking and monitoring via monthly gap reports. |
| Revamp the EPSDT first and second reminder and change it from a letter to an age-specific postcard, adding developmental screenings at appropriate periodicity. | This intervention's expected impact is to increase well-child visits per the developmental screenings at appropriate periodicity. |

| Prior Year's Recommendation from the EQR Technical Report for PIPs | |
|---|---|
| The outreach call spreadsheet will now include a reminder task for the EPSDT coordinator to remind the parent of a developmental screening. | This intervention's expected impact is to ensure EPSDT coordinators are consistently reminding members of developmental screenings and their importance. |
| The EPSDT coordinator will conduct 20 provider site visits per month. These visits educate providers about scheduling well visits, completing developmental screenings, and referring children to the dentist for their assigned members. During the site visit, the EPSDT coordinator gives the PCP a list of their members with a periodicity schedule and EPSDT materials. | This intervention's expected impact is to increase provider education around well-child visits, completing developmental screenings, and providing useful EPSDT material to providers. |
| The EPSDT team will present about completing well visits, referring to the dentist, and completing a developmental tool at the provider forums. | The EPSDT team will present about completing well visits, referring to the dentist, and completing a developmental tool at the provider forums. |
| Retrain the EPSDT staff to engage the member by conducting a three-way call to the doctor's office. | This intervention's expected impact is to improve EPSDT staff's communication with doctors' offices. |
| Address barriers when a member does not show up to a scheduled appointment, including transportation. | This intervention's expected impact is to address and reduce barriers around no-shows to scheduled appointments. |
| Promote the AzCH MHP Rewards program. | This intervention's expected impact is to increase member engagement and increase well-child visits and annual dental visits. |
| Conduct provider fax blast communications which will educate providers about the available developmental screening tools. | This intervention's expected impact is to increase provider engagement around developmental screening tools. |
| Utilize community outreach workers to engage members in the community. | This intervention's expected impact is to increase member engagement. |
| Path to 5 is distributed to providers to educate on quality and performance measures. | This intervention's expected impact is to educate providers. |

| Prior Year's Recommendation from the EQR Technical Report for PIPs | |
|---|---|
| Outreach members via SMS text messaging. | This interventions' expected impact is to improve the health plan's communication with members. |
| Conduct dental workgroups which review ongoing provider performance. | This intervention's expected impact is to educate and improve provider's performance around annual dental visits. |
| Back to School event outreaches members to encourage them to attend events to help complete needed screenings. | This intervention's expected impact is to increase needed screenings and educate members. |

AzCH-CCP ACC's plan for sustaining improvement in indicator rates will be analyzed via the Plan Do Study Act (PDSA) cycle to ensure that ongoing improvement and appropriate corrections are made. Indicator rates along with their identified interventions are evaluated via specific intervention PDSA cycles and during Performance Improvement Subcommittees' monthly meetings and Quality Improvement Committees' quarterly meetings. Additionally, indicator rates and interventions are monitored through the Performance Measure Monitoring Report (PMMR) to ensure performance improvement during each quarter.

- By the end of CY 2022, the MHP WCV reward was the highest obtained reward with a total of 53,838 rewarded.
- A total of 85,129 MHP Dental rewards were earned in CY 2022.
- In CY 2022, for child and adolescent well visit reminders, the SMS text outreach engaged 75.2% of members with an open care gap (total of 317,548 attempts), the well-child visits for the first 30 months of life (0–15), SMS text outreach had an engagement rate of 78.3% (total of 152,042 attempts), and the annual dental visit SMS text outreach ended the year with an engagement rate of 74.8% (total of 399,827 attempts).
- In CY 2022 Q3, Keeping Kids Healthy helped outreach to over 7,500 members via email to encourage them to attend events that would complete needed screenings.

**HSAG's Assessment:** HSAG determined that AzCH-CCP ACC-RBHA satisfactorily addressed these prior year's recommendations.

### Prenatal and Postpartum Care PIP

In CYE 2023, AzCH-CCP ACC-RBHA submitted baseline measurement results for the *Prenatal and Postpartum Care* PIP. AzCH-CCP ACC-RBHA submitted baseline performance indicator results and interventions implemented.

HSAG conducted an annual validation of the baseline year reflective of CY 2022 (January 1, 2022, through December 31, 2022) using AHCCCS-calculated and validated indicator rates. HSAG evaluated AzCH-CCP ACC-RBHA's performance indicator results based on an analysis of improvement

strategies implemented as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

### *Validation Results*

Table 5-11 displays the overall confidence levels for the AzCH-CCP ACC-RBHA *Prenatal and Postpartum Care* PIP.

**Table 5-11—AzCH-CCP ACC-RBHA *Prenatal and Postpartum Care* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| AzCH-CCP ACC-RBHA | *High Confidence* | 100% | 100% | *Not Assessed* | *Not Assessed* | *Not Assessed* |

### *Measure Results*

Table 5-12 and Table 5-13 provide the *Prenatal and Postpartum Care* PIP baseline rates for each indicator for AzCH-CCP ACC-RBHA.

**Table 5-12—AzCH-CCP ACC-RBHA *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 1**

| Contractor | PIP Indicator 1: *Timeliness of Prenatal Care* |
|---|---|
| | Baseline Year |
| | CY 2022 |
| AzCH-CCP ACC-RBHA | 82.7% |

**Table 5-13—AzCH-CCP ACC-RBHA *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 2**

| Contractor | PIP Indicator 2: *Postpartum Care* |
|---|---|
| | Baseline Year |
| | CY 2022 |
| AzCH-CCP ACC-RBHA | 66.4% |

### *Interventions*

Table 5-14 presents PIP interventions for AzCH-CCP ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 5-14—AzCH-CCP ACC-RBHA *Prenatal and Postpartum Care* PIP Interventions**

| Contractor | Interventions |
|---|---|
| AzCH-CCP ACC-RBHA | • Start Smart for Your Baby (SSFB) program, enrollment into care management (until 6 weeks after delivery).<br>• Envolve People Care (EPC), a self-management tool to provide prenatal resources and support that members are able to access via the AzCH-CCP member portal.<br>• Wellframe Mobile Application, a mobile app that provides a specialized care plan (based on certain tracks) for members with a specialized daily health checklist; provider alerts, care gaps, and progress tracking to CMs; allows for two-way video/text communication with Care Management.<br>• QI and MCH/CM collaboration to build a proactive outreach program.<br>• Notice of Pregnancy Reports are sent to strategic partners and federally qualified health centers (FQHCs) to begin outreach and engage members in a timely manner for prenatal and postpartum care. The report is now automated to reduce manual requirements.<br>• The PPC Workgroup is an internal monthly workgroup to include CM, QM, and other stakeholders to increase prenatal/postpartum outcome measures.<br>• A Strategic Partner Collaboration to target members for prenatal care. Strategic partners assist by outreaching, scheduling, and completing in-home or telehealth visits with appropriate physicians.<br>• Krames, an NCQA accredited self-management tool able to provide multiple resources, support, and education across a variety of topics inclusive of PPC, is accessible through the member portal.<br>• A Health Equity Dashboard provides a method to assess HEDIS measures by race and ethnicity, ZIP Code hot spotting (determined by rate of disparity for HEDIS) for aggregate or specific measures, year-over-year comparisons with tables, and run charts.<br>• Health Equity Committee coordination with the PPC Workgroup.<br>• A HEDIS Stratification Dashboard will provide an NCQA directed race and ethnicity stratification of applicable HEDIS performance measure. |

### *Strengths, Opportunities for Improvement, and Recommendations*

Table 5-15 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC-RBHA related to the *Prenatal and Postpartum Care* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-15—AzCH-CCP ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to the *Prenatal and Postpartum Care* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| AzCH-CCP ACC-RBHA developed and implemented measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 1. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| For indicator 1, 82.7 percent of women had a prenatal care visit in the first trimester and 66.4 percent had a postpartum visit between seven and 84 days after delivery during CYE 2022. **[Quality, Access]**<br><br>Recommendations: As the PIP progresses, HSAG recommends that AzCH-CCP ACC-RBHA:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

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

The *Prenatal and Postpartum Care* PIP was initiated in CY 2022; therefore, this section is not applicable.

## *Compliance Reviews*

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

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

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

ACC-RBHA contract began October 1, 2022. The compliance review for the ACC-RBHA Program will be conducted in CYE 2024 and will therefore be included in the CYE 2024 annual technical report.

## Network Adequacy Validation

### Results

HSAG evaluated AzCH-CCP ACC-RBHA's compliance results with AHCCCS' time/distance standards by geographic service areas (GSA) and county. This section presents semiannual validation findings specific to the ACC Program, with one results table for each of the following GSAs:

- Central GSA: Gila, Maricopa,[5-7] and Pinal counties
- South GSA: Cochise, Graham,[5-8] Greenlee, La Paz, Pima, Santa Cruz,[5-9] and Yuma counties

Each region-specific table summarizes semiannual validation results containing the percentage of members meeting each time/distance standard by quarter and county, with color-coding to identify whether or not the time/distance standard was "*Met*" or "*Not Met*."

The value "NA" is shown for time/distance standards that do not apply to the county or program.

The value "NR" is shown for time/distance standards in which no members met the network requirement denominator for the program and county; therefore, HSAG calculated no corresponding time/distance result.

Yellow color-coding identifies instances in which HSAG's time/distance results met the minimum network requirement but differed from the ACOM 436 results.

Red color-coding identifies instances in which HSAG's time/distance results did not meet the compliance standard, regardless of the ACOM 436 results.

An asterisk (*) indicates that fewer than 10 members were included in the denominator of HSAG's results.

A carat (^) indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

[5-7] Maricopa County includes the 85342, 85358, and 85390 ZIP Codes; these ZIP Codes are physically located in both Maricopa and Yavapai counties.
[5-8] Graham County includes the 85542, 85192, and 85550 ZIP Codes representing the San Carlos Tribal area; these ZIP Codes are physically located in Gila or Pinal County.
[5-9] Santa Cruz County includes the 85645 ZIP Code; this ZIP Code is physically located in both Pima and Santa Cruz counties.

**Table 5-16—AzCH-CCP ACC-RBHA Time/Distance Validation Results for Central GSA—Percentage of Members Meeting Minimum Network Requirements**

| | Gila | | Maricopa | | Pinal | |
|---|---|---|---|---|---|---|
| Minimum Network Requirement | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0^ | 100.0^[3] | 98.8^ | 99.2^[3] | 100.0^ | 100.0^[3] |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 100.0^ | 100.0^[3] | 98.9^ | 99.2^[3] | 100.0^ | 100.0^[3] |
| BHRF | NA | NA | 98.9 | 99.2 | NA | NA |
| Cardiologist, Adult | 100.0^ | 100.0^[3] | 99.7^ | 100.0^[3] | 100.0^ | 100.0^[3] |
| Cardiologist, Pediatric | 100.0^ | 100.0^[3] | 100.0^ | 100.0^[3] | 100.0^ | 100.0^[3] |
| Dentist, Pediatric | 100.0 | 100.0 | 99.3 | 99.3 | 100.0 | 99.6 |
| Hospital | 100.0 | 100.0 | 99.8 | 100.0 | 100.0 | 100.0 |
| OB/GYN | 100.0 | 100.0[3] | 99.9 | 100.0[3] | 100.0 | 100.0[3] |
| Pharmacy | 100.0 | 100.0 | 99.0 | 99.1 | 100.0 | 100.0 |
| PCP, Adult | 100.0^ | 100.0^[3] | 99.6^ | 99.7^[3] | 100.0^ | 100.0^[3] |
| PCP, Pediatric | 100.0^ | 100.0^[3] | 99.5^ | 99.7^[3] | 100.0^ | 100.0^[3] |

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

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

NA indicates results are not applicable to the county.

[3] In CYE 2023 Q4, AzCH-CCP ACC-RBHA's data included substantially increased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; Cardiologist, Adult and Pediatric; OB/GYN; and PCP, Adult and Pediatric. This potentially influenced the validated compliance for these provider types. The Contractor reported the increase was due to revisions in its extract file creating the PAT file that included all active provider addresses.

**Table 5-17—AzCH-CCP ACC-RBHA Time/Distance Validation Results for South GSA—Percentage of Members Meeting Minimum Network Requirements**

| | Cochise | | Graham | | Greenlee | | La Paz | | Pima | | Santa Cruz | | Yuma | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Minimum Network Requirement | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0^ | 100.0^[3] | 100.0^ | 100.0^[3] | 99.8 | 100.0^[3] | 99.5^ | 100.0^[3] | 96.9^ | 99.2^[3] | 100.0^ | 100.0^[3] | 99.8^ | 100.0^[3] |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 100.0^ | 100.0^[3] | 100.0^ | 100.0^[3] | 100.0 | 100.0^[3] | 99.9^ | 100.0^[3] | 97.0^ | 99.4^[3] | 100.0^ | 100.0^[3] | 99.9^ | 100.0^[3] |

| Minimum Network Requirement | Cochise | | Graham | | Greenlee | | La Paz | | Pima | | Santa Cruz | | Yuma | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Residential Facility (only Maricopa and Pima counties) | NA | NA | NA | NA | NA | NA | NA | NA | 93.1 | 95.3 | NA | NA | NA | NA |
| Cardiologist, Adult | 100.0^ | 100.0^[3] | 100.0^ | 100.0^[3] | 99.8 | 99.8[3] | 100.0^ | 100.0^[3] | 99.3^ | 99.3^[3] | 100.0 | 100.0^[3] | 100.0^ | 100.0^[3] |
| Cardiologist, Pediatric | 100.0^ | 100.0^[3] | 100.0^ | 100.0^[3] | 100.0 | 100.0[3] | 100.0^ | 100.0^[3] | 99.9^ | 99.9^[3] | 100.0 | 100.0^[3] | 100.0^ | 100.0^[3] |
| Dentist, Pediatric | 93.3 | 93.2 | 98.7 | 97.9 | 64.2 | 63.3 | 74.9 | 55.6 | 97.7 | 97.8 | 100.0 | 70.6 | 99.9 | 99.9 |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 99.4 | 99.5 | 100.0 | 100.0 | 100.0 | 100.0 |
| OB/GYN | 100.0 | 100.0[3] | 100.0 | 100.0[3] | 100.0 | 100.0[3] | 100.0 | 100.0[3] | 99.5 | 99.6[3] | 100.0 | 100.0[3] | 100.0 | 100.0[3] |
| Pharmacy | 99.7 | 99.7 | 99.3 | 99.4 | 99.9 | 99.9 | 88.8 | 88.1 | 98.0 | 98.3 | 100.0 | 100.0 | 99.8 | 99.8 |
| PCP, Adult | 99.7^ | 99.8^[3] | 99.0^ | 99.6^[3] | 99.8^ | 99.8^[3] | 99.6^ | 99.6^[3] | 99.7^ | 99.8^[3] | 100.0^ | 100.0^[3] | 99.8^ | 99.8^[3] |
| PCP, Pediatric | 99.7^ | 99.9^[3] | 99.1^ | 99.6^[3] | 100.0^ | 100.0^[3] | 99.8^ | 99.6^[3] | 99.7^ | 99.8^[3] | 100.0^ | 100.0^[3] | 99.9^ | 99.9^[3] |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
represents time/distance standard results that do not meet the compliance standard based on HSAG's results.
^indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.
3 In CYE 2023 Q4, AzCH-CCP ACC-RBHA's data included substantially increased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; Cardiologist, Adult and Pediatric; OB/GYN; and PCP, Adult and Pediatric. This potentially influenced the validated compliance for these provider types. The Contractor reported the increase was due to revisions in its extract file creating the PAT file that included all active provider addresses.

## Strengths, Opportunities for Improvement, and Recommendations

Table 5-18 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC-RBHA related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-18—AzCH-CCP ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to NAV**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths:<br>• AzCH-CCP ACC-RBHA met all time/distance network standards for both quarters in CYE 2023 in Cochise, Gila, Graham, Maricopa, Pima, Pinal and Yuma counties. **[Access]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| • AzCH-CCP ACC-RBHA met the time/distance standards for BHRF; Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; Cardiologist, Adult and Pediatric; Hospital; OB/GYN; and PCP, Adult and Pediatric standards. **[Access]**<br><br>Note: AzCH-CCP ACC-RBHA provides coverage in the following counties: Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Santa Cruz, and Yuma. |
| **Opportunities for Improvement and Recommendations** |
| HSAG identified the following opportunities for improvement:<br>• AzCH-CCP ACC-RBHA failed to meet the time/distance standards for Dentist, Pediatric and Pharmacy. **[Access]**<br><br>Recommendation: HSAG recommends that AzCH-CCP ACC-RBHA maintain current compliance with network standards but continue to address network gaps, as applicable. |

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

Table 5-19 presents NAV recommendations made to AzCH-CCP ACC in the CYE 2022 Annual Technical Report[5-10] and AzCH-CCP ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which AzCH-CCP ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 5-19—AzCH-CCP ACC-RBHA Follow-Up to CYE 2022 NAV Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for NAV |
|---|
| HSAG recommended that AzCH-CCP ACC maintain current compliance with network standards but continue to address network gaps, as applicable. |
| **AzCH-CCP ACC-RBHA's Response:**<br>AzCH-CCP ACC-RBHA did not provide a response to the prior year's recommendation. |
| **HSAG's Assessment:**<br>HSAG has determined that AzCH-CCP ACC-RBHA did not describe specific activities planned to address the recommendation. |

[5-10] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP) Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 8, 2024.

# BUFC ACC

## *Validation of Performance Measures*

### Results for Information Systems Standards Review

During CYE 2023, HSAG evaluated BUFC ACC's data system for processing of each data type used for reporting the Contractor's CY 2022 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that BUFC ACC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-20 displays HSAG's PMV findings for each data type reviewed during CYE 2023 in alignment with the CMS EQR Protocol 2 audit requirements.

**Table 5-20—CYE 2023 PMV Findings**

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

### Results for Performance Measures

Table 5-21 presents the CY 2021 and CY 2022 BUFC ACC performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and MY 2022. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and/or MY 2022. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*).

**Table 5-21—CY 2021 and CY 2022 BUFC ACC Performance Measure Results**

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| ***Maternal and Perinatal Care*** | | | | |
| ***Prenatal and Postpartum Care*** | | | | |
| *Timeliness of Prenatal Care*[#] | 63.2%[+] | 81.5%[+] | ↑ | ★★ |
| *Postpartum Care* | 50.7%[+] | 69.8%[+] | ↑ | ★ |

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| ***Behavioral Health*** | | | | |
| ***Antidepressant Medication Management*** | | | | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | 60.3% | 58.9% | → | ★★ |
| *Effective Continuation Phase Treatment—Total (18+ Years)* | 42.7% | 40.6% | ↓ | ★★ |
| ***Follow-Up After ED Visit for Substance Use*** | | | | |
| *7-Day Follow-Up—Total* | — | 26.5% | — | ★★★ |
| *30-Day Follow-Up—Total* | — | 35.4% | — | ★★ |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 34.9% | 35.6% | → | ★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 50.2% | 50.7% | → | ★★ |
| ***Follow-Up After ED Visit for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 40.9% | 40.3% | → | ★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 50.1% | 50.2% | → | ★★ |
| ***Use of Opioids at High Dosage*** | | | | |
| *18+ Years** | 6.6% | 11.6% | ↓ | ★ |
| ***Initiation and Engagement of Substance Use Disorder (SUD) Treatment*** | | | | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | — | 51.0% | — | ★★★★ |
| *Engagement of SUD Treatment—Total—Total (13+ Years)* | — | 19.8% | — | ★★★★ |
| ***Adherence to Antipsychotic Medications for Individuals with Schizophrenia*** | | | | |
| *18+ Years* | — | 55.2% | — | ★★ |
| ***Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication*** | | | | |
| *18–64 Years* | — | 79.4% | — | ★★★ |
| ***Care of Acute and Chronic Conditions*** | | | | |
| ***Controlling High Blood Pressure*** | | | | |
| *18–85 Years* | 33.6%+ | 60.1%+ | ↑ | ★★ |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | | | | |
| *HbA1c Control (<8.0 Percent)—Total (18–75 Years)* | — | 63.0%+ | — | ★★★★★ |
| *HbA1c Poor Control (>9.0 Percent)—Total (18–75 Years)** | 56.3%+ | 37.0%+ | ↑ | ★★★ |
| ***Pediatric Health*** | | | | |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotics*** | | | | |
| *Blood Glucose Testing—Total (1–17 Years)* | 57.5% | 62.1% | → | ★★★★ |
| *Cholesterol Testing—Total (1–17 Years)* | 42.2% | 49.4% | ↑ | ★★★★ |

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* | 41.3% | 48.4% | ↑ | ★★★★ |
| ***Childhood Immunization Status**** | | | | |
| *Combination 3* | 59.1% | 61.8%+ | → | ★★ |
| *Combination 7* | 53.0% | 56.7%+ | → | ★★★ |
| *Combination 10* | 34.0% | 30.9%+ | → | ★★★ |
| ***Developmental Screening in the First Three Years of Life*** | | | | |
| *Total (0–3 Years)* [N] | — | 41.6%+ | — | — |
| ***Immunizations for Adolescents*** | | | | |
| *Combination 1 (Meningococcal, Tdap)* | 83.9% | 88.1%+ | ↑ | ★★★★ |
| *Combination 2 (Meningococcal, Tdap, HPV)* | 39.5% | 42.3%+ | → | ★★★★ |
| ***Oral Evaluation, Dental Services*** | | | | |
| *Total (0–20 Years)* [N] | — | 35.3% | — | — |
| ***Well-Child Visits in the First 30 Months of Life*** | | | | |
| *Six or More Well-Child Visits* | 57.2% | 58.1% | → | ★★ |
| *15 Months–30 Months—Two or More Well-Child Visits* | — | 55.6% | — | ★ |
| ***Child and Adolescent Well-Care Visits*** | | | | |
| *Total (3–21 Years)* | 39.9% | 39.6% | → | ★ |
| ***Preventive Screening*** | | | | |
| ***Breast Cancer Screening*** | | | | |
| *Total (50–74 Years)* | 50.8% | 51.0% | → | ★★ |
| ***Cervical Cancer Screening*** | | | | |
| *21–64 Years* | 38.5% | 44.8%+ | ↑ | ★ |
| ***Appropriate Utilization of Services*** | | | | |
| ***Ambulatory Care*** | | | | |
| *Emergency Department (ED) Visits—Total (0–85+ Years)* [F] | 434.8 | 445.8 | — | — |
| ***Plan All-Cause Readmissions*** | | | | |
| *Observed Readmissions—Total (18–64 Years)* | 8.7% | 9.4% | → | — |
| *Expected Readmissions—Total (18–64 Years)* | — | 8.8% | — | — |
| *Outlier Rate—Total (18–64 Years)* | — | 44.3 | — | — |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)** | 0.9679 | 1.0705 | — | ★ |

* A lower rate indicates better performance for this measure.
**Table A-1 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
+ Indicates the measure was reported using hybrid methodology.
# Caution should be considered when comparing CY 2021 to CY 2022 results as changes to the measure specifications occurred.
Cells shaded green indicate that the rate met or exceeded the MY 2021 and/or MY 2022 national Medicaid mean.

[1] Indicates a 2021–2022 comparison is not presented in the CYE 2023 Annual Technical Report because either the CY 2021 rate was not presented in the CYE 2022 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

↑ Indicates improvement of measure rates.

↓ Indicates decline of measure rates.

→ Indicates stable measure rates.

[2] Performance Levels for CY 2022 were based on comparisons of the HEDIS MY 2022 measure rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks.

Performance Levels for 2022 represent the following percentile comparisons:

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

[N] Measure has no NCQA Medicaid mean for comparison

[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.

## Strengths, Opportunities for Improvement, and Recommendations

Table 5-22 presents strengths, opportunities for improvement, and recommendations for BUFC ACC related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-22—BUFC ACC Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| In the Behavioral Health measure group:<br>• BUFC ACC's performance measure rates for *Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* and *Engagement of SUD Treatment—Total—Total (13+ Years)* were at or above the 75th percentile, indicating that most members with diagnosed SUD may have initiated SUD treatment and had two or more additional SUD services or MAT within 34 days of the initiation visit, which, in conjunction with counseling or other behavioral therapies, has been shown to reduce SUD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.[5-11] **[Quality, Timeliness, Access]** |

[5-11] National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence. Available at https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-alcohol-and-other-drug-abuse-or-dependence/. Accessed on: Jan 25, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| In the Chronic Conditions measure group:<br>• BUFC ACC's performance measure rate for *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 %)—Total (18–75 Years)* was at or above the 90th percentile, indicating that most members diagnosed with diabetes are controlling their Hemoglobin A1c. **[Quality]**<br>In the Pediatric Health measure group:<br>• BUFC ACC's performance measure rates for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total (1–17 Years), Cholesterol Testing—Total (1—17 Years,* and *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* were at or above the 75th percentile, indicating that most children or adolescents with ongoing antipsychotic medication use had metabolic testing during the year. **[Quality]**<br>• BUFC ACC's performance measure rates for *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* were at or above the 75th percentile, indicating adolescents 13 years of age had one dose of meningococcal vaccine, one Tdap vaccine and the complete HPV vaccine series by their 13th birthday. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| In the Maternal and Perinatal Care measure group, BUFC ACC's performance measure rates for *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, indicating an opportunity to increase access to timely prenatal and postpartum care. **[Quality, Timeliness, Access]**<br><br>Recommendation: While BUFC ACC implemented targeted interventions specific to the CY 2022 *Prenatal and Postpartum Care—Postpartum Care* rate, this rate remained low in CY 2022; therefore, HSAG recommends that BUFC ACC conduct a root cause analysis and continue to implement appropriate interventions based on the root cause analysis to improve performance relative to prenatal and postpartum care. HSAG also recommends that BUFC ACC monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Postpartum Care* measure indicators. |
| In the Behavioral Health measure group, BUFC ACC's performance measure rate for *Use of Opioids at High Dosage—18+ Years* fell below the 25th percentile indicating an opportunity to identify trends leading to the opioid crisis. **[Quality]**<br><br>Recommendation: In 2016, opioid-related overdoses accounted for more than 42,000 deaths in the United States. Of those, 40 percent involved prescription opioids. Literature suggests there is a correlation between high dosages of prescription opioids and the risk of both fatal and nonfatal overdose. HSAG recommends that BUFC ACC follow the CDC guidelines on opioid prescribing for chronic, nonmalignant pain, which recommend the use of "additional precautions" when prescribing dosages ≥50 morphine equivalent dose (MED) and that providers avoid or "carefully justify" increasing dosages ≥90 mg MED. In 2019, the authors of the 2016 guidelines published commentary that cautioned providers, systems, payers, and states from developing policies and practices that are "inconsistent with and go beyond" the guideline recommendations. The commentary included cautions regarding strict enforcement of dosage and duration thresholds, as |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| well as abrupt tapering of opioids. The opioid dosage assessed in this measure is a reference point for health plans to identify members who may be at high risk for opioid overuse and misuse. HSAG recommends outreach to members who fall within this category to assess and schedule interventions as necessary. [5-12] |
| In the Pediatric Health measure group, BUFC ACC's performance measure rate for *Child and Adolescent Well-Care Visits Total (3–21 Years)* fell below the 25th percentile, indicating that children and adolescents were not always receiving well-care visits at the recommended intervals. Assessing physical, emotional, and social development is important at every stage of life, particularly for children and adolescents. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[5-13] **[Quality, Access]**<br><br>Recommendation: HSAG recommends that BUFC ACC identify best practices to support children in receiving well-care visits according to recommended schedules. HSAG also recommends that BUFC ACC consider conducting a root cause analysis to identify barriers that members are experiencing in accessing care and services to implement appropriate interventions to improve performance related to timely well-care visits. |
| In the Preventive Screening measure group, BUFC ACC's performance measure rate for *Cervical Cancer Screening—21–64 Years* fell below the 25th percentile, indicating that women were not always receiving timely screening for cervical cancer. Early detection reduces the risk of dying from this type of cancer and can lead to a greater range of treatment options and lower healthcare costs. Prolonged delays in screening may lead to delayed diagnoses, poor health consequences, and an increase in cancer disparities among women already experiencing health inequities.[5-14] **[Quality]**<br><br>Recommendation: While BUFC ACC implemented interventions related to its CY 2021 *Cervical Cancer Screening—21–64 Years* rate, HSAG recommends that BUFC ACC expand on its most successful interventions related to improving female members' receipt of timely screening for cervical cancer. BUFC ACC should continue to consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended cancer screenings and make health decisions. |

[5-12] National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/ Accessed on: Jan 25, 2024

[5-13] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Jan 25, 2024.

[5-14] Centers for Disease Control and Prevention. Sharp Declines in Breast and Cervical Cancer Screening. https://www.cdc.gov/media/releases/2021/p0630-cancer-screenings.html. Accessed on: Jan 25, 2024.

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

Table 5-23 presents performance measure recommendations made to BUFC ACC in the CYE 2022 Annual Technical Report[5-15] and BUFC ACC's follow-up to the recommendations, as well as an assessment of the degree to which BUFC ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 5-23—BUFC ACC Follow-Up to CYE 2022 Performance Measure Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| **Recommendation 1:** |
| As BUFC ACC did not report any measures following the hybrid methodology, HSAG recommended that BUFC ACC review and clarify expectations related to hybrid/medical record review (MRR) requirements for future years' reporting to ensure it is able to align with the AHCCCS-required methodology for the specified hybrid measures. This should include the planning and development of abstraction tools, data capture, and integration for non-HEDIS measures, if required. |
| **BUFC ACC's Response:** |
| BUFC ACC performed a HEDIS audit for the first time in MY 2022 using BUFC ACC's performance measure vendor. Sample records were extracted using the NCQA process, and hybrid medical record retrieval occurred in the performance measure vendor's NCQA-certified software. This mock audit fully paralleled BUFC ACC's official Medicare Advantage HEDIS audit, although BUFC ACC did not submit IDSS files for the ACC population. This mock audit ensures BUFC ACC can complete a HEDIS audit on the ACC population for MY 2023. |
| **HSAG's Assessment:** |
| HSAG determined that BUFC ACC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 2:** |
| While there were no concerns with the processing of practitioner data, the audit found that BUFC ACC could benefit from a practitioner credentialing software solution from the perspective of data processing and resource efficiency. HSAG recommended that BUFC ACC continue with planned efforts related to increased supplemental data capture via its planned vendor project and integration of AHCCCS' blind-spot data. |
| **BUFC ACC's Response:** |
| BUFC ACC hired a new health information exchange (HIE) and interoperability manager in April 2023 to focus on retrieving additional electronic medical record (EMR) data from practitioners. BUFC |

[5-15] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP) Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 1, 2024.

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| ACC is currently piloting a new data abstraction vendor to obtain data from contracted providers to fill in the "blind spot" data. BUFC ACC has also implemented a nonstandard supplemental data (NSSD) program to allow providers to send in evidence, which is then entered into the vendor's portal, that codifies those portable document format (PDF) documents to receive credit for care gaps. |
| **HSAG's Assessment:**<br>HSAG determined that BUFC ACC satisfactorily addressed this prior year's recommendation. |
| **Recommendation 3:** |
| HSAG recommended that BUFC ACC continue to explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require race and ethnicity stratifications. BUFC ACC should continue to work with AHCCCS related to collaborative efforts to improve completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information. |
| **BUFC ACC's Response:**<br>BUFC ACC pulls in race and ethnicity data from enrollment, then augments "blanks" or "unknown" with data coming in from the HIE. |
| **HSAG's Assessment:**<br>HSAG determined that BUFC ACC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 4:** |
| While BUFC ACC implemented targeted interventions specific to its CY 2020 *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* rates, these rates remained low in CY 2021; therefore, HSAG recommended that BUFC ACC conduct a root cause analysis and continue to implement appropriate interventions based on the root cause analysis to improve performance relative to prenatal and postpartum care. HSAG also recommended that BUFC ACC monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators. |
| **BUFC ACC's Response:**<br>BUFC ACC completed a Root Cause Analysis for the Prenatal and Postpartum Care performance measure. Additional interventions that have been established include the following:<br>• Develop a PCP/practice-specific Value-Based Provider/Pay-for-Performance program targeting *Timeliness of Prenatal Care* within PCPs' assigned membership.<br>• The Maternal and Child Health (MCH) team to provide a minimum of two pregnancy care submissions to each semiannual BUFC-ACC Member Newsletter, providing key maternity and family planning information to the membership.<br>• Prenatal packets will be distributed to all pregnant members following MCH's notification of the member's pregnancy and will be distributed every two weeks. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| • Expand utilization of technology platforms to improve accessibility to early and regular prenatal education, care, and health plan support.<br>• MCH review of all OB referrals originating outside of the Notification of Pregnancy (NOP) process, within one business day of receipt.<br>• Review weekly pregnancy indicator data to identify potential pregnancies and research and confirm pregnancies in order to provide education and assist with initiation of prenatal care.<br>• Distribute provider education on the health plan's coverage, requirements, and resources related to family planning, prenatal and postpartum coverage, services, and care. |
| **HSAG's Assessment:**<br>BUFC ACC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that BUFC ACC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 5:** |
| While BUFC ACC implemented targeted interventions specific to its CY 2020 *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total* rate, this rate remained low in CY 2021; therefore, HSAG recommended that BUFC ACC conduct a root cause analysis to determine why some members were not receiving timely follow-up care with a mental health provider. BUFC ACC should consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, a lack of mental health service providers, or the need for community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, BUFC ACC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, BUFC ACC should implement appropriate interventions to improve performance related to follow-up care following a hospitalization. |
| **BUFC ACC's Response:**<br>BUFC ACC completed a Root Cause Analysis for the *Follow-Up After Hospitalization for Mental Illness – 30 Day* performance measure. Additional interventions that have been established to further improve the overall compliance rates include the following:<br>• The *FUH* measure was included in the BUFC ACC VBP Program.<br>• BUFC ACC educates providers and members through newsletters on the importance of follow-up after all hospitalizations.<br>• The Pyx Health App is available to all members and assists with mental and physical health questions and issues the member may have. This app can also assist with encouraging and reminding members about appointments and can connect the members with assistance if they need it before the follow-up appointment.<br>• BUFC ACC developed Transitional Care Management tools to assist providers with patients.<br>• BUFC ACC registered with the Health Current HIE to receive statewide alerts for hospital discharges.<br>• Care managers outreach to members to promote follow-up appointments. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| • When scheduling, care managers will set two appointments if the provider is willing to do this. |
| **HSAG's Assessment:**<br>BUFC ACC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that BUFC ACC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 6:** |
| While BUFC ACC implemented interventions specific to its CY 2020 *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* rate, the CY 2021 performance remained low; therefore, HSAG continued to recommend that BUFC ACC conduct a root cause analysis or focus study to determine why some members with diabetes did not have controlled HbA1c levels. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, BUFC ACC should implement interventions that address the identified root cause of the low performance, targeting the interventions so that BUFC ACC improves performance related to diabetes management. |
| **BUFC ACC's Response:**<br>BUFC ACC completed a Root Cause Analysis for the *HbA1c Poor Control (>9.0%)* measure. Additional interventions that have been established to improve the overall compliance rates include the following:<br>• Create targeted provider-facing educational tools. |
| **HSAG's Assessment:**<br>While BUFC ACC addressed the recommendation to complete a root cause analysis, the resultant intervention did not seem to be based on the result of the analysis. HSAG therefore determined that BUFC ACC partially addressed these prior year's recommendations. |
| **Recommendation 7:** |
| HSAG recommended that BUFC ACC conduct a root cause analysis or focus study to determine why some members are not managing their high blood pressure optimally. Upon identification of a root cause, HSAG recommended that BUFC ACC implement appropriate interventions to improve the performance related to this chronic condition. |
| **BUFC ACC's Response:**<br>BUFC ACC completed a Root Cause Analysis for the Controlling High Blood Pressure measure. Additional interventions that have been established to improve the overall compliance rates include the following:<br>• The performance measure vendor's gap reports are being run and compared to medical record reports to identify potential members who may have supporting documentation available to close gaps.<br>• Education in member newsletters on diet and the importance of blood pressure monitoring. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| • The Care Management team will address SDOH factors including access and knowledge of proper nutrition.<br>• Create targeted provider-facing educational tools. |
| **HSAG's Assessment:**<br>BUFC ACC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that BUFC ACC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 8:** |
| HSAG recommended that BUFC ACC identify best practices to support children in receiving well-care visits according to recommended schedules. HSAG also recommended that BUFC ACC consider conducting a root cause analysis to identify barriers that members are experiencing in accessing care and services in order to implement appropriate interventions to improve performance related to timely well-care visits. |
| **BUFC ACC's Response:**<br>Best practices have been reviewed and assessed for implementation in the upcoming CY 2023. These have been identified through scholarly articles and presented for discussion during performance improvement plan workgroup meetings. Additionally, BUFC completed a Root Cause Analysis for the *Child/Adolescent Well-Care Visit* measure. |
| **HSAG's Assessment:**<br>While BUFC ACC did conduct a root cause analysis and reported doing a literature search, it did not elaborate on details of the best practices that it indicated were identified. HSAG therefore determined that BUFC ACC partially addressed these prior year's recommendations. |
| **Recommendation 9:** |
| While BUFC ACC implemented interventions related to its CY 2020 *Cervical Cancer Screening* rate, HSAG continued to recommend that BUFC ACC conduct a root cause analysis or focus study to determine why its female members were not always receiving timely screening for cervical cancer. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, BUFC ACC should implement appropriate interventions to improve performance related to preventive screenings. In doing so, BUFC ACC should consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended cancer screenings and make appropriate health decisions. |
| **BUFC ACC's Response:**<br>BUFC ACC will conduct additional research on best practices and review with leadership to assess for those interventions that will potentially have the biggest impact on the population. The Quality Management team has continued to monitor trends monthly and has identified that this measure has demonstrated consistent growth year over year. BUFC ACC completed a Root Cause Analysis for the |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
| --- |
| *Cervical Cancer Screening* measure. Additional interventions that have been established to improve the overall compliance rates include the following:<br>• Member education through flyers, post cards, and social media posts.<br>• Provider education on the importance of preventative screenings through JOC meetings, provider forums, and provider newsletter.<br>• Provide telephonic outreach and scheduling assistance to members with an open care gap.<br>• Coordinate bi-annual Wellness Events that provide onsite screening. |
| **HSAG's Assessment:**<br>HSAG determined that BUFC satisfactorily addressed the recommendations related to *Cervical Cancer Screening*. |

## *Validation of Performance Improvement Projects*

### Back to Basics PIP

In CYE 2023, BUFC ACC continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 1, PIP validation activities focused on improvement from the baseline results. BUFC ACC submitted Remeasurement 1 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes or discontinuation of the interventions.

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

### *Validation Results*

Table 5-24 displays the overall confidence levels for the BUFC ACC *Back to Basics* PIP.

**Table 5-24—BUFC ACC *Back to Basics* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| BUFC ACC | *Low Confidence* | 87% | 89% | *No Confidence* | 33% | 100% |

### *Measure Results*

Table 5-25 and Table 5-26 provide the *Back to Basics* PIP baseline, intervention, and Remeasurement Year 1 rates for each indicator for BUFC ACC.

**Table 5-25—BUFC ACC *Back to Basics* PIP Rates for PIP Indicator 1**

| Contractor | PIP Indicator 1: *W30 Rate 1* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| BUFC ACC | 63.5% | 58.1% |

**Table 5-26—BUFC ACC *Back to Basics* PIP Rates for PIP Indicator 2**

| Contractor | PIP Indicator 2: *WCV* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| BUFC ACC | 46.6% | 39.6% |

### *Interventions*

Table 5-27 presents PIP interventions for BUFC ACC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 5-27—BUFC ACC *Back to Basics* PIP Interventions**

| Contractor | Interventions |
|---|---|
| BUFC ACC | • Back-to-School Campaign offering incentive to members who complete well-care visits between June 1, 2023, and July 31, 2023.<br>• Promoting the Quality of Medicine (PQM) reports sent quarterly to providers to bring awareness to members who have not had or are due for wellness visits.<br>• Provider forums to provide education on related requirements to include detailed information on all mailings, expectations, and minimum performance standards.<br>• EPSDT reminder postcards sent at various times based on birthday.<br>• Well-child visit reminder postcards will annually notify guardians of members who are past due.<br>• First and second EPSDT reminder postcards will be sent to members identified as due for well-care visits.<br>• Member outreach phone calls for both dental and well-care visits.<br>• Member newsletters and handbook.<br>• Mailers to dental home providers with eligible members who need sealants and preventive services.<br>• Dental reminder postcards and phone calls for members ages 2–20 years.<br>• Health plan Facebook page with dental and well-child health messaging.<br>• Track dental referrals on EPSDT forms.<br>• Provider fax blast and newsletter with Dental Periodicity Schedule.<br>• Online provider manual.<br>• Provider manual is reviewed and updated to reflect AHCCCS' guidance and requirements.<br>• Pediatric webpage.<br>• Provide quality metrics to providers during site visits. |

### *Strengths, Opportunities for Improvement, and Recommendations*

Table 5-28 presents strengths, opportunities for improvement, and recommendations for BUFC ACC related to the *Back to Basics* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-28—BUFC ACC Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| BUFC ACC developed and implemented measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 2. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| For indicator 1, BUFC ACC had a decline of 5.39 percentage points in the indicator rate between the baseline year and Remeasurement Year 1. BUFC ACC had a decline of 6.97 percentage points in the indicator rate between the baseline year and Remeasurement Year 1 for indicator 2. **[Quality, Access]**<br><br>Recommendations: As the PIP progresses, HSAG recommends that BUFC ACC:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

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

Table 5-29 presents PIP recommendations made to BUFC ACC in the CYE 2022 Annual Technical Report[5-16] and BUFC ACC's follow-up to the recommendations, as well as an assessment of the degree to which BUFC ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 5-29—BUFC ACC Follow-Up to CYE 2022 PIP Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| HSAG recommended that BUFC ACC:<br>• Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary.<br>• Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available. |

[5-16] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP) Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 8, 2024.

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| • Develop and document a plan for sustaining the improvement for any demonstrated improvement in indicator rates. |
| **BUFC ACC's Response:**<br>The *Back-to-Basics* PIP has a workgroup established with key leaders from the Maternal and Child Health team. This workgroup meets as frequently as monthly or bimonthly to continue monitoring trends in compliance rates, reviewing best practices, and analyzing subpopulations to assess for disparities requiring targeted interventions. During these workgroup meetings, interventions are reviewed, successes are discussed, along with identified barriers to success. The workgroup uses the PDSA Cycle to monitor interventions implemented and their success and to ensure that progress is sustained. BUFC conducted a Root Cause analysis and an associated PDSA. |
| **HSAG's Assessment:** HSAG has determined that the Contractor has satisfactorily addressed these prior year's recommendations. |

## Prenatal and Postpartum Care PIP

In CYE 2023, BUFC ACC submitted baseline measurement results for the *Prenatal and Postpartum Care* PIP, which was initiated in CY 2022. BUFC ACC submitted baseline performance indicator results and interventions implemented during CYE 2022.

HSAG conducted an annual validation of the baseline year reflective of CY 2022 (January 1, 2022, through December 31, 2022) using AHCCCS-calculated and validated indicator rates. HSAG evaluated BUFC ACC's performance indicator results based on an analysis of improvement strategies implemented as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection in Appendix A. Methodology.

### *Validation Results*

Table 5-30 displays the overall confidence levels for the BUFC ACC *Prenatal and Postpartum Care* PIP.

**Table 5-30—BUFC ACC *Prenatal and Postpartum Care* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| BUFC ACC | *High Confidence* | 100% | 100% | *Not Assessed* | *Not Assessed* | *Not Assessed* |

### *Measure Results*

Table 5-31 and Table 5-32 provide the *Prenatal and Postpartum Care* PIP baseline year rates for each indicator for BUFC ACC.

**Table 5-31—BUFC ACC *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 1**

| Contractor | PIP Indicator 1: *Timeliness of Prenatal Care* |
|---|---|
| | Baseline Year |
| | CY 2022* |
| BUFC ACC | 81.5% |

*The CY 2022 indicator rate was provided by AHCCCS.

**Table 5-32—BUFC ACC *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 2**

| Contractor | PIP Indicator 2: *Postpartum Care* |
|---|---|
| | Baseline Year |
| | CY 2022* |
| BUFC ACC | 69.8% |

*The CY 2022 indicator rate was provided by AHCCCS.

### *Interventions*

Table 5-33 presents PIP interventions for BUFC ACC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 5-33—BUFC ACC *Prenatal and Postpartum Care* PIP Interventions**

| Contractor | Interventions |
|---|---|
| BUFC ACC | • Develop a PCP/practice-specific VBP/Pay-for-Performance program targeting *Timeliness of Prenatal Care* within the practice's assigned membership.<br>• MCH to provide a minimum of two pregnancy submissions to each semiannual BUFC-ACC Member Newsletter, providing key maternity and family planning information to the membership.<br>• Prenatal packets will be distributed to all pregnant members following MCH notification of the member's pregnancy and will be distributed every two weeks.<br>• Expand all utilization of technology platforms to improve accessibility to early and regular prenatal education, care, and health plan support.<br>• MCH review of all OB referrals originating outside of the NOP process within one business day of receipt. |

| Contractor | Interventions |
|---|---|
| | • Review weekly pregnancy indicator data to identify potential pregnancies, research and confirm pregnancies, provide education and assist with initiation of prenatal care.<br>• Conduct provider education on the health plan's coverage, requirements, and resources related to family planning, prenatal and postpartum coverage, services, and care.<br>• BabyScripts to engage and educate members through technology.<br>• Siebel customer care alert system that identifies members who have delivered or should have delivered; puts an alert on the Siebel file to help connect with the member.<br>• Webpage and social media posts to educate members on the importance of establishing prenatal care early and often, as well as providing education on postpartum care and postpartum depression.<br>• Members called within 72 hours post-discharge and educated on the importance of a postpartum visit, offered resources and additional assistance. |

### *Strengths, Opportunities for Improvement, and Recommendations*

The *Prenatal and Postpartum Care* PIP was initiated in CY 2022; therefore, this section is not applicable.

Table 5-34 presents strengths, opportunities for improvement, and recommendations for BUFC ACC related to the *Prenatal and Postpartum Care* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-34—BUFC ACC Strengths, Opportunities for Improvement, and Recommendations Related to the *Prenatal and Postpartum Care* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| BUFC ACC developed and implemented measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 1. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| For indicator 1, 81.5 percent of women had a prenatal care visit in the first trimester and 69.8 percent had a postpartum visit between seven and 84 days after delivery during CYE 2022. **[Quality, Access]**<br><br>Recommendations: As the PIP progresses, HSAG recommends that BUFC ACC:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

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

The *Prenatal and Postpartum Care* PIP was initiated in CY 2022; therefore, this section is not applicable.

## Compliance Reviews

### Results

AHCCCS conducted a compliance review of BUFC ACC from June 6, 2022, through June 9, 2022. On August 19, 2022, AHCCCS finalized the report findings, provided BUFC ACC with a CAP submission matrix, and required a CAP for any standard with a total score of less than 95 percent. On October 17, 2022, AHCCCS accepted BUFC ACC's proposed CAPs and required the Contractor to submit updated policies, manuals, desktop procedures, and other vital documents to provide evidence of CAP completion. On August 31, 2023, AHCCCS reviewed BUFC ACC's CAP status and determined that not all CAPs had been completed for closure. AHCCCS required the Contractor to reassess the CAPs and resubmit evidence of compliance by September 15, 2023. Remaining CAP items were under review by AHCCCS at the time of writing this report. Additional results of the CAP update will be included in the CYE 2024 annual technical report. Table 5-35 presents the compliance review results for BUFC ACC.

**Table 5-35—BUFC ACC Compliance Review Results**

| Compliance Focus Areas | CYE 2022 BUFC ACC Scores | CYE 2022 Program-Level Average | CYE 2023 BUFC ACC CAP Update |
|---|---|---|---|
| CC | 100% | 99% | NA |
| CIS | 97% | 96% | NA |
| DS | 87% | 91% | PM |
| GA | 96% | 92% | NA |
| GS | 99% | 99% | NA |
| MCH | 70% | 82% | M |
| MM | 90% | 94% | M |
| MI | 100% | 96% | NA |
| QM | 80% | 77% | PM |
| QI | 96% | 92% | NA |
| RI | 100% | 100% | NA |

| Compliance Focus Areas | CYE 2022 BUFC ACC Scores | CYE 2022 Program-Level Average | CYE 2023 BUFC ACC CAP Update |
|---|---|---|---|
| TPL | 100% | 100% | NA |
| ISOC | 100% | 96% | NA |

NA = "not applicable." A CAP was not required as the CYE 2022 score was 95% or above.
PM = "partially met." AHCCCS approved the Contractor's proposed CAP. The Contractor must submit evidence of compliance.
M = "met." AHCCCS accepted and closed the Contractor's CAP.

## Strengths, Opportunities for Improvement, and Recommendations

Table 5-36 presents strengths, opportunities for improvement, and recommendations for BUFC ACC based on compliance activities conducted in CYE 2023, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-36—BUFC ACC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| BUFC ACC successfully closed CAPs in the following Focus Areas:<br>• Adult, EPSDT and Maternal Child Health (MCH) **[Quality, Timeliness, Access]**<br>• Medical Management (MM) **[Timeliness, Access]** |
| **Opportunities for Improvement and Recommendations** |
| BUFC ACC has remaining CAPs in the following Focus Areas:<br>• Delivery Systems (DS) **[Timeliness, Access]**<br>• Quality Management (QM) **[Quality]**<br><br>Recommendations HSAG recommends that BUFC ACC continue to work on outstanding CAP items and submit to AHCCCS in the approved time frame. |

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

Table 5-37 presents compliance recommendations made to BUFC ACC in the CYE 2022 Annual Technical Report[5-17] and BUFC ACC's follow-up to the recommendations, as well as an assessment of

[5-17] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP) Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 8, 2024.

the degree to which BUFC ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 5-37—BUFC ACC Follow-Up to CYE 2022 Compliance Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for Compliance |
|---|
| HSAG recommends that BUFC ACC consider conducting a self-assessment of the DS, MCH, MM, and QM Focus Area requirements. |
| **BUFC ACC's Response:**<br>BUFC ACC will continue to correct any findings identified in its CAP to monitor compliance with the requirements in each of the AHCCCS Focus Areas listed above. In 2023, BUFC ACC was awarded a three (3) year NCQA Medicaid HMO Accreditation, Long Term Services and Supports Distinction and Deeming Status as a health plan and has an additional NCQA health equity accreditation on the way. This is a testament to BUFC ACC's overall quality improvement (QI) framework and illustrates BUFC ACC's ability to deliver efficient, effective, person-centered care to meet our members' needs and help keep members in the community. |
| **HSAG's Assessment:**<br>Based on the CAP closure for the MCH and MM Focus Areas, CAP acceptance for the DS and QM Focus Areas, and the response provided, HSAG determined that BUFC ACC has satisfactorily addressed the prior year's recommendations related to compliance. |

## *Network Adequacy Validation*

### Results

HSAG evaluated BUFC ACC's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents semiannual validation findings specific to the ACC Program, with one results table for each of the following GSAs:

- Central GSA: Gila, Maricopa,[5-18] and Pinal counties
- South GSA: Cochise, Graham,[5-19] Greenlee, La Paz, Pima, Santa Cruz,[5-20] and Yuma counties

Each region-specific table summarizes semiannual validation results containing the percentage of members meeting each time/distance standard by quarter and county, with color-coding to identify whether or not the time/distance standard was "*Met*" or "*Not Met*."

[5-18] Maricopa County includes the 85342, 85358, and 85390 ZIP Codes; these ZIP Codes are physically located in both Maricopa and Yavapai counties.
[5-19] Graham County includes the 85542, 85192, and 85550 ZIP Codes representing the San Carlos Tribal area; these ZIP Codes are physically located in Gila or Pinal County.
[5-20] Santa Cruz County includes the 85645 ZIP Code; this ZIP Code is physically located in both Pima and Santa Cruz counties.

The value "NA" is shown for time/distance standards that do not apply to the county or program.

The value "NR" is shown for time/distance standards in which no members met the network requirement denominator for the program and county; therefore, HSAG calculated no corresponding time/distance result.

Yellow color-coding identifies instances in which HSAG's time/distance results met the minimum network requirement but differed from the ACOM 436 results.

Red color-coding identifies instances in which HSAG's time/distance results did not meet the compliance standard, regardless of the ACOM 436 results.

An asterisk (*) indicates that fewer than 10 members were included in the denominator of HSAG's results.

A carat (^) indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

**Table 5-38—BUFC ACC Time/Distance Validation Results for Central GSA—Percentage of Members Meeting Minimum Network Requirements**

| | Gila | | Maricopa | | Pinal | |
|---|---|---|---|---|---|---|
| Minimum Network Requirement | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0^ | 100.0^ | 99.2^ | 99.3^ | 100.0^ | 100.0^ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 100.0^ | 100.0^ | 99.1^ | 99.2^ | 100.0^ | 100.0^ |
| BHRF | NA | NA | 99.1 | 99.1 | NA | NA |
| Cardiologist, Adult | 100.0 | 100.0^ | 99.7^ | 99.4^ | 100.0^ | 100.0^ |
| Cardiologist, Pediatric | 100.0 | 100.0 | 100.0^ | 100.0^ | 100.0 | 100.0^ |
| Dentist, Pediatric | 99.9 | 60.4 | 99.2 | 99.3 | 99.3 | 100.0 |
| Hospital | 100.0 | 100.0 | 99.9 | 99.9 | 100.0 | 100.0 |
| OB/GYN | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 100.0 | 100.0 | 99.1 | 99.1 | 100.0 | 100.0 |
| PCP, Adult | 100.0 | 100.0^ | 99.8^ | 99.8^ | 100.0^ | 100.0^ |
| PCP, Pediatric | 100.0 | 100.0^ | 99.7^ | 99.7^ | 100.0^ | 100.0^ |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
represents time/distance standard results that do not meet the compliance standard based on HSAG's results.

^indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.

**Table 5-39—BUFC ACC Time/Distance Validation Results for South GSA—Percentage of Members Meeting Minimum Network Requirements**

| | Cochise | | Graham | | Greenlee | | La Paz | | Pima | | Santa Cruz | | Yuma | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Minimum Network Requirement | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 99.5^ | 99.8^ | 100.0^ | 100.0^ | 97.2^ | 97.2^ | 100.0^ | 100.0^ | 99.7^ | 100.0^ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 99.8^ | 99.7^ | 100.0^ | 100.0^ | 97.2^ | 97.2^ | 100.0^ | 100.0^ | 99.8^ | 100.0^ |
| BHRF | NA | NA | NA | NA | NA | NA | NA | NA | 93.4 | 93.3 | NA | NA | NA | NA |
| Cardiologist, Adult | 100.0^ | 100.0^ | 100.0 | 100.0^ | 100.0 | 100.0 | 100.0 | 100.0^ | 99.4^ | 99.4^ | 100.0 | 100.0^ | 100.0^ | 99.9^ |
| Cardiologist, Pediatric | 100.0^ | 100.0^ | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 99.6 | 99.7^ | 100.0 | 100.0^ | 100.0^ | 100.0^ |
| Dentist, Pediatric | 99.7 | 99.7 | 97.7 | 91.9 | 99.2 | 62.1 | 49.2 | 51.0 | 98.6 | 98.6 | 100.0 | 100.0 | 99.8 | 99.8 |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 99.6 | 99.7 | 100.0 | 100.0 | 100.0 | 100.0 |
| OB/GYN | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 99.7 | 99.7 | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 99.5 | 99.6 | 99.3 | 99.3 | 99.6 | 99.8 | 88.6 | 74.9 | 97.3 | 98.1 | 100.0 | 100.0 | 99.7 | 99.7 |
| PCP, Adult | 99.7^ | 99.7^ | 99.5 | 99.5^ | 99.5 | 99.8^ | 100.0^ | 100.0^ | 99.8^ | 99.9^ | 100.0^ | 100.0^ | 99.7^ | 99.7^ |
| PCP, Pediatric | 99.8^ | 99.8^ | 99.2 | 99.0^ | 99.8 | 99.8^ | 100.0^ | 100.0^ | 99.7^ | 99.7^ | 100.0 | 100.0^ | 99.8^ | 99.8^ |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
represents time/distance standard results that do not meet the compliance standard based on HSAG's results.

^indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.

## Strengths, Opportunities for Improvement, and Recommendations

Table 5-40 presents strengths, opportunities for improvement, and recommendations for BUFC ACC related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-40—BUFC ACC Strengths, Opportunities for Improvement, and Recommendations Related to NAV**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths:<br>• BUFC ACC met all time/distance network standards in both quarters for CYE 2023 in Cochise, Graham, Maricopa, Pima, Pinal, Santa Cruz, and Yuma counties. **[Access]**<br>• BUFC ACC met all time/distance network standards for BHRF; Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; Cardiologist, Adult and Pediatric; Hospital; OB/GYN; and PCP, Adult and Pediatric standards. **[Access]**<br>Note: BUFC ACC provides coverage in the following counties: Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Santa Cruz, and Yuma. |
| **Opportunities for Improvement and Recommendations** |
| HSAG identified the following opportunities for improvement:<br>• BUFC ACC failed to meet the time/distance standard for at least one quarter and/or county for Dentist, Pediatric and Pharmacy. **[Access]**<br><br>Recommendations: HSAG recommends that BUFC ACC maintain current compliance with network standards but continue to address network gaps, as applicable. |

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

Table 5-41 presents NAV recommendations made to BUFC ACC in the CYE 2022 Annual Technical Report[5-21] and BUFC ACC's follow-up to the recommendations, as well as an assessment of the degree to which BUFC ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

[5-21] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP) Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 8, 2024.

**Table 5-41—BUFC ACC Follow-Up to CYE 2022 NAV Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for NAV |
|---|
| HSAG recommended that BUFC ACC:<br>• Continue to monitor its processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.<br>• Maintain current compliance with network standards but continue to address network gaps, as applicable. |
| **BUFC ACC's Response:**<br>• BUFC ACC runs the PAT file twice a year. Two weeks before the due date, BUFC ACC runs the file and compares it against the previous submission. BUFC ACC analyzes the comparison to see if any outliers stand out; if so, it conducts a deep dive to further investigate. If the variance is in line with natural network changes such as provider moves, adds, etc., those are submitted prior to the deadline.<br>• If there are additional providers in the area to fill the gap, the providers are approached to join the network. If there are no providers in the area, BUFC ACC is left with a gap and an exception is submitted. |
| **HSAG's Assessment:**<br>HSAG has determined that BUFC ACC has satisfactorily addressed these prior year's recommendations. |

# Care 1st ACC-RBHA

## *Validation of Performance Measures*

### Results for Information Systems Standards Review

During CYE 2023, HSAG evaluated Care 1st ACC-RBHA's data system for processing of each data type used for reporting the Contractor's CY 2022 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that Care 1st ACC-RBHA followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-42 displays HSAG's PMV findings for each data type reviewed during CYE 2023 in alignment with the CMS EQR Protocol 2 audit requirements.

**Table 5-42—CYE 2023 PMV Findings**

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

### Results for Performance Measures

Table 5-43 presents the CY 2021 and CY 2022 Care 1st ACC-RBHA performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and MY 2022. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and/or MY 2022. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

**Table 5-43—CY 2021 and CY 2022 Care 1st ACC-RBHA Performance Measure Results**

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| ***Maternal and Perinatal Care*** | | | | |
| ***Prenatal and Postpartum Care*** | | | | |
| *Timeliness of Prenatal Care*[#] | 82.7%[+] | 75.4%[+] | ↓ | ★ |
| *Postpartum Care* | 68.1%[+] | 68.4%[+] | → | ★ |
| ***Behavioral Health*** | | | | |
| ***Antidepressant Medication Management*** | | | | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | 57.3% | 60.5% | → | ★★ |
| *Effective Continuation Phase Treatment—Total (18+ Years)* | 38.9% | 42.3% | ↑ | ★★ |
| ***Follow-Up After ED Visit for Substance Use*** | | | | |
| *7-Day Follow-Up—Total* | — | 31.8% | — | ★★★★ |
| *30-Day Follow-Up—Total* | — | 44.2% | — | ★★★★ |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 49.7% | 54.7% | ↑ | ★★★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 65.2% | 69.8% | ↑ | ★★★★ |
| ***Follow-Up After ED Visit for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 39.0% | 41.9% | → | ★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 51.9% | 54.8% | → | ★★ |
| ***Use of Opioids at High Dosage*** | | | | |
| *18+ Years** | 3.5% | 3.6% | → | ★★★ |
| ***Initiation and Engagement of Substance Use Disorder (SUD) Treatment*** | | | | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | — | 41.8% | — | ★★ |
| *Engagement of SUD Treatment—Total—Total (13+ Years)* | — | 13.4% | — | ★★ |
| ***Adherence to Antipsychotic Medications for Individuals with Schizophrenia*** | | | | |
| *18+ Years* | — | 40.7% | — | ★ |
| ***Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication*** | | | | |
| *18–64 Years* | — | 78.5% | — | ★★ |
| ***Care of Acute and Chronic Conditions*** | | | | |
| ***Controlling High Blood Pressure*** | | | | |
| *18–85 Years* | 16.5%[+] | 43.1%[+] | ↑ | ★ |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | | | | |
| *HbA1c Control (<8.0 Percent)—Total (18–75 Years)* | — | 38.0%[+] | — | ★ |

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| *HbA1c Poor Control (>9.0 Percent)—Total (18–75 Years)** | 45.3%+ | 55.2%+ | ↓ | ★ |
| ***Pediatric Health*** | | | | |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotics*** | | | | |
| *Blood Glucose Testing—Total (1–17 Years)* | 59.6% | 58.5% | → | ★★★ |
| *Cholesterol Testing—Total (1–17 Years)* | 43.0% | 36.1% | ↓ | ★★ |
| *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* | 42.7% | 35.1% | ↓ | ★★★ |
| ***Childhood Immunization Status***** | | | | |
| *Combination 3* | 56.5% | 47.2% | ↓ | ★ |
| *Combination 7* | 49.4% | 42.3% | ↓ | ★ |
| *Combination 10* | 24.8% | 20.7% | → | ★ |
| ***Developmental Screening in the First Three Years of Life*** | | | | |
| *Total (0–3 Years)*[N] | — | 17.0% | — | — |
| ***Immunizations for Adolescents*** | | | | |
| *Combination 1 (Meningococcal, Tdap)* | 84.7% | 74.2% | ↓ | ★★ |
| *Combination 2 (Meningococcal, Tdap, HPV)* | 41.4% | 32.6% | ↓ | ★★ |
| ***Oral Evaluation, Dental Services*** | | | | |
| *Total (0–20 Years)*[N] | — | 45.1% | — | — |
| ***Well-Child Visits in the First 30 Months of Life*** | | | | |
| *Six or More Well-Child Visits* | 59.4% | 53.5% | ↓ | ★★ |
| *15 Months–30 Months—Two or More Well-Child Visits* | — | 53.5% | — | ★ |
| ***Child and Adolescent Well-Care Visits*** | | | | |
| *Total (3–21 Years)* | 46.6% | 33.7% | ↓ | ★ |
| ***Preventive Screening*** | | | | |
| ***Breast Cancer Screening*** | | | | |
| *Total (50–74 Years)* | 37.0% | 32.3% | ↓ | ★ |
| ***Cervical Cancer Screening*** | | | | |
| *21–64 Years* | 52.1%+ | 39.2%+ | ↓ | ★ |
| ***Appropriate Utilization of Services*** | | | | |
| ***Ambulatory Care*** | | | | |
| *Emergency Department (ED) Visits—Total (0–85+ Years)*[F] | 441.8 | 448.1 | — | — |
| ***Plan All-Cause Readmissions*** | | | | |
| *Observed Readmissions—Total (18–64 Years)* | 9.1% | 9.3% | → | — |
| *Expected Readmissions—Total (18–64 Years)* | — | 9.6% | — | — |

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| *Outlier Rate—Total (18–64 Years)* | — | 85.3 | — | — |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)** | 0.9765 | 0.9694 | — | ★★★ |

* A lower rate indicates better performance for this measure.
** Table A-1 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
+ Indicates the measure was reported using hybrid methodology.
# Caution should be considered when comparing CY 2021 to CY 2022 results as changes to the measure specifications occurred.
Cells shaded green indicate that the rate met or exceeded the MY 2021 and/or MY 2022 national Medicaid mean.
[1] Indicates a 2021–2022 comparison is not presented in the CYE 2023 Annual Technical Report because either the CY 2021 rate was not presented in the CYE 2022 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
↑ Indicates improvement of measure rates.
↓ Indicates decline of measure rates.
→ Indicates stable measure rates.
[2] Performance Levels for CY 2022 were based on comparisons of the HEDIS MY 2022 measure rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks.
Performance Levels for 2022 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile
[N] Measure has no NCQA Medicaid mean for comparison
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.

## Strengths, Opportunities for Improvement, and Recommendations

Table 5-44 presents strengths, opportunities for improvement, and recommendations for Care 1st ACC-RBHA related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-44—Care 1st ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| In the Behavioral Health measure group:<br>• Care 1st ACC-RBHA's performance measure rates for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total (6+ Years)* were at or above the 75th percentile, indicating |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| that most members were accessing follow-up care with a mental health provider within seven days following inpatient discharge. Individuals hospitalized for mental health disorders often do not receive adequate follow-up care. Providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes and decrease the likelihood of rehospitalization and the overall cost of outpatient care.[5-22] **[Quality, Timeliness, Access]**<br>• Care 1st ACC-RBHA's performance measure rates for *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* were at or above the 75th percentile, indicating that most members who had an ED visit and were 13 years of age and older with a principal diagnosis of alcohol or other drug abuse or dependence, had a follow-up visit for alcohol or other drug abuse or dependence. **[Quality, Timeliness, Access]** |
| **Opportunities for Improvement and Recommendations** |
| In the Maternal and Perinatal Care measure group, Care 1st ACC-RBHA's performance measure rate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, indicating an opportunity to increase access to timely prenatal and postpartum care. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.[5-23] **[Quality, Timeliness, Access]**<br><br>Recommendation: While Care 1st ACC-RBHA conducted root cause analyses and implemented interventions specific to its CY 2021 *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Prenatal and Postpartum Care—Postpartum Care* rates, these rates remained low in CY 2022; therefore, HSAG recommends that Care 1st ACC-RBHA continue to implement appropriate interventions to improve performance related to postpartum care. HSAG also recommends that Care 1st ACC-RBHA monitor and expand on interventions currently in place to improve performance for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Prenatal and Postpartum Care—Postpartum Care* measure indicators. |
| In the Preventive Screening measure group, Care 1st ACC-RBHA's performance measure rates for *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* fell below the 25th percentile, indicating that some women were not receiving timely screening for breast and cervical cancers. Of note, the measure rate for *Cervical Cancer Screening* experienced a significant decline from MY 2021. Early detection reduces the risk of dying from these types of cancers and can lead to a greater range of treatment options and lower healthcare costs. **[Quality]**<br><br>Recommendation: While Care 1st ACC-RBHA conducted root cause analyses and implemented interventions specific to its CY 2021 *Breast Cancer Screening—Total (50–74 Years)* and *Cervical* |

[5-22] National Committee for Quality Assurance. Follow-Up After Hospitalization for Mental Illness (FUH). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/. Accessed on: Jan 25, 2024.
[5-23] National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/. Accessed on: Jan 26, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| *Cancer Screening—21–64 Years* rates, these rates remained low in CY 2022 and both declined from the prior year; therefore, HSAG recommends that Care 1st ACC-RBHA continue to implement appropriate interventions to improve performance related to these rates. HSAG also recommends that Care 1st ACC-RBHA monitor and expand on interventions currently in place to improve performance related to these screenings. In addition, HSAG recommends that Care 1st ACC-RBHA conduct outreach to its members as well as educate them on the importance of these screenings. |
| In the Care of Acute and Chronic Conditions measure group, Care 1st ACC-RBHA's performance measure rate for *Controlling High Blood Pressure—18–85 Years* fell below the 25th percentile, indicating that not all members were receiving appropriate screenings and treatment for managing blood pressure. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[5-24] **[Quality]**<br><br>Recommendation: HSAG recommends that Care 1st ACC-RBHA conduct a root cause analysis to determine why some members are not managing their high blood pressure optimally. This could include conducting focus groups to identify barriers that members are experiencing in accessing care and services in order to implement appropriate interventions. Care 1st ACC-RBHA should consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). Upon identification of a root cause, HSAG recommends that Care 1st ACC-RBHA implement appropriate interventions to improve performance related to this chronic condition. |
| In the Pediatric Health measure group, Care 1st ACC-RBHA's performance measure rates for *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10* fell below the 25th percentile, indicating that children were not always getting their immunizations by their second birthday. Vaccination coverage must be maintained in order to prevent a resurgence of vaccine-preventable diseases.[5-25] **[Quality, Access]**<br><br>Recommendation: HSAG recommends that Care 1st ACC-RBHA conduct a root cause analysis to determine why some children are not getting their immunizations by their second birthday. This could include conducting focus groups to identify barriers that members are experiencing in accessing care and services in order to implement appropriate interventions. Care 1st ACC-RBHA should consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). Upon identification of a root cause, HSAG recommends that Care 1st ACC-RBHA implement appropriate interventions to improve the performance related to childhood immunizations. |

[5-24] National Committee for Quality Assurance. Controlling High Blood Pressure. Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Jan 31, 2024.
[5-25] National Committee for Quality Assurance. Childhood Immunization Status (CIS). Available at: https://www.ncqa.org/hedis/measures/childhood-immunization-status/. Accessed on: Jan 31, 2024.

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

Table 5-45 presents performance measure recommendations made to Care 1st ACC in the CYE 2022 Annual Technical Report[5-26] and Care 1st ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Care 1st ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 5-45—Care 1st ACC-RBHA Follow-Up to CYE 2022 Performance Measure Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| **Recommendation 1:** |
| HSAG recommended that Care 1st ACC conduct monitoring to ensure all measures that AHCCCS requires to be reported as hybrid are reported as hybrid in future performance measure reporting. This should include planning and development of abstraction tools as well as data capture and integration for non-HEDIS measures, as the Care 1st ACC MRR vendor only had standard abstraction tools available for the hybrid HEDIS measures. |
| **Care 1st ACC-RBHA's Response:**<br>Activities in MY 2022 and status as of November 2023:<br>Care 1st ACC reviewed and clarified its internal policies and processes related to hybrid/MRR requirements for the MY 2021 performance measure record review requirements for the following:<br><br>• Planning and development of abstraction tools<br>• Data capture<br>• Integration for non-HEDIS measures<br>• Supplemental data streams<br>• Race and ethnicity stratification for all applicable measures<br><br>During MY 2022, Care 1st ACC completed hybrid data review for all HEDIS and CMS Core Set measures that offer hybrid data collection. Care 1st ACC is currently preparing for the MY 2023 performance measure record review. For MY 2023, Care 1st ACC will perform hybrid data review for all the HEDIS and CMS Core Set measures that offer MRR for data collection in order to increase its rates.<br><br>In preparation for the MY 2023 Performance Measure Validation Audit, Care 1st ACC worked with a new HEDIS certified vendor to institute abstraction tools for the HEDIS and CMS Core Set measures |

[5-26] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP) Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 1, 2024.

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| requiring hybrid data collection. These tools helped to enhance the collection of medical record documentation. Race and ethnicity stratification for all applicable measures is included in updated processes. Additionally, Care 1st ACC adopted new policies for MRR related to HEDIS chart chases. This includes year-round chart abstraction. |
| **HSAG's Assessment:**<br>HSAG determined that Care 1st ACC-RBHA satisfactorily addressed these prior year's recommendations. |
| **Recommendation 2:** |
| HSAG recommended that Care 1st ACC continue to explore other potential data streams for future supplemental data submissions, which could have a positive impact on multiple Care 1st ACC performance measure rates. This may include electronic health record data feeds, exclusion history files, year-round abstracted data, etc. |
| **Care 1st ACC-RBHA's Response:**<br>As part of the new processes, Care 1st ACC now requests full copies of medical records for members in the samples for each HEDIS and CMS Core Set measure being reviewed as part of hybrid data collection. The goal of reviewing members' full and complete medical record is to provide more robust data, thus helping to increase the supporting documentation that impacts rates for each of the measures. Care 1st ACC also worked with providers to access complete medical records, both through EMR access and in-person MRR.<br>During CYE 2023, Care 1st ACC also launched a Health Equity Committee to explore additional data sources, monitor performance rates, and provide recommendations for interventions aimed at increased health equity. |
| **HSAG's Assessment:**<br>HSAG determined that Care 1st ACC-RBHA satisfactorily addressed this prior year's recommendation. |
| **Recommendation 3:** |
| HSAG recommended that Care 1st ACC explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratifications related to race and ethnicity. Care 1st ACC should continue working with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information. |
| **Care 1st ACC-RBHA's Response:**<br>Race and ethnicity stratification for all applicable measures is included in updated processes. Additionally, Care 1st ACC utilizes artificial intelligence (AI)-based predictive modeling software for additional context when considering health equity interventions. |
| **HSAG's Assessment:**<br>HSAG determined that Care 1st ACC-RBHA satisfactorily addressed these prior year's recommendations. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| **Recommendation 4:** |
| While Care 1st ACC conducted root cause analyses and implemented interventions specific to its CY 2020 *Prenatal and Postpartum Care—Postpartum Care* rate, this rate remained low in CY 2021; therefore, HSAG recommended that Care 1st ACC continue to implement appropriate interventions to improve performance related to postpartum care. HSAG also recommended that Care 1st ACC monitor and expand on interventions currently in place to improve performance for the *Prenatal and Postpartum Care—Postpartum Care* measure indicator. |
| **Care 1st ACC-RBHA's Response:** |
| Activities during CYE 2023 and status as of November 2023:<br>Care 1st ACC performed an analysis of MY 2021 rates by GSA, county, age group, race and ethnicity, and primary language spoken to identify disparities in utilization of services and identify opportunities for improvement. Analysis of why members were not receiving timely postpartum care provided no new barriers to meeting the goal. However, based on administrative data for MY 2023, opportunities for improvement have been identified in Navajo and Mohave counties, which are performing below the current aggregate rate. There were not enough data for members whose primary language was not English to conduct analysis of PPC postpartum rates by language. Data by race and ethnicity are of limited value because of missing values for a large portion of members included in the measure denominator; however, current data do not suggest any significant differences in rates among members based on race.<br><br>Care 1st ACC implemented or continued the following activities to impact the *Prenatal and Postpartum Care—Postpartum Care* measure during CYE 2023:<br>• Monitor administrative rates for the *Postpartum Care* measure indicator of the HEDIS *Prenatal and Postpartum Care* measure monthly using NCQA-certified software. Year-end evaluation will include claims runout and hybrid measure data.<br>• Educate pregnant members about family planning options and the importance of a postpartum visit beginning in the second trimester through written material, texts, and live phone outreach to help reinforce the value of a postpartum visit.<br>• Attempt to contact third trimester and postpartum members by telephone; remind them of the importance of keeping postpartum visits, attempt to assist in making postpartum appointments, and provide member education materials by mail whenever possible.<br>• Send text messages to postpartum members to reinforce the value of a postpartum visit.<br>• Revamp the Care 1st ACC member incentive program. Members are now provided incentives based on claims/encounters instead of the prior process that required the member to complete an attestation. This program includes a financial incentive for completion of the postpartum visit.<br>• Attempt to enroll more postpartum members in a breast feeding support program and mobile application, which provides push notifications about the importance of postpartum visits to enrolled members' phones, as well as 24/7 access to advice and support from a lactation consultant or nutritionist. The application also includes a custom button that provides a direct |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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connection to the Care 1st ACC MCH team, which can help in making a postpartum appointment and arranging for transportation.

- Maintain contact with pregnant members at delivery and immediately post-delivery through text messaging, to educate members on the importance of the postpartum visit and ensure compliance with postpartum visits.
- Launch a Care 1st ACC member portal, which allows members to access individual care gaps 24/7, including the need for a postpartum visit; utilize mini-health screeners; track incentives; change their PCP assignment; and locate in-network providers.
- Care 1st ACC executed a contract with a large telehealth provider. Members have access to licensed physical and behavioral health providers 24/7 via telephone call or video call, aimed at overcoming SDOH barriers such as lack of reliable transportation in rural areas with long distances to services and the need for childcare or having to work.
- Hold JOC meetings with VBP groups, review care gap lists and provider performance, and discuss barriers to care and best practices and strategies for improvement.
  - Launch a provider portal, which allows providers to access member care gap lists for outreach, prior authorization requests, and clinical practice guidelines 24/7.
  - Distribute *Prenatal and Postpartum Care* Measure Guides with appropriate billing codes to providers in order to capture more complete data. Work with provider offices on billing a separate, "zero-dollar" claim with the date of service for the postpartum visit.
- Analyze rates of postpartum visits by race and ethnicity, language, county, and other factors to identify subpopulations with lower-than-average rates of postpartum visits.
  - Launch a Care 1st ACC Health Equity Committee to explore additional data sources, monitor performance rates, and provide recommendations for interventions aimed at increased health equity in postpartum care rates.

Care 1st ACC's self-identified goal for MY 2022 was to achieve a rate of 70.0%, based on hybrid data collection. This is a realistic interim goal to narrow the gap between the most recent national Medicaid mean (MY 2020) of 75.1% and Care 1st ACC's current performance.

The hybrid rate for CY 2022 was 68.4%, and Care 1st ACC did not meet the MY 2022 goal based on hybrid data. The MY 2023 administrative rate as of October 2023 is 37.8% and is 2% higher than the corresponding rate for MY 2021, indicating interventions are effective. However, evaluating the effectiveness of interventions for this measure is difficult based on administrative data alone as a final rate for MY 2023 will be calculated based on hybrid data.

In addition to the interventions discussed above, Care 1st ACC has contracted with a population health management company to outreach members and provide adult care visits, including postpartum visits, via video/telehealth or at the member's home. Outreach started by this vendor in Q3 2023 and performance is monitored biweekly by the Care 1st ACC QI team.

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| **HSAG's Assessment:**<br>HSAG determined that Care 1st ACC-RBHA satisfactorily addressed these prior year's recommendations. |
| **Recommendation 5:** |
| While Care 1st ACC conducted root cause analyses and implemented interventions specific to its CY 2020 *Breast Cancer Screening* and *Cervical Cancer Screening* rates, its rates remained low in CY 2021; therefore, HSAG recommended that Care 1st ACC continue to implement appropriate interventions to improve performance related to its *Breast Cancer Screening* and *Cervical Cancer Screening* rates. HSAG also recommended that Care 1st ACC monitor and expand upon interventions currently in place to improve performance related to these screenings. |
| **Care 1st ACC-RBHA's Response:**<br>***Breast Cancer Screening***<br>Care 1st ACC performed analysis of this measure based on MY 2021 data. Analysis identified the following barriers:<br>• Lack of knowledge of breast cancer risks and screening methods is a continuing barrier cited in the literature.<br>• Fear of bad news; this barrier affects all women but may be a greater negative influence on American Indian (AI) women, along with uncertainty of resources for treatment if diagnosed.<br>• Other cultural factors may negatively influence AI members' decision to obtain mammograms, including traditional sense of female/body, modesty/respect among older generation, and discomfort with clinical settings.<br>• Belief that getting a mammogram is a time-consuming process.<br>• Travel time and distance to mammography facilities.<br>• Lack of a recommendation from a health care provider to get a mammogram also has been cited as a barrier in the literature.<br><br>Women's reluctance to obtain mammograms also appears to have been exacerbated during the COVID-19 PHE, since the service can only be rendered in close contact with a radiology technician. In addition, the rate in the North GSA has historically lagged behind the rate of the rest of the state, and quantitative and qualitative analyses indicate this is due to fewer mammogram facilities in the North and unwillingness of members to travel longer distances to obtain a mammogram.<br><br>Care 1st ACC's self-identified goal for MY 2023 for Breast Cancer Screening is to achieve a rate of 40.0%. This is a realistic interim goal to narrow the gap between the most recent national Medicaid mean (MY 2020) of 53.7% and Care 1st ACC's current performance based on administrative data only, of 34.5%. Although data analysis is limited with the administrative rate only, the current rate is 3.5% higher than MY 2022 administrative rate during the same time period. This indicates that interventions are at least partially effective. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| Activities during CYE 2023 and Status as of October 2023:<br>• Monitor rates for the HEDIS Breast Cancer Screening measure on a monthly basis, using NCQA-certified software.<br>• Attempt to contact members with gaps in care by phone to engage members about well visits and the importance of breast cancer screening. Attempt to make appointments for screening.<br>• Utilize Member Newsletter articles to educate members on the risks associated with breast cancer and importance of regular screening mammography.<br>• Work with a mobile mammography vendor and community organizations to promote access to breast cancer screening and schedule appointments.<br>• Continue sending text messages to members with gaps in care, in order to reinforce the value of preventive services, including messages specific to breast cancer screening.<br>• Revamp the member incentive program. Member incentives are paid based on claims/encounters, no longer requiring members to complete an attestation that the service was completed. The incentive amount for breast cancer screenings was doubled from CYE 2022- CYE 2023. Care 1st ACC will distribute information on the program to members and providers.<br>• Launch the member portal, allowing members to access individual care gaps, including breast cancer screening, and utilize health plan tools including Find a Provider (FAP) to find the nearest mammogram provider.<br>• In-person Member Welcome Pop-Up events, work in conjunction with community events, food banks, health fairs, etc. These events help Care 1st ACC to educate members on benefits and services available, how to get the most from their healthcare, etc. Some events will include provision of services, such as blood pressure checks, well-child visits and immunizations, and mammograms. Outreach staff apprise area members of these events and services available during outreach calls. The QI Team also provides information that allows the Member Advocacy team to engage any Care 1st ACC members with gaps in care who are attending the event.<br>• Continue JOC meetings with VBP practices to review care gaps, provider performance, and best practices, and target barriers that may exist. Additionally, updated care gap lists are provided monthly to the VBP office for outreach.<br>• Launch of the provider portal, allows providers to access health plan tools and to review member care gap lists and current provider performance.<br>• Distribute Breast Cancer Screening Measure Guides with appropriate billing codes to providers in order to capture more complete data on visits.<br>• Analyze rates of breast cancer screening each quarter by race and ethnicity, language, county, and other factors to identify subpopulations with lower-than-average rates of screening.<br>• Work with high-volume contracted providers and community organizations, including tribal entities, to identify and address barriers to completing screening, including those related to race /ethnicity, language, and SDOH (e.g., low health literacy, unemployment, homeless/lack of stable housing, lack of social support systems, or distance to access services). |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| • Utilize the SDOH dashboard to identify barriers such as lack of stable housing, homelessness, lack of reliable transportation, etc., to identify opportunities for additional interventions.<br>• Launch of the Care 1st ACC Health Equity Committee to explore additional data sources, monitor performance rates, and provide recommendations for interventions aimed at increased Health Equity in Breast Cancer Screening rates.<br><br>Care 1st ACC conducted analysis of BCS rates by language and race and ethnicity to identify any additional opportunities for improvement. Analysis by language did not show significant opportunities among members whose primary language was not English. Data by race and ethnicity are of limited value because of missing values for a large portion of members included in the measure denominator; however, data suggest there is an opportunity for improvement in closing gaps among members who are Native American.<br><br>Opportunities for improvement have been identified in all counties.<br>These opportunities include:<br>• Seeking to engage tribal entities and community-based organizations to explore strategies to address language, cultural and physical barriers, including evidence-based approaches to increasing BCS among American Indian women, such as those that incorporate interpersonal/social interactions and community health workers.<br>• Exploring culturally appropriate patient education, as well as culturally competent PCP training.<br>• Revising messaging that addresses members' concerns or fear of bad news and pain from the mammogram, as well as lack of knowledge about breast cancer risks and screening methods (e.g., mammogram technology has improved over the years so that getting a mammogram takes much less time than it used to).<br>• Continuing discussing individual provider performance on this measure with VBPs in lowest performing counties and providing member gaps in care information on a monthly basis.<br><br>Care 1st ACC has partnered with North Country Health Care and its mobile mammography vendor to utilize those mobile services to better address access barriers. Additional opportunities for improvement exist in Apache, Coconino and Navajo counties, which are performing under the GSA average.<br><br>In addition to the interventions discussed above, Care 1st ACC has contracted with a population health management company to outreach members and provide visits via telehealth or at the member's home. Outreach started by this provider in the third quarter of 2023. The goal of the adult care visits with a member who has a BCS care gap, is to engage the member and refer to needed screenings. The member will be given information on incentives available for the completion of breast cancer screenings. The provider group's performance is monitored on a bi-weekly basis by the Care 1st ACC QI team. |

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

***Cervical Cancer Screening***

Activities during CYE 2023 and Status as of October 2023:

Care 1st ACC's self-identified goal for MY 2023 for Cervical Cancer Screening is to achieve a rate of 50.0%, based on hybrid data collection. This is a realistic interim goal to narrow the gap between the most recent national Medicaid mean (MY 2020) of 56.9% and Care 1st ACC's current performance.

The hybrid rate for MY 2022 is 39.2%, and the MY 2023 administrative rate as of October 2023 is 33.3%. A final rate for MY 2023 will be calculated based on hybrid data.

Care 1st ACC performed analysis of MY 2021 and MY 2022 rates by Geographic Service Area (GSA), county, and age group to identify disparities in utilization of services and identify opportunities for improvement. No new barriers to meeting the goal were identified. However, based on administrative data for MY 2022, opportunities for improvement have been identified in all counties except Yavapai, which are performing under the current aggregate rate of 29.0%. The rate in Yavapai County, which accounts for 45% of the measure's total denominator, is 34.1%. Continued opportunities for improvement exist in Apache, Mohave and Navajo counties, which are performing under the GSA average. The rate is especially low among members identified as Native American (American Indian), at 16.3%. Analysis by age shows a significant decline in CCS after age 45 years, with the rate continuing to decline; the rate of screening among women after 55 years of age is about 22.0%.

Analysis by language did not show significant opportunities among members whose primary language was not English. Data by race and ethnicity are of limited value because of missing values for a large portion of members included in the measure denominator; however, data suggest there are opportunities for improvement in closing gaps among members who are Black and Native American.

Care 1st began working with North Country Health Care, which sponsors mobile mammography events in several locations throughout the North, including Apache, Coconino and Navajo Counties, to directly schedule members for those events, most of which also offer cervical cancer screening.

Analysis also identified the following barriers:

- The top reason why women don't get screened is because they don't think they will get cervical cancer, according to the Centers for Disease Control and Prevention (CDC); citing evidence that women who have had a tubal ligation were about half as likely to be screened as women who hadn't, and women who don't need to go to a doctor to get birth control may not talk to any provider about cervical cancer screening.
- Another study found that some women do not continue to get screened for cervical cancer as they get closer to 65 years old, supporting Care 1st ACC's analysis by age.

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| To achieve its goal for Cervical Cancer Screening Care 1st ACC continued or implemented the following interventions for CYE 2023:<br>• Monitor administrative rates for the HEDIS Cervical Cancer Screening measure on a monthly basis, using NCQA-certified software. Year-end evaluation will include claims runout and hybrid measure data.<br>• Attempt to contact members with gaps in care by phone to engage members about well visits and the importance of cervical cancer screening. Attempt to make appointments for screening.<br>• Utilize Member Newsletter articles to educate members on the risks associated with HPV and cervical cancer and importance of regular screening for HPV and cervical cancer. Explore messaging specific to older women, since the screening rate declines after age 50.<br>• Engage members through text messages to members with gaps in care, in order to reinforce the value of preventive services, including messages specific to cervical cancer screening.<br>• Revamp the member incentive program. Member incentives are paid based on claims/encounters, no longer requiring members to complete an attestation that the service was completed. Adult care well visits are eligible for incentive, encouraging member to establish care and receive needed preventative health screenings. Care 1st ACC will distribute information on the program to members and providers.<br>• Launch the member portal, allowing member to access individual care gaps, including cervical cancer screening, and utilize health plan tools including FAP.<br>• In-person Member Welcome Pop-up events, work in conjunction with community events, food banks, health fairs, etc. These events help Care 1st ACC to educate members on benefits and services available, how to get the most from their health care, etc. The QI Team also provides information that allows the Member Advocacy team to engage any Care 1st ACC members with gaps in care who are attending the event.<br>• Continue JOC meetings with VBP to review care gaps, provider performance, best practices and targeting barriers that may exist. Additionally, updated care gap lists are provided monthly to the VBP office for outreach.<br>• Launch of the provider portal, which allows providers to access health plan tools and review member care gap lists and current provider performance.<br>• Distribute Cervical Cancer Screening Measure Guides with appropriate billing codes, to providers, in order to capture more complete data on visits.<br>• Analyze, on a quarterly basis, rates of cervical cancer screening by race and ethnicity, language, county and other factors to identify subpopulations with lower-than-average rates of screening.<br>• Work with high-volume contracted providers and community organizations, including tribal entities, to identify and address barriers to completing screening, including those related to race and ethnicity, language, and SDOH (low health literacy, unemployment, homeless/lack of stable housing, lack of social support systems, distance to access services). Explore participation in events tailored to specific populations, such as "Turquoise Tuesday," a cervical cancer awareness day for Native American women. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| • Explore a partnership with the Arizona chapter of the American Cancer Society (ACS) on possible joint interventions, such as offering ACS training and resource materials to PCPs and OB/GYNs or co-branding ACS patient education materials.<br>• Utilize a dashboard to analyze SDOH, such as lack of family support, unemployment, homelessness/lack of stable housing, etc., to identify opportunities for interventions to address these factors.<br>• Launch of Care 1st ACC Health Equity Committee to explore additional data sources, monitor performance rates and provide recommendations for interventions aimed at increased Health Equity in Cervical Cancer Screening Rates.<br><br>Analysis identified the following opportunities for improvement:<br>• Revise member messaging to stress that all women who have a cervix are at risk of cervical cancer.<br>• Explore collaboration with tribal and community-based organizations to reach Native American women; participate in or sponsor event in conjunction with "Turquoise Thursday," a cervical cancer awareness day for American Indian women.<br>• Continue discussing individual provider performance on this measure with VBPs in lowest performing counties and providing member gaps in care on a monthly basis.<br><br>Care 1st ACC also increased the number of value-based primary care provider groups in the North GSA from 10 to 25 currently. Care 1st ACC is providing each group's performance on this measure, compared with all groups in the Care 1st ACC network and the Care 1st ACC goal, on a monthly basis, along with gaps in care. Quality Improvement staff will meet with those groups at least quarterly to discuss performance, identify barriers, and identify any best practices by high-performing providers, particularly those in Yavapai County.<br><br>In addition to the interventions discussed above, Care 1st ACC has contracted with a population health management company to outreach members and provide visits via telehealth or at the member's home. Outreach started by this provider in the third quarter of 2023. The goal of the adult care visits with a member who has a CCS care gap, is to engage member and refer to needed screenings. The provider group's performance is monitored on a bi-weekly basis by the Care 1st ACC QI team. |
| **HSAG's Assessment:**<br>HSAG determined that Care 1st ACC-RBHA satisfactorily addressed these prior year's recommendations. |
| **Recommendation 6:** |
| While Care 1st ACC conducted a root cause analysis and implemented interventions specific to the CY 2020 *Antidepressant Medication Management—Effective Continuation Phase Treatment* measure, this rate remained low in CY 2021; therefore, HSAG recommended that Care 1st ACC continue to implement appropriate interventions to improve performance related to the *Antidepressant Medication Management—Effective Continuation Phase Treatment* rate. HSAG also recommended that Care 1st |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| ACC monitor and expand on interventions currently in place to improve performance related to continuous medication treatment for members with a diagnosis of major depression. |

**Care 1st ACC-RBHA's Response:**

Analysis of MY 2021 for this measure showed Care 1st ACC exceeded its set goal by 2.4%. The final rate is based on the combined data for the Central and North GSAs. The MY 2021 year-end rate is 5.6% higher than the MY 2020 year-end rate, a statistically significant improvement. These results indicate that interventions in MY 2021 were effective.

The rate for the North GSA was higher than for the Central GSA, at 59.2% compared with 54.3%. Analysis by county shows the lowest rate in Apache County, at 36.8%, although the denominator in that county accounts for only about 3% of the total denominator in the North GSA. While race and ethnicity data provided by AHCCCS are incomplete, analysis by race does not suggest any significant disparities by race. No significant disparities were identified between members whose primary language was English and those whose primary language was not English.

The goal for MY 2023 is to meet the most recent Medicaid mean and to achieve a rate of 44.6%. Care 1st ACC is currently on track to meet the goal with a rate of 44.8%, indicating that interventions are effective.

Activities during CYE 2023 and status as of October 2023:
To achieve its goal for *Antidepression Medication Management*, Care 1st ACC continued or implemented the following interventions for MY 2023:

- Monitor rates for the HEDIS *Antidepressant Medication Management* measure monthly, using NCQA-certified software.
- Utilize member newsletter articles to educate members about the importance of continuing to take medications as prescribed and tips for medication adherence.
- Send text messages to members in the denominator for this measure quarterly, reminding them to not stop taking medication for depression unless their doctor says it is okay. Members who call the Care 1st ACC phone number provided on the text or respond with a text back will be referred to Care Management.
- Educate members about prescription refill options to help ensure they have antidepressant medications as needed, including asking their doctors for 90-day prescriptions and having prescriptions delivered to their homes by mail order.
- Include a "wellness message" in the Care 1st ACC health information system when members have gaps in care for this measure; Care 1st ACC staff having contact with members for any reason (e.g., QI outreach, care management staff) check the system for wellness messages and remind members of gaps in care and assist as needed.
- Share provider performance for this measure versus other network providers with value-based groups monthly, along with member gaps in care for the measure. Identify any best practices of high-performing providers.

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

- Launch of new medication adherence mobile application and incentive program. Members are able to self-report medication compliance daily. Members are able to earn incentives based on percentage of compliance.

Following are Care 1st ACC rates for *Antidepressant Medication Management* over multiple measurement years:

| AMM | Medicaid Mean MY 2020 | Current Oct 2023 | MY 2022 | MY 2021 | MY 2020 |
|---|---|---|---|---|---|
| Effective Acute Phase Treatment | 60.8% | 60.7% | 60.5% | 57.3% | 51.8% |
| Effective Continuation Phase Treatment | 44.6% | 44.8% | 42.3% | 38.9% | 36.0% |

Care 1st ACC is on track to meet the Medicaid mean. Care 1st ACC will continue to monitor rates and evaluate interventions.

**HSAG's Assessment:**

HSAG determined that Care 1st ACC-RBHA satisfactorily addressed these prior year's recommendations.

**Recommendation 7:**

HSAG recommended that Care 1st ACC conduct a root cause analysis to determine why some members were not managing their high blood pressure optimally. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Care 1st ACC should consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). Additionally, Care 1st ACC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, HSAG recommended that Care 1st ACC implement appropriate interventions to improve performance related to this chronic condition.

**Care 1st ACC-RBHA's Response:**

Activities during CYE 2023 and status as of October 2023:

Recently published national data demonstrate inadequate and worsening control of high blood pressure (HBP) in the United States, outcomes that likely have been made worse by the COVID-19 pandemic.[1] Failing to correctly diagnose and control HBP increases cardiovascular disease (CVD) and other major health concerns.

Care 1st ACC conducted a root cause analysis (RCA), using tools such as literature search, cause-and-effect (Ishikawa) diagramming, and brainstorming. The RCA was conducted by a Care 1st ACC team comprised of quality improvement and medical management staff to identify causes/barriers to blood

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

pressure screening and control and opportunities for improvement. Recent feedback from contracted providers, including those providing care in the most underserved areas or to populations with significant health disparities, was considered in this RCA.

Some barriers to controlling HBP cited in literature include poor health literacy, not having access to blood pressure monitoring at home, medication adherence, diet, and other lifestyle choices that negatively impact blood pressure. Patient education tailored to member needs may help remove the negative effects of limited health literacy on the outcomes of effective education.[2] Patients should receive self-management education tailored to their literacy needs, as well as interventions that promote medication adherence, to help with proper management of HBP. HBP was the most-prevalent chronic condition among the Care 1st ACC adult population in 2021, affecting at least 20% of members. Specific barriers to control of HBP among Care 1st ACC members also include factors associated with race and poverty, lack of engagement with primary care services, and lack of transportation and distance to providers in rural counties. Lack of social support has also been linked to higher risks for HBP, heart disease, obesity, and other chronic conditions.[3]

Care 1st ACC identified the following opportunities for improvement: facilitating member engagement with primary care services, ensuring proper blood pressure measurement and assessment of cardiovascular risk, effective patient-centered team-based care, and addressing SDOH (lack of transportation and social support, poverty, etc.)

American Indians comprise the second-largest racial group of Care 1st ACC members, behind Whites, accounting for 10.2% of the membership. ADHS and CDC analyzed data from the 2017 Behavioral Risk Factor Surveillance System (BRFSS) survey, for which American Indian/Alaska Native (AI/AN) people were oversampled, to identify health disparities among AI/AN people living in Arizona. Compared with Whites, AI/AN peoples had significantly higher prevalence of having HBP (32.9% versus 27.6%), as well as being overweight or having obesity (76.7% versus 63.2%), which is associated with hypertension.[4] However, Care 1st ACC was unable to identify a disparity among AI/AN members, with the administrative rate for this population actually higher than for White members.

While administrative data for CBP provides an incomplete picture, Apache and Yavapai counties had the lowest rates, with both showing significantly lower rates than the Care 1st ACC total. Residents in both counties often have to travel long distances to healthcare and other services.

Care 1st ACC's goal is to achieve a rate of 58.6% for this measure, based on the MY 2021 national mean reported by NCQA in the State of Health Care Quality report. Because of the gap between the current rate (MY 2022) of 42.1% and this goal, the health plan has set an interim target of achieving a rate of 45.0% by MY 2024.

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| To achieve its goal for high blood pressure management, Care 1st ACC continued or implemented the following interventions for MY 2023:<br>• Send text messages focused on blood pressure risks and the importance of getting it checked. Other texts encourage members to resume regular doctor visits.<br>• Utilize member newsletter articles to educate members on the importance of an annual adult wellness visit and having their blood pressure checked, as well as risk factors for HBP and tips for lifestyle choices to control BP.<br>• Share providers' performance rate for this measure versus other network providers with value-based groups monthly, along with member gaps in care for the measure; review performance with the provider at least quarterly and discuss barriers and strategies for improvement.<br>• Contract with Catalytic Health Partners to provide in-home visits for care management of members with hypertension (HTN) and high-risk criteria; provide telemonitoring through tablet technology, and connection of member to PCP so members can monitor and upload vital signs (blood pressure, weight, and blood glucose readings). Catalytic staff help participants access community resources to address SDOH, as well as help with stress, anxiety, and other mental health needs.<br>• Deploy the Pharmacy Advisor Support (PAS) Program, with tailored messages to providers to meet the needs of members with chronic conditions, focusing on adherence and gaps in care. HBP was one of the targeted disease states.<br>• Deploy the new HealthTag Hypertension campaign; members 18 years of age and older with a diagnosis of HBP receive messages when they pick up prescriptions to get their blood pressure checked with their PCP or at the pharmacy, and results are sent to the PCP to ensure the member is being appropriately treated.<br>• Utilize a mobile clinic serving Mohave County to provide blood pressure checks; promote availability and schedule to members in the area via outreach calls, member newsletter, and targeted text messages.<br>• Launch "Welcome Rooms" in conjunction with community events, food banks, health fairs, etc., to engage and educate members. Some events will include blood pressure checks. QI provides information that allows the Member Advocacy team to engage any Care 1st ACC members with gaps in care who are attending the event.<br>• Deploy the Wellth mobile application, which incentivizes members for medication adherence; members can earn incentives for daily check-ins to show they are taking their medications and (depending on their diagnosed conditions) monitoring their blood sugar and blood pressure.<br>• Promote new member incentives for completion of adult well visit, to encourage more members to establish care with a PCP and get help controlling blood pressure if needed; distribute information on the program to members and providers. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| [1] Casey DE, Daniel DM, Bhatt J, et.al. Controlling High Blood Pressure: An Evidence-Based Blueprint for Change. *Am J Med Qual.* 2022. Available at https://pubmed.ncbi.nlm.nih.gov/34038915/). Accessed on: Feb 15, 2024.<br>[2] Delavar F, Pashaeypoor S, Negarandeh R. The effects of self-management education tailored to health literacy on medication adherence and blood pressure control among elderly people with primary hypertension: A randomized controlled trial. *Patient Education and Counseling*. 2020. Available at https://www.sciencedirect.com/science/article/abs/pii/S0738399119303684?via%3Dihub). Accessed on: Feb 15, 2024.<br>[3] Organization for Economic Co-operation and Development. Social Support. 2022. Available at https://data.oecd.org/healthrisk/social-support.htm. Accessed on: Feb 27, 2024.<br>[4] Centers for Disease Control and Prevention. Health Disparities Among American Indians/Alaska Natives — Arizona, 2017. 2018. Available at: https://www.cdc.gov/mmwr/volumes/67/wr/mm6747a4.htm). Accessed on: Feb 15, 2024. |
| **HSAG's Assessment:**<br>HSAG determined that Care 1st ACC-RBHA satisfactorily addressed these prior year's recommendations. |
| **Recommendation 8:** |
| HSAG recommended that Care 1st ACC conduct a root cause analysis to determine why some children were not always getting their immunizations by their second birthday. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Care 1st ACC should consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). Additionally, Care 1st ACC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, HSAG recommended that Care 1st ACC implement appropriate interventions to improve the performance related to childhood immunizations. |
| **Care 1st ACC-RBHA's Response:**<br>Activities during CYE 2023 and status as of October 2023:<br>RCA using tools such as a literature search, cause-and-effect (Ishikawa) diagramming, and brainstorming was conducted by a Care 1st ACC team composed of QI staff to identify causes/barriers to childhood immunizations and opportunities for improvement. Recent feedback from contracted providers, including those providing care in the most underserved areas or to populations with significant health disparities, was considered in this RCA.<br><br>According to the CDC, vaccination coverage declined for children living below the federal poverty level or in rural areas during the pandemic,[1] The CDC has also noted substantial declines in doses of long-recommended vaccines such as diphtheria, tetanus and acellular pertussis (DTaP) and measles, mumps and rubella (MMR) administered to children ages 0–23 months during mid-2020, compared with the same period in 2019, which is attributed to the COVID-19 pandemic.[2] |

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

Recent declines in vaccine coverage levels, whether attributed directly to the pandemic or not, have affected all three *CIS* combination submeasures:

Combo 3—For children reaching 24 months, coverage estimates were lower for the 7-vaccine series that comprises the HEDIS *Combination 3* submeasure during the pandemic. In particular, the CDC noted significantly lower rates for Hib-PS and HepB completion for Arizona children at the 13-month and 16-month age milestones.

Combo 10—In addition to the nine vaccines that make up the *Combination 7* series, *Combination 10* includes the influenza vaccine, which has shown to be at significantly lower levels among children in rural areas. Data from the National Immunization Survey for the 2016–17 season show that influenza vaccination coverage in children residing in rural areas was 12.6 percentage points lower than children residing in urban areas and 7.4 percentage points lower than children residing in suburban areas.[3] Care 1st ACC data for MY 2021 and MY 2022 show the lowest rate of vaccine completion is for the influenza vaccine, resulting in a statistically significant difference between the rate for *Combination 7* and the rate for *Combination 10*. When analyzing data for all the combinations included in HEDIS MY 2020 and MY 2021 specifications, flu vaccination had the greatest effect on any combination for which it was included.

March of Dimes, in partnership with Pfizer, recently conducted a survey to understand barriers to routine childhood immunization.[4] Among a sample of parents who said their youngest child had not received any of the recommended childhood vaccines, 17% said their child missed routine vaccinations because of impacts of the COVID-19 pandemic. Among these parents, their healthcare provider's lack of availability during the pandemic (63%) and being afraid of contracting COVID-19 while at the doctor (58%) were influential factors in their youngest child missing a routine vaccine during the pandemic. These were factors observed by Care 1st ACC staff in attempting to engage parents to complete childhood immunizations.

Other barriers to completion of childhood immunizations identified by Care 1st ACC include time/travel distance to obtain services, inability of parents to take time off work for well-child visits, and lack of childcare for other children in the home. In addition, Care 1st ACC has experienced increasing resistance from parents to recommended preventive services, as reflected by a decline in rates for well visits from birth through 15 months and childhood immunizations in 2020 and 2021. Health plan staff have noticed the culture in the north often reflects an attitude of "I will schedule (a visit) when I can" and "I don't need you telling me when to schedule." This experience echoes findings of focus groups conducted by Strong Families AZ with support of the Arizona Department of Health, Bureau of Women's and Children's Health.[5] Focus group participants first sought information from Facebook "mom groups" and Google before deciding to obtain well-child visits, where most immunizations take place. Most focus group participants said they are comfortable with "calling the shots" and avoiding pediatric visits altogether.

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| COVID-19 vaccine hesitancy appears to have translated into anti-vaccine sentiment in general, according to Care 1st ACC provider feedback and national pediatric health experts.[6] In the March of Dimes survey, 70% said concerns about the safety of vaccines were an influential factor in not having their children immunized. CDC estimates of COVID-19 vaccine hesitancy by county in the North GSA ranged from 13.7% to 21%, with rates of "strongly hesitant" at 10% to 15%.[7] Apache and Navajo counties had the highest rates of hesitancy.<br><br>As noted, vaccination coverage declined for children living below the federal poverty level or in rural areas from 2019 through 2021. Both of these demographic factors affect most of the Care 1st ACC child population. Census data show that approximately one-third of children in Apache, Mohave, and Navajo counties were living below the federal poverty threshold in 2021, compared with 17.3% of Arizona children overall. Rates of child poverty in Coconino and Yavapai counties were 15.7% and 19.2%, respectively. Care 1st ACC data for *CIS* show the lowest rates for all three *CIS* combinations in Apache and Navajo counties in MY 2021. Mohave County also showed much lower rates than Coconino and Yavapai counties, especially for the combinations that included the flu vaccine.<br><br>Care 1st ACC analysis did not show a significant disparity in MY 2021 or MY 2022 *CIS* rates between children identified as AI/AN compared to children identified as White; in fact, rates among AI/AN members were higher than those of White members.<br><br>Thus, effects of COVID-19, coupled with unique challenges and barriers associated with the frontier and remote (FAR) areas that comprise northern Arizona greatly impacted Care 1st ACC's performance for this measure.<br><br>Care 1st ACC's goal is to achieve the following rates, based on the MY 2021 national means reported by NCQA: *Combination 3* – 63.0%, *Combination 10* – 35.9%. Because of the gap to goal for these rates, Care 1st ACC has set interim rates to be achieved by MY 2024, which represent realistic targets that demonstrate improvement:<br>*Combination 3* – 60% (increase of 4% over MY 2021), *Combination 10* – 29% (increase of 3% over MY 2021).<br><br>To achieve its goal for Well Child Visits, Care 1st ACC continued or implemented the following interventions for MY 2023:<br>• Attempt to contact parents/healthcare decision makers of members with gaps in care by phone to engage them about well visits and the importance of childhood immunizations; attempt to make appointments for visits. Two Care 1st ACC care engagement specialists are assigned to this outreach.<br>• Send text messages to parents/healthcare decision makers of members 0–15 months of age, with tips on developmental milestones and child wellness, including immunizations; encourage them to make an appointment or call Care 1st ACC for help. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| • Maternal Child Health staff educate birth parents/healthcare decision makers about visits and vaccinations needed for infants during newborn calls.<br>• Promote the Care 1st ACC member incentive for completion of well-child visits in the first 15 months of life to allow providers to educate about vaccines, immunize, and distribute information on the program to members and providers.<br>• Share providers' performance rate for *CIS* combination measures versus other network providers with value-based groups monthly, along with member gaps in care for the measure; review performance with the provider at least quarterly and discuss barriers and strategies for improvement.<br>• Send monthly provider rosters identifying members due for visits; distribute lists of gaps in care of assigned members overdue for visits to allow providers to educate about vaccines and immunize, at least quarterly (monthly to value-based provider groups).<br>• Utilize member newsletter articles to educate parents on the value of well-child visits and immunizations and address vaccine-related myths and misunderstandings.<br>• Partner with providers such as FQHCs and community organizations to close gaps during health fairs, which include childhood immunizations; provide gaps to the contracted FQHC. This intervention started with Creek Valley Health Clinic health fair in June 2022; Care 1st ACC continues to work more closely with various organizations, including the Arizona Partnership for Immunization (TAPI), Colorado City Medical Center, Mohave County Department of Public Health (DPH) and Mohave County Immunization Coalition, to bring resources to rural communities.<br>• A strong focus on influenza vaccines was added to every outreach call; talking points added to EPSDT and MCH staff job aids.<br>• Enhance member incentive for completion of early childhood well visits by increasing the incentive.<br>• Promote AHCCCS-wide Back to School campaign, tying into parents' desires to complete sports/school physicals; talk with parents/caregivers about how they will receive a more valuable service through the well-child visit at no cost to them instead of paying a fee for the sports physical, which is not covered by AHCCCS.<br>• Participate in "Fluvention" outreach campaign; postcards will be sent to all members to remind them of the need for a yearly flu vaccination.<br>• Expand the text message program for parents/healthcare decision makers of young children from texts in the first 15 months of life up to 30 months; include information to combat vaccine myths/misunderstandings. |

[1] Hill HA, Chen M, Elam-Evans LD. Vaccination Coverage by Age 24 Months Among Children Born During 2018–2019 — National Immunization Survey–Child, United States, 2019–2021. 2023. *MMWR* Available at https://www.cdc.gov/mmwr/volumes/72/wr/mm7202a3.htm#). Accessed on: Feb 15, 2024.

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| [2] Centers for Disease Control and Prevention. Childhood Vaccination Coverage Before and During the COVID-19 Pandemic among Children Born January 2017-May 2020, National Immunization Survey-Child (NIS-Child), 2018–2021. 2023. Available at: https://www.cdc.gov/vaccines/imz-managers/coverage/childvaxview/pubs-presentations/nis-child-pandemic-effects-2018-2021.html. Accessed on: Feb 15, 2024.<br>[3] Zhai Y, Santibanez T, Kahn K, et al. Rural, urban, and suburban differences in influenza vaccination coverage among children. Vaccine. Nov 2020. Available at: https://www.sciencedirect.com/science/article/abs/pii/S0264410X20313244. Accessed on: Feb 15, 2024.<br>[4] Understanding Barriers to Routine Childhood Immunization. 2022. Available at https://www.marchofdimes.org/sites/default/files/2023-04/March-of-Dimes-Barriers-to-Routine-Childhood-Immunization-Fact-Sheet-9-9-22.pdf. Accessed on: Feb 15, 2024.<br>[5] Strong Families AZ. 2019 Conference Presentation.<br>[6] Joseph A. Routine vaccinations drop among U.S. kindergartners for the third year in a row. *STAT*. 2023. Available at: https://www.statnews.com/2023/01/12/routine-vaccinations-kindergartners/. Accessed on: Feb 15, 2024.<br>[7] Centers for Disease Control and Prevention. Estimates of vaccine hesitancy for COVID-19. 2021. Available at https://data.cdc.gov/stories/s/Vaccine-Hesitancy-for-COVID-19/cnd2-a6zw/. Accessed on: Feb 15, 2024. |
| **HSAG's Assessment:**<br>HSAG determined that Care 1st ACC-RBHA satisfactorily addressed these prior year's recommendations. |

## *Validation of Performance Improvement Projects*

### Back to Basics PIP

In CYE 2023, Care 1st ACC-RBHA continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 1, PIP validation activities focused on improvement from the baseline results. Care 1st ACC-RBHA submitted Remeasurement 1 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes or discontinuation of the interventions.

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

### *Validation Results*

Table 5-46 displays the overall confidence levels for the Care 1st ACC-RBHA *Back to Basics* PIP.

**Table 5-46—Care 1st ACC-RBHA *Back to Basics* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| Care 1st ACC-RBHA | *High Confidence* | 100% | 100% | *No Confidence* | 33% | 100% |

### *Measure Results*

Table 5-47 and Table 5-48 provide the *Back to Basics* PIP baseline, intervention, and Remeasurement Year 1 rates for each indicator for Care 1st ACC-RBHA.

**Table 5-47—Care 1st ACC-RBHA *Back to Basics* PIP Rates for PIP Indicator 1**

| Contractor | PIP Measure Indicator 1: *W30 Rate 1* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| Care 1st ACC-RBHA | 70.5% | 53.5% |

**Table 5-48—Care 1st ACC-RBHA *Back to Basics* PIP Rates for PIP Indicator 2**

| Contractor | PIP Measure Indicator 2: *WCV* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| Care 1st ACC-RBHA | 51.4% | 33.7% |

### *Interventions*

Table 5-49 presents PIP interventions for Care 1st ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 5-49—Care 1st ACC-RBHA *Back to Basics* PIP Interventions**

| Contractor | Interventions |
|---|---|
| Care 1st ACC-RBHA | • Send monthly reminders for children due for a well or dental visit.<br>• Conduct proactive phone outreach to parents/healthcare decision makers of children for recommended visits, Calls made at 3 and 6 weeks of age, and at 3, 5, 11, 14, 17, 23, and 29 months of age.<br>• Educate parents/healthcare decision makers about the value of well visits and the recommended interval for visits through the member newsletter; the update to this includes utilization of social media and the health plan website.<br>• Text message campaign to parents/healthcare decision makers of members 0–15 months of age; tailored messages include education on developmental milestones, and texts also include outreach prior to the first birthday to encourage a dental visit.<br>• Text message campaign to parents/healthcare decision makers of members 3–20 years old advising of well and dental visits due, and brief education of why the visit is important. Members ages 18–20 years receive messages directly with a message tailored to that age group.<br>• Offer the Healthy Rewards Program to incentivize completion of six well visits by 15 months of age. A revamp of the program included contracting with a new vendor with a streamlined claims-based incentive payout. Members no longer need to take the extra step of filling out and submitting an attestation of a completed visit.<br>• Offer the Healthy Rewards Program to incentivize completion of an annual visit for members 2–20 years old. A revamp of the program included contracting with a new vendor with a streamlined claims-based incentive payout. Members no longer need to take the extra step of filling out and submitting an attestation.<br>• Send monthly provider rosters identifying members due for visits to PCPs (VBP practices receive gaps in care on a monthly basis).<br>• Send Practice Pointers to PCPs with topics related to the EPSDT Periodicity Schedule completed on a well visit during a problem-focused visit, when possible; oral health screening and referral to dental provider; correct coding.<br>• Utilize agreements/financial incentives with providers to reach out to assigned members to complete well and dental visits, share care gaps in JOC meetings and discuss best practices/barriers to increasing rates.<br>• Actively work with Head Start agencies to facilitate the completion of well and dental visits.<br>• Partner with community-based organizations to sponsor/participate in community health fairs that provide well checks and dental screenings. |

| Contractor | Interventions |
|---|---|
| | • Launch the Member Portal that allows parents/healthcare decision makers of members 24/7 on-demand access to individual care gaps, to complete mini-health screening, to change their PCP, search for a provider, and view authorization status.<br>• Launch the provider portal, which allows providers 24/7 on-demand access to view measure rates and member rosters, submit OneTouch prior authorization requests, and access practice support tools such as EPSDT forms.<br>• Execute a large telehealth contract with Teladoc, allowing access to physical and behavioral health non-emergency on-demand 24/7 through telephone call or video.<br>• Subcontract with Adobe Health Care to engage and complete in-home or telephonic visits for difficult-to-reach members with gaps in care. |

### *Strengths, Opportunities for Improvement, and Recommendations*

Table 5-50 presents strengths, opportunities for improvement, and recommendations for Care 1st ACC-RBHA related to the *Back to Basics* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-50—Care 1st ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG noted that Care 1st ACC-RBHA performed accurate statistical testing between the baseline and Remeasurement 1 results. **[Quality, Access]**<br><br>Care 1st ACC-RBHA developed and implemented measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 2. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| For indicator 1, Care 1st ACC-RBHA had a decline of 16.97 percentage points in the indicator rate between the baseline year and Remeasurement Year 1. Care 1st ACC-RBHA had a decline of 17.69 percentage points in the indicator rate between the baseline year and Remeasurement Year 1 for indicator 2. **[Quality, Access]**<br><br>Recommendations: As the PIP progresses, HSAG recommends that Care 1st ACC-RBHA:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

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

Table 5-51 presents PIP recommendations made to Care 1st ACC in the CYE 2022 Annual Technical Report[5-27] and Care 1st ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Care 1st ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 5-51—Care 1st ACC-RBHA Follow-Up to CYE 2022 PIP Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for PIP |
|---|
| HSAG recommended that Care 1st ACC:<br>• Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary.<br>• Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available.<br>• Develop and document a plan for sustaining the improvement for any demonstrated improvement in indicator rates. |
| **Care 1st ACC-RBHA's Response:**<br>Activities during CYE 2023 and status as of October 2023:<br>In CY 2022, Care 1st ACC continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP is in an intervention year, PIP validation activities focused on intervention analysis. Care 1st ACC submitted interventions implemented during CY 2022 along with the intervention status, focus, and rationale for changes or discontinuation of the intervention for the following year.<br><br>To achieve its goal to increase rates for all members in the PIP, Care 1st ACC continued or implemented the following interventions for MY 2023:<br>• Monitor administrative rates for the HEDIS measures monthly using NCQA-certified software. Year-end evaluation will include claims runout and hybrid measure data. |

[5-27] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP) Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 8, 2024.

| Prior Year's Recommendation from the EQR Technical Report for PIP |
|---|
| • Attempt to contact members with gaps in care by phone to engage members about well visits and the importance of cervical cancer screening. Attempt to make appointments for screening.<br>• Utilize Member Newsletter articles to educate parents/decision makers of members on recommended screenings.<br>• Engage members through text messages to members with gaps in care to reinforce the value of preventive services, including messages specific to cervical cancer screening.<br>• Revamp the member incentive program. Member incentives are paid based on claims/encounters, no longer requiring members to complete an attestation that the service was completed. The health plan will distribute information on the program to members and providers.<br>• Launch the Member Portal, which allows members to access individual care gaps, including well child, immunizations, and dental screenings, and to utilize health plan tools including FAP.<br>• In-person Member Welcome Pop-Up events, work in conjunction with community events, food banks, health fairs, etc. These events help Care 1st ACC to educate members on benefits and services available, how to get the most from their healthcare, etc. The QI Team also provides information that allows the Member Advocacy team to engage any Care 1st ACC members with gaps in care who are attending the event.<br>• Continue JOC meetings with VBP practices to review care gaps, provider performance, and best practices, and target barriers that may exist. Additionally, updated care gap lists are provided monthly to the VBP office for outreach.<br>• Launch of the provider portal, which allows providers to access health plan tools and review member care gap lists and current provider performance.<br>• Distribute developmental screening Measure Guides with appropriate billing codes to providers in order to capture more complete data on visits.<br>• Analyze HEDIS measures within the PIP quarterly by race and ethnicity, language, county and other factors to identify subpopulations with lower-than-average rates of screening.<br>• Work with high-volume contracted providers and community organizations, including tribal entities, to identify and address barriers to completing screening, including those related to race and ethnicity, language, and SDOH (e.g., low health literacy, unemployment, homeless/lack of stable housing, lack of social support systems, or distance to access services).<br>• Utilize the dashboard to analyze SDOH, such as lack of family support, unemployment, homelessness/lack of stable housing, etc., to identify opportunities for interventions to address these factors.<br>• Launch of the Care 1st ACC Health Equity Committee, with a Children's Health subcommittee, to explore additional data sources, monitor performance rates, and provide recommendations for interventions.<br><br>In addition to the interventions discussed above, Care 1st ACC has contracted with a population health management company to outreach members and provide visits via telehealth or at the member's home. Outreach was started by this provider in Q3 of 2023. |

| Prior Year's Recommendation from the EQR Technical Report for PIP |
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| Care 1st ACC will continue to implement identified interventions and assess the impact and effectiveness of the interventions after the first remeasurement year. |
| **HSAG's Assessment:** HSAG has determined that the Contractor has satisfactorily addressed these prior year's recommendations. |

## Prenatal and Postpartum Care PIP

In CYE 2023, Care 1st ACC-RBHA submitted baseline measurement results for the *Prenatal and Postpartum Care* PIP, which was initiated in CY 2022. Care 1st ACC submitted baseline performance indicator results and interventions implemented.

HSAG conducted an annual validation of the baseline year reflective of CY 2022 (January 1, 2022, through December 31, 2022) using AHCCCS-calculated and validated indicator rates. HSAG evaluated Care 1st ACC-RBHA's performance indicator results based on an analysis of improvement strategies implemented as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

### *Validation Results*

Table 5-52 displays the overall confidence levels for the Care 1st ACC-RBHA *Prenatal Care and Postpartum Care* PIP.

**Table 5-52—Care 1st ACC-RBHA *Prenatal and Postpartum Care* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| Care 1st ACC-RBHA | *High Confidence* | 100% | 100% | *Not Assessed* | *Not Assessed* | *Not Assessed* |

### *Measure Results*

Table 5-53 and Table 5-54 provide the *Prenatal and Postpartum Care* PIP baseline year rates for each indicator for Care 1st ACC-RBHA.

**Table 5-53—Care 1st ACC-RBHA *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 1**

| Contractor | PIP Indicator 1: *Timeliness of Prenatal Care* |
|---|---|
| | Baseline Year |
| | CY 2022 |
| Care 1st ACC-RBHA | 75.4% |

**Table 5-54 Care 1st ACC-RBHA *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 2**

| Contractor | PIP Indicator 2: *Postpartum Care* |
|---|---|
| | Baseline Year |
| | CY 2022 |
| Care 1st ACC-RBHA | 68.4% |

### *Interventions*

Table 5-55 presents PIP interventions for Care 1st ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 5-55—Care 1st ACC-RBHA *Prenatal and Postpartum Care* PIP Interventions**

| Contractor | Interventions |
|---|---|
| Care 1st ACC-RBHA | • Care engagement staff attempt to educate pregnant members about the importance of timely prenatal care through written material, texts, and live phone outreach. Prenatal text messages focus of education is tailored to the members' week of pregnancy to engage and provide information for self-care and content of prenatal visits specific to trimester.<br>• Attempt to contact members immediately after Notice of Pregnancy is received by telephone to remind them of the importance of prenatal care visits, assist in making appointments, and provide member education materials by mail whenever possible.<br>• Attempt to enroll pregnant members in the Pacify Program, which will provide push notifications to their phones about the importance of prenatal nutrition and visits. The application also includes a custom button that provides a direct connection to the Care 1st MCH team, which can help in making appointments and arranging transportation.<br>• Offer the Healthy Rewards Program to incentivize completion of a postpartum visit. A revamp of the program included contracting with a new vendor with a streamlined claims-based incentive payout. Members no |

| Contractor | Interventions |
|---|---|
| | longer need to take the extra step of filling out and submitting an attestation of a completed visit.<br>• Educate pregnant members about family planning options and the importance of postpartum visits beginning in the second trimester through written material, texts, and live phone outreach to help reinforce the value of a postpartum visit.<br>• Send monthly provider rosters identifying members due for visits to PCPs (VBP practices receive gaps in care monthly).<br>• Attempt to enroll postpartum members in the Pacify Program, which will provide push notifications to their phones about the importance of postpartum visits. The application also includes a custom button that provides a direct connection to the Care 1st MCH team, which can help in making a postpartum appointment and arranging for transportation.<br>• Launch the member portal, which allows parents/healthcare decision makers of members 24/7 on-demand access to fill out notice of pregnancy, view individual care gaps, complete mini-health screener, change a PCP, search for a provider, and view authorization status.<br>• Launch the provider portal, which allows providers 24/7 on-demand access to view measure rates and member rosters; submit OneTouch prior authorization requests; and access practice support tools such as the EPSDT form.<br>• Execute a large telehealth contract with Teladoc, allowing access to physical and behavioral health non-emergency on-demand 24/7 through telephone call or video.<br>• Subcontract with Adobe Health Care to engage and complete in-home or telephonic visits for difficult-to-reach members with gaps in care. |

### *Strengths, Opportunities for Improvement, and Recommendations*

Table 5-56 presents strengths, opportunities for improvement, and recommendations for Care 1st ACC-RBHA related to the *Prenatal and Postpartum* Care PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-56—Care 1st ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to the *Prenatal and Postpartum Care* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| Care 1st ACC-RBHA developed and implemented measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 1. **[Quality, Access]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Opportunities for Improvement and Recommendations** |
| For indicator 1, 75.4 percent of women had a prenatal care visit in the first trimester and 68.4 percent had a postpartum visit between seven and 84 days after delivery during CYE 2022. **[Quality, Access]**<br><br>Recommendations: As the PIP progresses, HSAG recommends that Care 1st ACC-RBHA:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

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

The *Prenatal and Postpartum Care* PIP was initiated in CY 2022; therefore, this section is not applicable.

## *Compliance Reviews*

In November 2021, AHCCCS awarded Care 1st a new ACC-RBHA contract, expanding the current ACC contract. As a result, the Contractor went through an extensive readiness review, which was conducted from April through October 2022.

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

AHCCCS stated that it views the readiness review process as an ongoing series of activities to monitor and ensure Contractor progress. AHCCCS initiates the readiness review process roughly six months prior to the contract effective date. These readiness activities are essential to establishing the capacity of the awarded Contractors to function in a number of critical areas, including operations and administration, service delivery, financial management, and systems management. The Care 1st ACC-RBHA contract began on October 1, 2022. The compliance review will be conducted in CYE 2024 and will therefore be included in the CYE 2024 annual technical report.

## Network Adequacy Validation

### Results

HSAG evaluated Care 1st ACC-RBHA's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents semiannual validation findings specific to the ACC Program, with one results table for the following GSA:

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

Each region-specific table summarizes semiannual validation results containing the percentage of members meeting each time/distance standard by quarter and county, with color-coding to identify whether or not the time/distance standard was "*Met*" or "*Not Met*."

The value "NA" is shown for time/distance standards that do not apply to the county or program.

The value "NR" is shown for time/distance standards in which no members met the network requirement denominator for the program and county; therefore, HSAG calculated no corresponding time/distance result.

Yellow color-coding identifies instances in which HSAG's time/distance results met the minimum network requirement but differed from the ACOM 436 results.

Red color-coding identifies instances in which HSAG's time/distance results did not meet the compliance standard, regardless of the ACOM 436 results.

An asterisk (*) indicates that fewer than 10 members were included in the denominator of HSAG's results.

A carat (^) indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

**Table 5-57—Care 1st ACC-RBHA Time/Distance Validation Results for North GSA—Percentage of Members Meeting Minimum Network Requirements**

| | Apache | | Coconino | | Mohave | | Navajo | | Yavapai | |
|---|---|---|---|---|---|---|---|---|---|---|
| Minimum Network Requirement | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 79.7^ | 79.9^ | 98.7^ | 98.8^ | 99.9^ | 99.9^ | 95.0^ | 95.3^ | 100.0^ | 100.0^ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 75.9^ | 74.8^ | 98.5^ | 98.4^ | 99.8^ | 99.8^ | 92.1^ | 92.3^ | 100.0^ | 100.0^ |
| BHRF | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Cardiologist, Adult | 91.7^ | 92.1^ | 99.1^ | 99.1^ | 99.9^ | 99.9^ | 96.3^ | 96.6^ | 100.0^ | 100.0^ |

| Minimum Network Requirement | Apache | | Coconino | | Mohave | | Navajo | | Yavapai | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Cardiologist, Pediatric | 98.6 | 98.3 | 100.0^ | 100.0^ | 100.0 | 100.0 | 100.0 | 100.0 | 100.0^ | 100.0^ |
| Dentist, Pediatric | 68.0 | 84.2 | 87.6 | 86.2 | 94.4 | 98.6 | 89.9 | 90.3 | 98.4 | 98.3 |
| Hospital | 97.0 | 81.4 | 100.0 | 100.0 | 99.9 | 99.9 | 99.9 | 99.8 | 100.0 | 100.0 |
| OB/GYN | 96.8 | 95.5 | 99.9 | 100.0 | 99.9 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 89.7 | 90.7 | 92.6 | 93.0 | 98.8 | 98.8 | 96.5 | 96.5 | 98.6 | 98.7 |
| PCP, Adult | 90.9^ | 92.7^ | 99.2^ | 98.9^ | 98.9^ | 98.8^ | 99.9^ | 99.7^ | 100.0^ | 99.7^ |
| PCP, Pediatric | 88.6^ | 90.2^ | 98.5^ | 98.4^ | 99.0^ | 98.9^ | 96.7^ | 97.0^ | 100.0^ | 99.6^ |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
represents time/distance standard results that do not meet the compliance standard based on HSAG's results.
^indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.

## Strengths, Opportunities for Improvement, and Recommendations

Table 5-58 presents strengths, opportunities for improvement, and recommendations for Care 1st ACC-RBHA related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-58—Care 1st ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to NAV**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths:<br><br>• Care 1st ACC-RBHA met all time/distance network standards for both quarters in CYE 2023 in Mohave and Yavapai counties. **[Access]**<br>• Care 1st ACC-RBHA met time/distance network standards for Cardiologist, Adult and Pediatric; OB/GYN; and PCP, Adult and Pediatric. **[Access]**<br><br>Note: Care 1st ACC-RBHA provides coverage in the following counties: Apache, Coconino, Mohave, Navajo, and Yavapai. |
| **Opportunities for Improvement and Recommendations** |
| HSAG identified the following opportunities for improvement: |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| • Care 1st ACC-RBHA failed to meet the time/distance standard for at least one quarter and/or county for Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric, Dentist, Pediatric, Hospital and Pharmacy. **[Access]**<br><br>Recommendation: HSAG recommends that Care 1st ACC-RBHA maintain current compliance with network standards, but continue to address network gaps, as applicable. |

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

Table 5-59 presents NAV recommendations made to Care 1st ACC in the CYE 2022 Annual Technical Report[5-28] and Care 1st ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Care 1st ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 5-59—Care 1st ACC-RBHA Follow-Up to CYE 2022 NAV Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for NAV |
|---|
| HSAG recommended that Care 1st ACC maintain current compliance with network standards but continue to address network gaps, as applicable. |
| **Care 1st ACC-RBHA's Response:**<br>During CYE 2022, Care 1st ACC continued to use Quest Analytics software to verify the adequacy of the geographic distribution of its PCP, OB/GYN, dental, behavioral health, specialist, and pharmacy providers. Quest Analytics reports are run at least bi-annually and maps the existing membership against the contracted practice sites and locations of the identified providers.<br><br>The results of the availability analysis are reviewed against AHCCCS standards outlined in Policy 436 of the AHCCCS ACOM and used to update the Network Needs List. The Network Needs List was and continues to be used throughout the year to correct network gaps through recruiting efforts focused on key areas without desired access to care. In addition to the specialties that are broken out in the analysis, Care 1st ACC works to contract with all other available specialties in its geographic service areas. Through this analysis, Network Management targets ZIP Codes and provider types identified as at risk for failure to meet AHCCCS and Care 1st ACC standards.<br><br>The following are updates on Care 1st ACC's follow-up activities on EQRO findings and recommendations. |

[5-28] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP) Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 8, 2024.

**Prior Year's Recommendation from the EQR Technical Report for NAV**

Behavioral Health Outpatient and Integrated Clinics, Adult

According to HSAG's results, Care 1st ACC' rate of compliance with ACC network time/distance standards for Behavioral Health Outpatient and Integrated Clinics, Adult in Apache County was 75.1% as of the end of Q4 2021 and has increased to 78.3% in Q4 2022.

Activities during CYE 2023 and Status as of October 2023: Care 1st ACC continued to perform analyses to identify gaps and will continue to closely monitor any changes in the network and potential recruitment opportunities. To ensure members in this county receive needed services, outpatient behavioral health and integrated clinics have been providing telehealth services to adult members in Apache County. The other ACC Contractor in the North did not meet the time/distance standards for CYE 2021, underscoring the challenges of providing Behavioral Health Outpatient and Integrated Clinic services to adults in this area.

While this rate was previously exceeding the goal, current results show that the rate of Care 1st ACC members who have access to behavioral health services within the defined time/distance requirements has declined to below the standard and the plan's goal of 90%. Care 1st ACC has multiple providers in Apache County, but they are outside the time/distance standards for some members. Based on claims utilization, more than 20 behavioral health and integrated clinics are currently providing telehealth services to adult members in Apache County.

Behavioral Health Outpatient and Integrated Clinics, Pediatric

According to HSAG's results, Care 1st ACC decreased its rate of compliance with ACC network time/distance standards for Behavioral Health Outpatient and Integrated Clinics, Pediatric providers in Apache County to 71.5%, as of the end of Q4 2021, increasing to 73.1% in Q4 2022.

Activities during CYE 2023 and Status as of October 2023: Care 1st ACC continued to perform analyses to identify gaps and will continue to closely monitor any changes in the network and potential recruitment opportunities. To ensure members in this county receive needed services, outpatient behavioral health and integrated clinics have been providing telehealth services to adult members in Apache County. The other ACC Contractor in the North did not meet the time/distance standards for CYE 2021, underscoring the challenges of providing Behavioral Health Outpatient and Integrated Clinic services to children and adolescents in this area.

While this rate continues to improve and exceeding the previous goal, current results show that the rate of Care 1st ACC members who have access to behavioral health services within the defined time/distance requirements has declined to below the standard and the plan's goal of 90%. Care 1st ACC performed an analysis to identify impacted members and those members were referred to Flagstaff and Prescott Area due to limited services available in Apache County. Care 1st ACC has additional providers in Apache County, but they are outside the time/distance standards for some

| Prior Year's Recommendation from the EQR Technical Report for NAV |
|---|
| members. Based on claims utilization, more than a dozen behavioral health and integrated clinics are currently providing telehealth services to pediatric members in Apache County.<br><br>Pediatric Dentists<br>According to HSAG's results, Care 1st ACC decreased its rate of compliance with ACC network time/distance standards for pediatric dental providers in Apache County to 63.6% as Quarter 4 (Q4) 2021 has increased to 71.4% in Q4 2022.<br><br>Activities during CYE 2023 and Status as of October 2023: Care 1st ACC continues its search for dentists in Apache County to add to its network. For CYE 2023 Care 1st ACC partnered with Envolve Dental to administer its dental program. The AHCCCS Saturation data was used to identify any opportunities to recruit new providers and found that the Plan is already contracted with the providers or that the providers are not viable due to being Indian Health Service (IHS) providers, providers are out of adequacy guidelines, or the data was incorrect. It should be noted that the other ACC Contractor in the North also fell short of the ACC time/distance standards for pediatric dentists in both Apache and Coconino counties indicating a shortage of dentists in those areas.<br><br>Pharmacies<br>According to HSAG's results, Care 1st ACC decreased its rate of compliance with network time/distance standards for pharmacy providers in Apache County to 77.6% Q4 2021 and increased in Q4 2022 to 79.8%.<br><br>Activities during CYE 2023 and Status as of October 2023: For CYE 2023, the pharmacy network was delegated and administered by Envolve Pharmacy, our pharmacy benefit manager (PBM). CVS Caremark is responsible for the recruitment and management of the pharmacy network. As a national PBM, CVS Caremark maintains a large pharmacy network with most national pharmacy chains, as well as independent and in-store pharmacy providers. Similar to the efforts to ensure network adequacy as described above, Care 1st ACC used Quest analytics reports and the AHCCCS Saturation data to identify gaps and any opportunities to recruit new providers. Both Envolve pharmacy and Care 1st ACC continue to use geographic mapping software to assess for possible inadequacies in the pharmacy network. Here again, it should be noted that the other ACC Contractor in the North also fell short of the time/distance standards for pharmacists in Apache County for CYE 2021, indicating a shortage of dentists in that area.<br><br>PCP, Pediatric<br>According to HSAG's results, Care 1st ACC' rate of compliance with network time/distance standards for adult PCP providers in Apache County decreased to 84.0% Q4 2021 and increased to 90.0% in Q4 2022.<br><br>Activities during CYE 2023 and Status as of October 2023: To ensure network adequacy Care 1st ACC used Quest analytics reports and the AHCCCS Saturation data to identify gaps and any opportunities to recruit new providers. Care 1st ACC has additional providers in Apache County, but they are outside the time/distance standards for some pediatric members. Extensive education has |

| Prior Year's Recommendation from the EQR Technical Report for NAV |
| --- |
| been rolled out to providers and members on the use of telehealth services. Pediatric PCP providers are currently providing telehealth services to members under the age of 21 in Apache County. Care 1st ACC has continued to perform analyses to identify gaps and will continue to closely monitor any changes in the network and potential recruitment opportunities. |
| **HSAG's Assessment:**<br>HSAG has determined that the Care 1st ACC-RBHA has satisfactorily addressed this prior year's recommendations. |

# HCA ACC

## *Validation of Performance Measures*

### Results for Information Systems Standards Review

During CYE 2023, HSAG evaluated HCA ACC's data system for processing of each data type used for reporting the Contractor's CY 2022 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that HCA ACC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-60 displays HSAG's PMV findings for each data type reviewed during CYE 2023 in alignment with the CMS EQR Protocol 2 audit requirements.

**Table 5-60—CYE 2023 PMV Findings**

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

### Results for Performance Measures

Table 5-61 presents the CY 2021 and CY 2022 HCA ACC performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and MY 2022. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and/or MY 2022. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

**Table 5-61—CY 2021 and CY 2022 HCA ACC Performance Measure Results**

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| ***Maternal and Perinatal Care*** | | | | |
| ***Prenatal and Postpartum Care*** | | | | |
| *Timeliness of Prenatal Care*[#] | 77.6%[+] | 86.8%[+] | ↑ | ★★★ |
| *Postpartum Care* | 56.9%[+] | 65.3%[+] | ↑ | ★ |
| ***Behavioral Health*** | | | | |
| ***Antidepressant Medication Management*** | | | | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | 56.3% | 60.2% | ↑ | ★★ |
| *Effective Continuation Phase Treatment—Total (18+ Years)* | 38.4% | 43.1% | ↑ | ★★ |
| ***Follow-Up After ED Visit for Substance Use*** | | | | |
| *7-Day Follow-Up—Total* | — | 32.7% | — | ★★★★ |
| *30-Day Follow-Up—Total* | — | 42.9% | — | ★★★★ |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 41.7% | 54.4% | ↑ | ★★★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 57.1% | 71.7% | ↑ | ★★★★ |
| ***Follow-Up After ED Visit for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 44.3% | 43.6% | → | ★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 56.1% | 52.0% | → | ★★ |
| ***Use of Opioids at High Dosage*** | | | | |
| *18+ Years** | 4.6% | 4.4% | → | ★★ |
| ***Initiation and Engagement of Substance Use Disorder (SUD) Treatment*** | | | | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | — | 48.3% | — | ★★★ |
| *Engagement of SUD Treatment—Total—Total (13+ Years)* | — | 18.3% | — | ★★★ |
| ***Adherence to Antipsychotic Medications for Individuals with Schizophrenia*** | | | | |
| *18+ Years* | — | 51.6% | — | ★ |
| ***Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication*** | | | | |
| *18–64 Years* | — | 77.2% | — | ★★ |
| ***Care of Acute and Chronic Conditions*** | | | | |
| ***Controlling High Blood Pressure*** | | | | |
| *18–85 Years* | 51.3%[+] | 62.0%[+] | ↑ | ★★★ |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | | | | |
| *HbA1c Control (<8.0 Percent)—Total (18–75 Years)* | — | 50.1%[+] | — | ★★ |

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| *HbA1c Poor Control (>9.0 Percent)—Total (18–75 Years)** | 42.6%+ | 38.9%+ | → | ★★ |
| ***Pediatric Health*** | | | | |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotics*** | | | | |
| *Blood Glucose Testing—Total (1–17 Years)* | 56.5% | 57.9% | → | ★★★ |
| *Cholesterol Testing—Total (1–17 Years)* | 38.3% | 40.5% | → | ★★★ |
| *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* | 36.9% | 38.9% | → | ★★★ |
| ***Childhood Immunization Status***** | | | | |
| *Combination 3* | 51.6%+ | 52.8%+ | → | ★ |
| *Combination 7* | 45.5%+ | 46.5%+ | → | ★ |
| *Combination 10* | 26.5%+ | 20.2%+ | ↓ | ★ |
| ***Developmental Screening in the First Three Years of Life*** | | | | |
| *Total (0–3 Years)* [N] | — | 41.1%+ | — | — |
| ***Immunizations for Adolescents*** | | | | |
| *Combination 1 (Meningococcal, Tdap)* | 80.3%+ | 82.7%+ | → | ★★★ |
| *Combination 2 (Meningococcal, Tdap, HPV)* | 30.4%+ | 31.9%+ | → | ★★ |
| ***Oral Evaluation, Dental Services*** | | | | |
| *Total (0–20 Years)* [N] | — | 46.6% | — | — |
| ***Well-Child Visits in the First 30 Months of Life*** | | | | |
| *Six or More Well-Child Visits* | 51.9% | 56.1% | ↑ | ★★ |
| *15 Months–30 Months—Two or More Well-Child Visits* | — | 54.7% | — | ★ |
| ***Child and Adolescent Well-Care Visits*** | | | | |
| *Total (3–21 Years)* | 38.9% | 39.8% | ↑ | ★ |
| ***Preventive Screening*** | | | | |
| ***Breast Cancer Screening*** | | | | |
| *Total (50–74 Years)* | 39.6% | 40.9% | ↑ | ★ |
| ***Cervical Cancer Screening*** | | | | |
| *21–64 Years* | 46.2%+ | 47.4%+ | → | ★ |
| ***Appropriate Utilization of Services*** | | | | |
| ***Ambulatory Care*** | | | | |
| *Emergency Department (ED) Visits—Total (0–85+ Years)* [F] | 500.3 | 514.8 | — | — |
| ***Plan All-Cause Readmissions*** | | | | |
| *Observed Readmissions—Total (18–64 Years)* | 10.3% | 8.8% | ↑ | — |
| *Expected Readmissions—Total (18–64 Years)* | — | 9.4% | — | — |

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| *Outlier Rate—Total (18–64 Years)* | — | 45.0 | — | — |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)** | 1.0901 | 0.9296 | — | ★★★ |

* A lower rate indicates better performance for this measure.
** Table A-1 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
+ Indicates the measure was reported using hybrid methodology.
# Caution should be considered when comparing CY 2021 to CY 2022 results as changes to the measure specifications occurred.
Cells shaded green indicate that the rate met or exceeded the MY 2021 and/or MY 2022 national Medicaid mean.
[1] Indicates a 2021–2022 comparison is not presented in the CYE 2023 Annual Technical Report because either the CY 2021 rate was not presented in the CYE 2022 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
↑ Indicates improvement of measure rates.
↓ Indicates decline of measure rates.
→ Indicates stable measure rates.
[2] Performance Levels for CY 2022 were based on comparisons of the HEDIS MY 2022 measure rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks.
Performance Levels for 2022 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile
[N] Measure has no NCQA Medicaid mean for comparison
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.

## Strengths, Opportunities for Improvement, and Recommendations

Table 5-62 presents strengths, opportunities for improvement, and recommendations for HCA ACC related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-62—HCA ACC Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| Within the Behavioral Health measure group, eight of 13 (61.5 percent) HCA ACC measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. [**Quality, Timeliness, Access**]<br>• *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*<br>• *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| • *Follow-Up After ED for Mental Illness—7-Day Follow-Up—Total (6+ Years)*<br>• *Use of Opioids at High Dosage—18+ Years*<br>• *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* and *Engagement of SUD Treatment—Total—Total (13+ Years)* |
| Within the Care of Acute and Chronic Conditions measure group:<br>• HCA ACC's performance measure rate for *Controlling High Blood Pressure—18–85 Years* met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. **[Quality]**<br>• HCA ACC's performance measure rate for *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 %)—Total (18–75 Years)* met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. **[Quality]** |
| **Opportunities for Improvement and Recommendations** |
| In the Maternal and Perinatal Care measure group, HCA ACC's performance measure rates for *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, indicating an opportunity to increase access to timely postpartum care. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.[5-29] **[Quality, Timeliness, Access]**<br><br>Recommendation: While HCA ACC conducted a root cause analysis and implemented interventions specific to its *Prenatal and Postpartum Care—Postpartum Care* measure indicator, this rate remained low in CY 2022; therefore, HSAG recommends that HCA ACC continue to implement appropriate interventions to improve performance related to postpartum care. HSAG also recommends that HCA ACC monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Postpartum Care* measure. |
| In the Behavioral Health measure group, HCA ACC's performance measure rate for *Adherence to Antipsychotic Medications for Individuals with Schizophrenia—18+ Years* fell below the 25th percentile, indicating adults 18 years of age and older who have schizophrenia or schizoaffective disorder who were dispensed an antipsychotic medication did not remain on the medication for at least 80 percent of their treatment period. **[Quality]**<br><br>Recommendation: Schizophrenia is a chronic and disabling psychiatric disorder that requires ongoing treatment and monitoring. Symptoms include hallucinations, illogical thinking, memory impairment, and incoherent speech. Medication non-adherence is common and a major concern in the treatment of schizophrenia. Using antipsychotic medications as prescribed reduces the risk of |

[5-29] National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/. Accessed on: Jan 31, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
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| relapse or hospitalization.[5-30] HSAG recommends that HCA ACC conduct a root cause analysis to determine why members with a diagnosis of schizophrenia were not always receiving continuous medication treatment. Upon identification of a root cause, HCA ACC should continue to implement appropriate interventions to improve performance related to its *Adherence to Antipsychotic Medications for Individuals with Schizophrenia—18+ Years* measure rate. HSAG also recommends that HCA ACC monitor and expand on interventions currently in place to improve performance related to continuous medication treatment for members with a diagnosis of schizophrenia. |
| In the Pediatric Health measure group:<br>• HCA ACC's performance measure rate for *Child and Adolescent Well-Care Visits—Total (3–21 Years)* fell below the 25th percentile, indicating that children and adolescents were not always receiving their well-care visits. Assessing physical, emotional, and social development is important at every stage of life, particularly for children and adolescents. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[5-31] **[Quality, Access]**<br><br>Recommendation: While HCA ACC conducted a root cause analysis and implemented interventions specific to the CY 2021 *Child and Adolescent Well-Care Visits—Total (3–21 Years)* rate, this rate remained low in CY 2022; therefore, HSAG recommends that HCA ACC identify best practices to support children in receiving well-care visits according to recommended schedules. Additionally, HSAG recommends that HCA ACC monitor and expand on interventions currently in place to improve the performance related to well-care visits.<br><br>HCA ACC's performance measure rates for *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10* fell below the 25th percentile, indicating that children were not always getting their immunizations by their second birthday. Vaccination coverage must be maintained in order to prevent a resurgence of vaccine-preventable diseases.[5-32] **[Quality, Access]**<br><br>Recommendation: HSAG recommends that HCA ACC conduct a root cause analysis to determine why some children are not always getting their immunizations by their second birthday. This could include conducting focus groups to identify barriers that members are experiencing in accessing care and services in order to implement appropriate interventions. HCA ACC should consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, |

[5-30] National Committee for Quality Assurance. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA). Available at: https://www.ncqa.org/hedis/measures/adherence-to-antipsychotic-medications-for-individuals-with-schizophrenia/ Accessed on: Jan 31, 2024

[5-31] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Jan 31, 2024.

[5-32] National Committee for Quality Assurance. Childhood Immunization Status (CIS). Available at: https://www.ncqa.org/hedis/measures/childhood-immunization-status/. Accessed on: Jan 31, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
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| a lack of service providers, or the need for community outreach and education). Upon identification of a root cause, HSAG recommends that HCA ACC implement appropriate interventions to improve performance related to childhood immunizations. |
| In the Preventive Screening measure group, HCA ACC's performance measure rates for *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* fell below the 25th percentile, indicating that some women were not receiving timely screening for breast and cervical cancers. Early detection reduces the risk of dying from these types of cancers and can lead to a greater range of treatment options and lower healthcare costs. **[Quality]**<br><br>Recommendation: While HCA ACC implemented interventions specific to the CY 2021 *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—Total (50–74 Years)* rates, these rates remained low in CY 2022; therefore, HSAG recommends that HCA ACC conduct a root cause analysis for these measures and continue to implement appropriate interventions to improve performance related to these rates. HSAG also recommends that HCA ACC monitor and expand on interventions currently in place to improve performance related to these screenings. |

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

Table 5-63 presents performance measure recommendations made to HCA ACC in the CYE 2022 Annual Technical Report[5-33] and HCA ACC's follow-up to the recommendations, as well as an assessment of the degree to which HCA ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 5-63—HCA ACC Follow-Up to CYE 2022 Performance Measure Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| **Recommendation 1:** |
| HSAG recommended that HCA ACC ensure that all measures AHCCCS requires to be reported as hybrid are reported as hybrid in future performance measure reporting. This should include planning and development of abstraction tools as well as data capture and integration for all hybrid non-HEDIS measures, including *Developmental Screening in the First Three Years of Life.* |

[5-33] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP) Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 8, 2024.

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| **HCA ACC's Response:**<br>HCA ACC reported the *Developmental Screening in the First Three Years of Life* measure using the hybrid methodology in MY 2022. The custom measure from its performance measure vendor that allowed for developmental screenings using CPT code 96110, regardless of EP modifier, within the administrative performance measure calculations was used to select a random sample. Since the custom measure did not allow for a hybrid sample and abstraction in the vendor's software system, which was the reason for reporting the measure as administrative only in the previous year, HCA ACC abstracted the hybrid sample in a database outside of the vendor's system. HCA ACC was able to reflect the deviation from the CMS Child Core Set specifications allowed by AHCCCS and apply the hybrid methodology for measure reporting. |
| **HSAG's Assessment:** HCA ACC reported the *Developmental Screening in the First Three Years of Life* measure using the hybrid methodology, therefore HSAG determined that HCA ACC satisfactorily addressed this prior year's recommendation. |
| **Recommendation 2:** |
| HSAG continued to recommend that HCA ACC maintain routine monitoring of its PCP mapping results in comparison to its known FQHCs to ensure that it identifies appropriate FQHCs as PCPs in final performance measure reporting, which could otherwise result in missed claims for numerator compliance. HCA ACC indicated that it focused on enhancing PCP mapping for CY 2021, yet measures dependent on PCPs did not demonstrate significant improvements. HSAG also recommended that HCA ACC prioritize prospectively monitoring its rates throughout the year, since it had multiple rate decreases or lower benchmarking rates, which were not readily identified by HCA ACC until HSAG conducted a rate review. When questioned about reasons for the rate decreases, HCA ACC required some additional time to research the factors contributing to decreased rates or rates with lower benchmarking. If HCA ACC monitors its performance routinely throughout the year, it will not only be more likely to identify barriers in real time, but it will also have an opportunity to implement interventions to positively impact rates well before the close of the MY. Additionally, HCA ACC was encouraged to explore the use of other available supplemental data sources, as it indicated the potential for at least one nonstandard supplemental data source but had not identified a large numerator impact, and therefore elected not to proceed with the source for CY 2021. |
| **HCA ACC's Response:**<br>• HCA ACC conducts monthly reviews of provider specialty mappings to provider practice type to ensure new provider IDs are appropriately mapped based on the provider's primary taxonomy and/or claim specialty. HCA ACC also conducts additional research of prevalent provider taxonomies to identify secondary provider practice types that may be applicable to measure compliance.<br>• The list of FQHCs and rural health clinics (RHCs) are downloaded from the azahcccs.gov website when the new list is available every October. Taxpayer identification numbers (TINs) for the FQHCs and RHCs are loaded to a reference table in the data warehouse that is used in the PCP mapping process. Providers associated with the FQHC and/or RHC TIN from claims are mapped to a PCP practice type code to its performance measure vendor's software. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| • HCA ACC monitors and reports prospective measure performance trends monthly. The monthly trends are compared to prior year trends and NCQA/CMS Medicaid benchmarks. HCA ACC also tracks the month-over-month change in numerators, denominators, and rates relative to historical averages and standard deviations for the respective measure in order to identify significant changes.<br>• HCA ACC has engaged with provider groups and started receiving monthly supplemental data files for use in measure performance reporting. HCA ACC is also receiving medical records that are abstracted directly into its vendor's software system as non-standard supplemental data. |
| **HSAG's Assessment:** HSAG determined that HCA ACC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 3:** |
| HSAG recommended that HCA ACC explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratifications related to race and ethnicity. HCA ACC should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information. |
| **HCA ACC's Response:**<br>HCA ACC is supplementing race and ethnicity data from enrollment data with race and ethnicity data captured through Health Appraisal Survey responses. HCA ACC plans to explore use of Natural Language Processing (NLP) to identify available race and ethnicity data on medical records retrieved for HEDIS and risk adjustment. |
| **HSAG's Assessment:** HSAG determined that HCA ACC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 4:** |
| While HCA ACC conducted a root cause analysis and implemented interventions specific to the *Prenatal and Postpartum Care—Postpartum Care* measure indicators, this rate remained low in CY 2021; therefore, HSAG recommended that HCA ACC continue to implement appropriate interventions to improve performance related to prenatal and postpartum care. HSAG also recommended that HCA ACC monitor and expand on interventions currently in place to improve performance related to the *Postpartum Care* measure. |
| **HCA ACC's Response:**<br>• As HSAG mentioned, HCA ACC began to introduce a variety of interventions and initiatives to influence prenatal and postpartum rates. Based on those initiatives, CY 2022 saw a significant increase in prenatal rates with continuing trends for CY 2023. As verified by our HEDIS auditor and HSAG, prenatal rates are now above the 50th percentile. As with other measures, HCA ACC is ensuring all data are collected for reporting, either through administrative data or through MRR. Supplemental data have been instrumental in ensuring rates are accurately reflected in reporting. Additionally, use of estimated date of delivery, when appropriate for premature deliveries, has also improved the accuracy of reporting. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| • HCA ACC's Maternal Health team has spent countless hours working with OB providers to facilitate members' timely prenatal and postpartum appointments to increase compliance rates. The team has outreached to pregnant members with two or more missed appointments to assist with rescheduling. The teams conducted outreach to all newly identified pregnant women within their first trimester or within 42 days of enrollment. The team developed a pregnancy newsletter (Stork Newsletter) targeted to newly identified pregnant members. The team continues to participate in education sessions with providers to augment prenatal and postpartum visits.<br>• The Maternal Health team works jointly with Network Services and Provider Contracting regarding how providers are reimbursed, in order to eliminate any perceived disincentive to providing care and services. Specifically, HCA ACC introduced a FFS payment methodology versus a total OB Pack to improve postpartum rates. The team has collaborated with Community Outreach to implement initiatives that promote culturally sensitive education on preconception health, maternal health, and barriers to prenatal and postpartum care in the community.<br>• HCA ACC initially introduced a Diaper Bag program to improve prenatal and postpartum rates but transitioned to newly introduced member healthy rewards and incentives for members which have also proven effective in generating interest in scheduling and maintaining appointments for prenatal and postpartum care. As HSAG recommended, current initiatives are assessed monthly for effectiveness, modifications are made where necessary, and new initiatives are introduced when appropriate based on discussion with Quality Management/Performance Improvement Committee members, Health Equity Committee members, and during meetings with subgroups responsible for monitoring performance and implementing programs that will increase access to care.<br>• HCA ACC also introduced a *Prenatal and Postpartum* PIP to better identify factors related to lower rates of pregnancy care. |
| **HSAG's Assessment:** HCA ACC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that HCA ACC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 5:** |
| HSAG recommended that HCA ACC conduct a root cause analysis or focus study to determine why some members were not managing their high blood pressure optimally. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. HCA ACC should consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). Additionally, HCA ACC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, HSAG recommended that HCA ACC implement appropriate interventions to improve performance related to this chronic condition. |
| **HCA ACC's Response:** |
| • According to recommendations from HSAG, HCA ACC conducted a root cause analysis. HCA ACC also conducted several analyses and incorporated findings from focus groups to understand the low rates associated with *Controlling High Blood Pressure* and members who had a diagnosis |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| of hypertension. Much of the noncompliance within the rate is due to missing tests or missing values. More than 50% of HCA ACC members are missing blood pressure values or tests. Based on the analysis, there has been a concerted effort to collect administrative and supplemental data regarding administered blood pressure readings and identifying the most recent blood pressure reading taken during the measurement year. HCA ACC has worked collaboratively with provider groups with the lowest rates, provided education regarding blood pressure readings and how to submit claim data to HCA, in addition to using supplemental sources such as the HIE and provider EMR integration opportunities to further collect information regarding members' most recent results.<br>• The HCA ACC Care Management team works with members with heart failure or HBP, whose conditions notably affect their ability to perform activities of daily living (ADLs) or have difficulty following their treatment plan which results in frequent hospitalizations. These members may receive additional assistance with coordinating care with their providers, education as to the disease process and the importance of treatment compliance and/or referral to community-based supports and services. Identifying potential gaps and assisting members to improve compliance with their treatment plan, which includes scheduling appointments, medication adherence, and following nutritional guidelines, are key focuses. The Transition of Care (TOC) team contacts every member upon hospital discharge to identify care, knowledge, or resource gaps. They work directly with members and providers to ensure members have the appropriate resources, services, and appointments scheduled, which improves members' ability to manage their condition. Members who have multiple, complex, or longer-term care needs are referred to care management for more intense, direct education and follow-up. The integrated care manager will complete a full assessment, work with the member to identify goals, and bring together an interdisciplinary team which includes the provider and/or specialist, member, and/or support person.<br>• Care managers and pharmacy staff provide members with education to improve compliance (Health Literacy). Other interventions may include the use of Remote Patient Monitoring (RPM) equipment if that need is identified by Care Management and appropriate to the member's individual circumstance. This may include blood pressure cuffs, scales, and telemonitoring equipment that could transmit results to care managers and their PCPs or treatment specialists.<br>• QI specialists complete regular outreach and coordination with our providers. They send lists of member gaps for many measures, educate providers on proper coding (use of CPT II) to report identified measures, conduct regular phone and in-person meetings to troubleshoot issues, and provide technical assistance. They provide each provider with a toolkit containing information about measure specifications and coding, as well as coordinate on assigned measures.<br>• In addition to the initiatives listed above, HCA ACC also contracts with a number of vendors that assist with specific measures such as *Controlling High Blood Pressure*, including a medication adherence program that uses member rewards and incentives to keep blood pressures in range. Based on these programs, we have seen significant increases in *Controlling High Blood Pressure* rates over the last two years, not only in the HCA ACC population but also in the "Dual-Eligible" populations (Medicaid-Medicare), especially with the collection of new data sources for existing tests and values. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| **HSAG's Assessment:** HCA ACC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that HCA ACC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 6:** |
| While HCA ACC implemented interventions specific to the CY 2020 *Antidepressant Medication Management—Effective Continuation Phase Treatment* rate, this rate remained low in CY 2021; therefore, HSAG recommended that HCA ACC conduct a root cause analysis to determine why members with a diagnosis of major depression were not always receiving continuous medication treatment. Upon identification of a root cause, HCA ACC should continue to implement appropriate interventions to improve performance related to its *Antidepressant Medication Management—Effective Continuation Phase Treatment* rate. HSAG also recommended that HCA ACC monitor and expand on interventions currently in place to improve performance related to continuous medication treatment for members with a diagnosis of major depression. |
| **HCA ACC's Response:**<br>• Based on recommendations from HSAG, HCA ACC conducted a root cause analysis.<br>• HCA ACC works with behavioral health homes and behavioral health ACOs, and rates for *Antidepressant Medication Management*, both *Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*, have increased (above the 50th percentile for *Effective Acute Phase Treatment* and close to the 50th percentile for *Effective Continuous Phase Treatment*).<br>• As HSAG recommended, HCA ACC has developed data and analytics to identify populations and provider patterns regarding prescriptions that would impact *AMM*. Clinical Operations provides care management to ACC members meeting high-risk/high-cost program selection criteria. Care managers complete a comprehensive initial assessment of clinical and SDOH needs and strengths, incorporating the health appraisal, and data from claims, pharmacy, authorizations, the Controlled Substances Prescription Monitoring Program, the HIE, and provider records. Care managers develop and regularly update a care management plan, based on member/family needs, preferences, and priorities. The care management plan is distributed to the member's care team and includes pharmacy fill and diagnosis history and, when applicable, care alerts related to antidepressant medication management and medication adherence.<br>• HCA ACC also collaborates with prescribers regarding patient education. Outreach is conducted with providers and members to schedule appointments for diagnosis and prescribe and/or refill antidepressant medications. As mentioned above, we also have value-based payment (VBP) arrangements in place with provider partners like behavioral health homes and ACOs to incentivize access to care and address needs of members related to *AMM*. |
| **HSAG's Assessment:** HCA ACC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that HCA ACC satisfactorily addressed these prior year's recommendations. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| **Recommendation 7:** |
| While HCA ACC conducted a root cause analysis and implemented interventions specific to the CY 2020 *Child and Adolescent Well-Care Visits* rate, this rate remained low in CY 2021; therefore, HSAG recommended that HCA ACC identify best practices to support children in receiving well-care visits according to recommended schedules. Additionally, HSAG recommended that HCA ACC monitor and expand on interventions currently in place to improve the performance related to well-care visits. |
| **HCA ACC's Response:**<br>• HCA ACC conducted a root cause analysis.<br>• HCA ACC continues to utilize the EPSDT team to drive performance in *Child and Adolescent Well-Care Visits (WCV)* for children 3–21 years of age. As mentioned in the best practices, HCA ACC has seen improvement in rates based on programs and initiatives such as "Back-to-School" (BTS) campaign. The BTS campaign targeted school-aged members to increase well-care visits and immunizations prior to the start of the school year, including partnering with large primary care and pediatric groups to provide additional access points for well-care visits.<br>• HCA ACC has educated providers and members through provider newsletters, electronic messaging (text and email), and outbound call campaigns targeting noncompliant members to remind them to schedule a well-care appointment. HCA ACC has focused on outreach to the parents and guardians of members with missed appointments to educate and address barriers related to SDOH. HCA ACC has incorporated telehealth provider solutions as well as physical healthcare. HCA ACC has worked to increase member awareness of telehealth as an alternative to in-person visits, when applicable. Provider groups have reported a shortage of pediatric physicians on staff, HCA ACC has looked at telehealth solutions as an alternative, where appropriate. Turning "sick visits" and sports physicals into well-care visits, where appropriate, have also been useful.<br>• The EPSDT team also continues to work with VBP and ACO partners and pediatric practices to schedule appointments. VBP provider groups are incentivized to schedule well-care visits. The Quality Improvement Specialist team also assists EPSDT with roster updates such as reconciling members and claim searches for members seen by out-of-network providers.<br>• HCA ACC is also attempting to address concerns from provider groups who have reported a large number of "no-shows" for scheduled appointments. Providers submit missed appointment logs to the EPSDT team, and they outreach to members to reschedule appointments. |
| **HSAG's Assessment:** HCA ACC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that HCA ACC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 8:** |
| HSAG recommended that HCA ACC conduct a root cause analysis to determine why some children were not always getting their immunizations by their second birthday. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. HCA ACC should consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, a lack of service providers, or the need |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| for community outreach and education). Additionally, HCA ACC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, HSAG recommended that HCA ACC implement appropriate interventions to improve performance related to childhood immunizations. |

**HCA ACC's Response:**

- According to recommendations from HSAG, HCA ACC conducted several analyses and focus groups to understand the low rates associated with *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10*. Based on the analyses, there has been a concerted effort to collect administrative and supplemental data regarding immunizations and identifying deficient well-child visits during the measurement year that would have provided the opportunity for immunizations. HCA ACC worked collaboratively with provider groups, ACOs, and VBP partners with the lowest rates, provided education regarding immunization schedules and how to submit claim data to HCA, in addition to using supplemental sources such as the HIE and the Arizona State Immunization Information System (ASIIS) to further collect information regarding members' immunizations. We continue to work on improved "matching" with ASIIS data that could prove beneficial in reporting as well as encouraging members to update names with AHCCCS regarding "baby girl" and "baby boy" that prove to be problematic for reporting.
- The HCA ACC EPSDT Team continues to work with provider groups, pediatricians, VBP partners, and ACOs regarding improvement of *CIS* measures and access to immunizations. In concert with *W30* initiatives, the EPSDT team has engaged internal and external teams to educate members and incentivize providers to provide immunizations according to recommended CDC and American Academy of Pediatrics (AAP) schedules. Schedules of immunizations are provided to individuals who have recently had a child. Member rewards, through the Healthy Rewards program, are also in place to incentivize members and providers.
- The EPSDT Team completes regular member outreach including calls to members, parents, guardians, and their PCPs to ensure care is received and correct billing codes are used. The team can assist directly with scheduling appointments for well-care visits, immunizations, and other services. They are also able to review immunization records and schedules and encourage the opportunity to catch up on missed immunizations. They can also provide education on the importance of completing each vaccine series.
- HCA ACC has resumed holding and participating in live health events for members. These had been on hold during the COVID-19 global pandemic. At these events, members can receive, or schedule needed well-care visits and services. Vaccinations are frequently provided during these events. In 2023, HCA ACC is excited to have partnered with two more large practices to hold health events.
- As HSAG recommended, HCA ACC also assessed barriers to getting immunizations. like how well-care visits and well-child visits "no-shows" for scheduled well-child appointments are contributing to lower rates. HCA ACC worked with several provider partners to create additional pediatric events to collect immunizations. HCA ACC also evaluated mobile immunization vendors and transportation to and from appointments, including child daycare, to address identified barriers.

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| **HSAG's Assessment:** HCA ACC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that HCA ACC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 9:** |
| While HCA ACC implemented interventions specific to the CY 2020 *Breast Cancer Screening* and *Cervical Cancer Screening* rates, these rates remained low in CY 2021; therefore, HSAG recommended that HCA ACC conduct a root cause analysis for these measures and continue to implement appropriate interventions to improve performance related to *Breast Cancer Screening* and *Cervical Cancer Screening* rates. HSAG also recommended that HCA ACC monitor and expand on interventions currently in place to improve performance related to these screenings. |
| **HCA ACC's Response:**<br>• According to recommendations by HSAG, HCA ACC conducted a root cause analysis.<br>• HCA ACC conducted several analyses to understand the low rates associated with breast and cervical cancer screenings. Based on the analyses, there has been a concerted effort to collect administrative and supplemental data regarding screenings. HCA ACC has worked collaboratively with provider groups, ACOs, and VBP partners with the lowest rates, provided education regarding the need for screenings and how to submit claim data to HCA ACC, in addition to using supplemental sources such as the HIE, Blindspot data, and Other Health Insurance (OHI) to further collect information regarding the member screenings.<br>• Regarding initiatives that HSAG commented on, Quality Improvement Specialists have continued to identify members with gaps, outreach to members to coordinate scheduling, and collaborate with provider groups and mobile screening vendors regarding possible events. They also provide practices with updated mammogram gaps and rosters and work with providers on orders, as well as follow through with imaging centers. They are also working with MRR to identify potential opportunities to close gaps through supplemental data. They work with Network Services to assist with provider education and review noncompliant records during monthly meetings. HCA ACC tracks gap closure and assesses intervention required to ensure practices are tracking to meet year-end gap closure targets.<br>• HCA ACC has also introduced alerts into our Care Management and Member Services documentation systems. HCA ACC has also introduced care gaps on our provider portal and introduced provider scorecards that specifically assist with promoting cancer screening gap closure. HCA ACC also continues to coordinate activities with vendor partners such as Simon Medical and AZ Diagnostic to conduct outreach and schedule appointments. The member reward and incentive program has also been enhanced for completion of breast cancer screenings and cervical cancer screenings, which has been very effective in increasing rates.<br>• HCA ACC continues to collaborate with Mobile Mammography vendors throughout the State of Arizona. Mobile units supplement other interventions, specifically stand-alone facilities. HCA ACC has found that the mobile events are most appreciated in rural areas due to the length of time needed to schedule a regular screening at a facility. These units perform breast cancer screenings, and some offer cervical cancer and bone density screenings as well. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| **HSAG's Assessment:** HCA ACC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that HCA ACC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 10:** |
| HSAG recommended that HCA ACC identify best practices for reducing unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay. HSAG also recommended that HCA ACC consider conducting a root cause analysis to identify factors contributing to members experiencing unplanned acute readmissions, which should include evaluating that appropriate follow-up care is available to members on discharge from an acute inpatient admission or observation. |
| **HCA ACC's Response:**<br>• In accordance with recommendations from HSAG, HCA ACC conducted analysis to understand observed over expected rates for all-cause readmissions (*PCR*). The Quality Informatics team has worked with our Business Intelligence team to introduce additional reporting that assists Clinical and Quality Management teams regarding *PCR* trends to identify opportunities for improvement. This includes granular analysis by facility and diagnosis to prevent avoidable readmissions.<br>• The TOC team continues to monitor hospital readmissions closely. As an example of the monitoring, the TOC staff utilize utilization review (UR) nurses to ensure safe discharges for members, including transition to a skilled nursing facility (SNF) as needed to prevent the need to be readmitted to the acute care facility. Home health and other wraparound services are utilized to create the best scenario for the member's discharge and wellbeing. The TOC staff contacts the member after discharge from an acute care setting to ensure the member received his or her discharge instructions and understands them. If any additional services, home health, durable medical equipment (DME), etc., were ordered, TOC staff made sure that they were delivered or scheduled; if not, the TOC staff assists with the arrangements. Staff will verify or assist in scheduling the PCP or specialist post-discharge follow-up as needed. The UR nurse or the TOC nurse will make a care management referral when the nurse feels the member would benefit from care management services.<br>• HCA ACC has witnessed significant improvement in *PCR* over the last two years and now has rates greater than the 50th percentile, trending toward the 66th percentile for CY 2023. |
| **HSAG's Assessment:** HCA ACC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that HCA ACC satisfactorily addressed these prior year's recommendations. |

## Validation of Performance Improvement Projects

### Back to Basics PIP

In CYE 2023, HCA ACC continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 1, PIP validation activities focused on improvement from the baseline results. HCA ACC submitted Remeasurement 1 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes or discontinuation of the interventions.

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

#### *Validation Results*

Table 5-64 displays the overall confidence levels for the HCA ACC *Back to Basics* PIP.

**Table 5-64—HCA ACC *Back to Basics* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| HCA ACC | *High Confidence* | 100% | 100% | *No Confidence* | 33% | 100% |

#### *Measure Results*

Table 5-65 and Table 5-66 provide the *Back to Basics* PIP baseline, intervention, and Remeasurement 1 year rates for each indicator for HCA ACC.

**Table 5-65—HCA ACC *Back to Basics* PIP Rates for PIP Indicator 1**

| Contractor | PIP Indicator 1: *W30 Rate 1* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| HCA ACC | 59.4% | 56.1% |

**Table 5-66—HCA ACC *Back to Basics* PIP Rates for PIP Indicator 2**

| Contractor | PIP Indicator 2: *WCV* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| HCA ACC | 43.6% | 39.8% |

### *Interventions*

Table 5-67 presents PIP interventions for HCA ACC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 5-67—HCA ACC *Back to Basics* PIP Interventions**

| Contractor | Interventions |
|---|---|
| HCA ACC | • EPSDT staff conduct outreach calls to member with gaps in care. During the calls, the staff educated members on the benefits of the well-child visit, questioned the parents to determine what barriers have hindered them from scheduling, assisted with scheduling appointments, and arranged transportation.<br>• HCA ACC also conducts regular outreach via other methods to ensure providers and members are aware of the need for these services and that these measures remain a focus for pediatric providers. HCA ACC sent fax blasts, spoke about these measures at the provider forum, discussed value-based contracts with providers, and sent reminder letters to members.<br>• Missed Appointment Logs. HCA ACC receives missed appointment logs from a number of our larger providers. The HCA ACC care managers then make follow-up calls to assist the member in rescheduling the missed appointment. This also provides an opportunity to assist the member in overcoming any barriers that prevented the member from being able to attend the appointment.<br>• HCA ACC has initiated a project to ensure that all certified recovery support members have adequate coordination of care. An audit will take place to review certified recovery support members. The purpose will be to ensure that |

| Contractor | Interventions |
|---|---|
| | care management has been offered to all certified recovery support worker (CRSW) qualifying member and that there are no issues with missing paperwork which may lead to delays in care, and to complete outreach specific to the *W30* and *WCV* measures. |

### *Strengths, Opportunities for Improvement, and Recommendations*

Table 5-68 presents strengths, opportunities for improvement, and recommendations for HCA ACC related to the *Back to Basics* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-68—HCA ACC Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG noted that HCA ACC performed accurate statistical testing between the baseline and Remeasurement 1 results. **[Quality, Access]**<br><br>HCA ACC developed and implemented measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 2. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| For indicator 1, HCA ACC had a decline of 3.27 percentage points in the indicator rate between the baseline year and Remeasurement Year 1. HCA ACC had a decline of 3.81 percentage points in the indicator rate between the baseline year and Remeasurement Year 1 for indicator 2. **[Quality, Access]**<br><br>Recommendations: As the PIP progresses, HSAG recommends that HCA ACC:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

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

Table 5-69 presents PIP recommendations made to HCA ACC in the CYE 2022 Annual Technical Report[5-34] and HCA ACC's follow-up to the recommendations, as well as an assessment of the degree to which HCA ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 5-69—HCA ACC Follow-Up to CYE 2022 PIP Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| HSAG recommended that HCA ACC:<br>• Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary.<br>• Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available.<br>• Develop and document a plan for sustaining the improvement for any demonstrated improvement in indicator rates. |
| **HCA ACC's Response**:<br>*Back-to-Basics* PIP<br>Well-care and annual dental visits for children and adolescents aim to promote optimal health and development. Ensuring that children and adolescents receive regular well-care and dental visits is critically important in disease prevention, early detection, and treatment. It is equally important in evaluating a child's developmental milestones, addressing parental concerns, and assessing a child's or adolescent's psychological and social development.<br><br>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.<br><br>HCA ACC is working diligently to improve the measures associated with the *Back-to-Basics* PIP. These, as HSAG has noted in the EQR, have been negatively impacted by the COVID-19 PHE. This was one of the primary reasons that HCA ACC chose to initiate the Back-to-School program in 2022 rather than in 2023 with the other AHCCCS health plans. |

[5-34] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP) Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 8, 2024.

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| Interventions included in the *Back to Basics* PIP submission are as follows:<br>• W30 - Ensure all guardians receive outreach regarding gaps in care via the EPSDT team or the performance improvement coordination (PIC) team.<br>• W30 - Ensure all clinics can access gaps in care reports on the provider portal.<br>• W30 - Retrieve medical records for all noncompliant members who appear to be overdue. Load compliance as supplemental data monthly; cascade to PIC trackers.<br>• W30 - Provide reports to practices that track members who are due within the open schedule time frame, members who are overdue, and members who need to be rescheduled; provide a summary of completed members versus target.<br>• W30 - Provider outreach to ensure that correct billing codes are utilized and submitted within the claim data.<br>• W30 - Ensure monthly refresh of gaps in care notifications for EHR users.<br>• W30 - Continued EPSDT efforts; sent an EPSDT mailer to families; extended clinic hours for two large primary care groups.<br>• WCV - Educate the member/parents/guardians on the importance of EPSDT/well visits through monthly member newsletters, birthday cards, reminder letters, and phone communication.<br>• WCV - Outreach to the member/parents/guardians of members with missed appointments to educate and assist in rescheduling.<br>• WCV - Member incentive for obtaining an EPSDT/well visit.<br>• WCV - Collaborate with the Community Relations Department to organize health fairs and assist with calls to schedule appointments.<br>• WCV - EPSDT staff will utilize the gap in care list to conduct outreach calls to noncompliant members and providers.<br>• WCV - To bridge the gaps in care for EPSDT members ages 3–21 years and reduce barriers, HCA ACC engaged with Matrix Medical Network to offer in-home well-child visits.<br>• WCV – Sent fax blast to provider offices about the updated periodicity schedule, best practices to improve the wellness visit rate, and access to care in March. Additional education about the EPSDT visits was provided during the Q1 provider forum. HCA ACC continued to partner with VBPs by sharing performance data related to well-child visits and identifying priority target populations for outreach to ensure that members are receiving all preventive services.<br>• ADV - Collaborate with providers and the Marketing Department to increase the number of oral health fairs.<br>• ADV - Partner with a pediatric dental provider to bring a mobile dental van to rural communities to close the gap in care.<br>• ADV – Deliver a member roster with gaps in care to providers monthly.<br>• ADV - Outreach members to educate about dental benefits as part of EPSDT services for all EPSDT members ages 0 to 21 years and that benefits will not terminate after the member turns 18 years of age, through phone calls and written communication. |

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| • ADV - Identify EPSDT tracking forms with dental referrals and contact the member/parents for follow-up.<br>• ADV - Monitor provider submission of Missed Dental Appointment logs and follow up on members with missed appointments to educate, address barriers, and assist in rescheduling.<br><br>Changes in population and methodology for these measures have made it difficult to demonstrate the impact interventions have had. HCA ACC is now exceeding the identified target for two of the three indicators. The *WCV* measure remains the only measure that has not met the identified target. |
| **HSAG's Assessment:** HSAG has determined that the Contractor has satisfactorily addressed these recommendations. |

## Prenatal and Postpartum Care PIP

In CYE 2023, HCA ACC submitted baseline measurement results for the *Prenatal and Postpartum Care* PIP, which was initiated in CY 2022. HCA ACC submitted baseline performance indicator results and interventions implemented.

HSAG conducted an annual validation of the baseline year reflective of CY 2022 (January 1, 2022, through December 31, 2022) using AHCCCS-calculated and validated indicator rates. HSAG evaluated HCA ACC's performance indicator results based on an analysis of improvement strategies implemented as described in Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

### *Validation Results*

Table 5-70 displays the overall confidence levels for the HCA ACC *Prenatal Care and Postpartum Care* PIP.

**Table 5-70—HCA ACC *Prenatal and Postpartum Care* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| HCA ACC | *High Confidence* | 100% | 100% | *Not Assessed* | *Not Assessed* | *Not Assessed* |

### *Measure Results*

Table 5-71 and Table 5-72 provide the *Prenatal and Postpartum Care* PIP baseline year rates for each indicator for HCA ACC.

**Table 5-71—HCA ACC *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 1**

| Contractor | PIP Indicator 1: *Timeliness of Prenatal Care* |
|---|---|
| | Baseline Year |
| | CY 2022 |
| HCA ACC | 86.8% |

**Table 5-72—HCA ACC *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 2**

| Contractor | PIP Indicator 2: *Postpartum Care* |
|---|---|
| | Baseline Year |
| | CY 2022* |
| HCA ACC | 65.3% |

### *Interventions*

Table 5-73 presents PIP interventions for HCA ACC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 5-73—HCA ACC *Prenatal and Postpartum Care* PIP Interventions**

| Contractor | Interventions |
|---|---|
| HCA ACC | • Provider Education—The MCH Leadership team will participate in education sessions with providers to augment prenatal visits. This will be a joint effort with the provider network.<br>• Stork Newsletter—Develop pregnancy newsletter (Stork Newsletter) targeted to newly identified pregnant members.<br>• Community Collaboration—Collaborate with Community Outreach to implement initiatives that promote culturally sensitive education on preconception health, maternal health, and barriers to prenatal care in the community.<br>• Provider Partnership—Work with OB providers to facilitate members' timely prenatal appointment compliance rates. |

| Contractor | Interventions |
|---|---|
| | • Targeted Outreach—Outreach pregnant members with two or more missed appointments to assist with rescheduling.<br>• Member Outreach—Outreach all newly identified pregnant women within their first trimester or within 42 days of enrollment.<br>• VBP Contracting—HCA ACC has *PPC* measures included in appropriate provider contracts to promote the success of the *PPC* measures. |

### *Strengths, Opportunities for Improvement, and Recommendations*

Table 5-74 presents strengths, opportunities for improvement, and recommendations for HCA ACC related to the *Prenatal and Postpartum Care* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-74—HCA ACC Strengths, Opportunities for Improvement, and Recommendations Related to the *Prenatal and Postpartum Care* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HCA ACC developed and implemented measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 1. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| For indicator 1, 86.9 percent of women had a prenatal care visit in the first trimester and 65.3 percent had a postpartum visit between seven and 84 days after delivery during CYE 2022. **[Quality, Access]**<br><br>Recommendations: As the PIP progresses, HSAG recommends that HCA ACC:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

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

The *Prenatal and Postpartum Care* PIP was initiated in CY 2022; therefore, this section is not applicable.

## Compliance Reviews

### Results

AHCCCS conducted a compliance review of HCA ACC from July 25, 2022, through July 28, 2022. On October 17, 2022, AHCCCS finalized the report findings, provided HCA ACC with a CAP submission matrix, and required a CAP for any standard with a total score of less than 95 percent. After the Contractor's first CAP submission, AHCCCS accepted some of the proposed CAPs but required additional information. On June 28, 2023, AHCCCS accepted HCA ACC's proposed CAPs and required the Contractor to submit updated policies, manuals, desktop procedures, and other vital documents to provide evidence of CAP completion by December 22, 2023. Remaining CAP items were under review by AHCCCS at the time this report was being written. Additional results of the CAP update will be included in the CYE 2024 annual technical report. Table 5-75 presents the compliance review results for HCA ACC.

**Table 5-75—HCA ACC Compliance Review Results**

| Focus Areas | CYE 2022 HCA ACC Scores | CYE 2022 Program-Level Average | CYE 2023 HCA ACC CAP Update |
|---|---|---|---|
| CC | 100% | 99% | NA |
| CIS | 99% | 96% | NA |
| DS | 98% | 91% | NA |
| GA | 78% | 92% | PM |
| GS | 99% | 99% | NA |
| MCH | 98% | 82% | NA |
| MM | 97% | 94% | NA |
| MI | 94% | 96% | PM |
| QM | 75% | 77% | PM |
| QI | 83% | 92% | PM |
| RI | 100% | 100% | NA |
| TPL | 100% | 100% | NA |
| ISOC | 98% | 96% | NA |

NA = "not applicable." A CAP was not required as the CYE 2022 score was 95% or above.
PM = "partially met." AHCCCS approved the Contractor's proposed CAP. The Contractor must submit evidence of compliance.
M = "met." AHCCCS accepted and closed the Contractor's CAP.

## Strengths, Opportunities for Improvement, and Recommendations

Table 5-76 presents strengths, opportunities for improvement, and recommendations for HCA ACC based on compliance activities conducted in CYE 2023, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-76—HCA ACC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| AHCCCS approved HCA ACC's proposed CAPs for all Focus Areas with scores less than 95 percent. HCA ACC will provide evidence of CAP completion in CYE 2024. |
| **Opportunities for Improvement and Recommendations** |
| HCA ACC has remaining CAPs in the following Focus Areas:<br>• General Administration (GA) **[Timeliness, Access]**<br>• Member Information (MI) **[Quality]**<br>• Quality Management (QM) **[Quality]**<br>• Quality Improvement (QI) **[Quality, Access]**<br><br>Recommendation: HSAG recommends that HCA ACC continue to work on outstanding CAP items and submit to AHCCCS in the approved time frame. |

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

Table 5-77 presents compliance recommendations made to HCA ACC in the CYE 2022 Annual Technical Report[5-35] and HCA ACC's follow-up to the recommendations, as well as an assessment of the degree to which HCA ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 5-77—HCA ACC Follow-Up to CYE 2022 Compliance Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for Compliance |
|---|
| HSAG did not have recommendations for HCA ACC in CYE 2022, as HCA ACC compliance results were not available for the CYE 2022 Annual Technical Report. |

[5-35] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP) Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 8, 2024.

| Prior Year's Recommendation from the EQR Technical Report for Compliance |
|---|
| **HCA ACC's Response:**<br>Not applicable. |
| **HSAG's Assessment:**<br>Not applicable. |

## *Network Adequacy Validation*

### Results

HSAG evaluated HCA ACC's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents semiannual validation findings specific to the ACC Program, with one results table for each of the following GSAs:

- Central GSA: Gila, Maricopa,[5-36] and Pinal counties
- North GSA: Apache, Coconino, Mohave, Navajo, and Yavapai counties

Each region-specific table summarizes semiannual validation results containing the percentage of members meeting each time/distance standard by quarter and county, with color-coding to identify whether or not the time/distance standard was "Met" or "Not Met."

The value "NA" is shown for time/distance standards that do not apply to the county or program.

The value "NR" is shown for time/distance standards in which no members met the network requirement denominator for the program and county; therefore, HSAG calculated no corresponding time/distance result.

Yellow color-coding identifies instances in which HSAG's time/distance results met the minimum network requirement but differed from the ACOM 436 results.

Red color-coding identifies instances in which HSAG's time/distance results did not meet the compliance standard, regardless of the ACOM 436 results.

An asterisk (*) indicates that fewer than 10 members were included in the denominator of HSAG's results.

[5-36] Maricopa County includes the 85342, 85358, and 85390 ZIP Codes; these ZIP Codes are physically located in both Maricopa and Yavapai counties.

A carat (^) indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

**Table 5-78—HCA ACC Time/Distance Validation Results for Central GSA—Percentage of Members Meeting Minimum Network Requirements**

| | Gila | | Maricopa | | Pinal | |
|---|---|---|---|---|---|---|
| Minimum Network Requirement | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0^[1] | 100.0^ | 96.7^[1] | 98.3^ | 100.0^[1] | 100.0^ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 100.0^[1] | 100.0^ | 97.5^[1] | 98.6^ | 100.0^[1] | 100.0^ |
| BHRF | NA | NA | 97.2 | 99.0 | NA | NA |
| Cardiologist, Adult | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| Cardiologist, Pediatric | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| Dentist, Pediatric | 100.0 | 100.0 | 99.5 | 99.4 | 100.0 | 100.0 |
| Hospital | 100.0 | 100.0 | 99.9 | 99.9 | 100.0 | 100.0 |
| OB/GYN | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 100.0 | 100.0 | 99.2 | 99.2 | 100.0 | 100.0 |
| PCP, Adult | 100.0^ | 100.0^ | 99.8^ | 99.7^ | 100.0^ | 100.0^ |
| PCP, Pediatric | 100.0^ | 100.0^ | 99.8^ | 99.8^ | 100.0^ | 100.0^ |

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

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

NA indicates results are not applicable to the county.

[1] In CYE 2023 Q2, HCA ACC's data included decreased numbers of providers used to measure the Behavioral Health Outpatient and Integrated Clinic for Adult and Pediatric standards, as compared to prior submissions. This potentially influenced the validated compliance for this provider type. HCA ACC identified the cause and successfully tested the solution.

**Table 5-79—HCA ACC Time/Distance Validation Results for North GSA—Percentage of Members Meeting Minimum Network Requirements**

| | Apache | | Coconino | | Mohave | | Navajo | | Yavapai | |
|---|---|---|---|---|---|---|---|---|---|---|
| Minimum Network Requirement | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 87.6^[1] | 88.1^ | 76.8^[1] | 98.0^ | 95.1^[1] | 100.0^ | 95.1^[1] | 96.0^ | 100.0^[1] | 100.0^ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 88.7^[1] | 88.9^ | 68.1^[1] | 96.7^ | 90.4^[1] | 99.9^ | 93.7^[1] | 95.0^ | 100.0^[1] | 100.0^ |

| | Apache | | Coconino | | Mohave | | Navajo | | Yavapai | |
|---|---|---|---|---|---|---|---|---|---|---|
| Minimum Network Requirement | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| BHRF | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Cardiologist, Adult | 95.5^ | 95.6^ | 99.5^ | 99.5^ | 99.9^ | 100.0^ | 97.0^ | 97.5^ | 100.0^ | 100.0^ |
| Cardiologist, Pediatric | 99.2^ | 99.3^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| Dentist, Pediatric | 85.2 | 86.3 | 85.5 | 95.5 | 99.3 | 99.3 | 97.4 | 97.5 | 98.2 | 98.3 |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| OB/GYN | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 95.0 | 95.7 | 93.5 | 93.8 | 99.2 | 99.2 | 99.5 | 99.7 | 98.7 | 98.9 |
| PCP, Adult | 93.1^ | 94.0^ | 99.1^ | 98.3^ | 99.9^ | 99.9^ | 99.9^ | 99.6^ | 100.0^ | 100.0^ |
| PCP, Pediatric | 93.6^ | 94.2^ | 98.7^ | 96.9^ | 99.9^ | 99.9^ | 98.1^ | 97.6^ | 100.0^ | 100.0^ |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
represents time/distance standard results that do not meet the compliance standard based on HSAG's results.
^indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.
[1] In CYE 2023 Q2, HCA ACC's data included decreased numbers of providers used to measure the Behavioral Health Outpatient and Integrated Clinic for Adult and Pediatric standards, as compared to prior submissions. This potentially influenced the validated compliance for this provider type. HCA ACC identified the cause and successfully tested the solution.

## Strengths, Opportunities for Improvement, and Recommendations

Table 5-80 presents strengths, opportunities for improvement, and recommendations for HCA ACC related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-80—HCA ACC Strengths, Opportunities for Improvement, and Recommendations Related to NAV**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths:<br>• HCA ACC met all time/distance network standards in assigned counties for both quarters in CYE 2023 except Apache and Coconino counties. [Access]<br>• HCA ACC met time/distance network standards for BHRF; Cardiologist, Adult and Pediatric; Hospital; OB/GYN; PCP, Adult and Pediatric; and Pharmacy. [Access]<br>Note: HCA ACC provides coverage in the following counties: Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal, and Yavapai. |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Opportunities for Improvement and Recommendations** |
| HSAG identified the following opportunities for improvement:<br>• Isolated data issues may have contributed to specific instances affecting HCA ACC's compliance with time/distance standards. **[Access]**<br>• HCA ACC failed to meet the time/distance standard for at least one quarter and/or county for Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric and Dentist, Pediatric. **[Access]**<br><br>Recommendation: HSAG recommends that HCA ACC maintain current compliance with network standards but continue to address network gaps, as applicable. |

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

Table 5-81 presents NAV recommendations made to HCA ACC in the CYE 2022 Annual Technical Report[5-37] and HCA ACC's follow-up to the recommendations, as well as an assessment of the degree to which HCA ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 5-81—HCA ACC Follow-Up to CYE 2022 NAV Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for NAV |
|---|
| HSAG recommended that HCA ACC maintain current compliance with network standards but continue to address network gaps, as applicable. |
| **HCA ACC's Response:**<br>HCA ACC acknowledges the opportunities for improvement and recommendations in the areas shaded red and has taken steps to address network gaps. The chart below recognizes improvements in network adequacy from CYE 2022 to CYE 2023. |

| County | Provider Category | Q2 2022 | Q4 2022 | Q2 2023 | Q4 2023 |
|---|---|---|---|---|---|
| Apache | Dentist, Pediatric | 83.2 | 85.8 | 87.0 | 87.8 |
| Coconino | Dentist, Pediatric | 84.9 | 85.6 | 85.3 | 95.8 |

[5-37] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP) Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Dec 13, 2022.

| Prior Year's Recommendation from the EQR Technical Report for NAV | | | | | |
|---|---|---|---|---|---|
| Gila | Dentist, Pediatric | 100 | 59.2 | 100 | 100 |
| Coconino | Pharmacy | 89.5 | 92.1 | 99.2 | 99.9 |

At the end of Q4 CYE 2023, HCA ACC's network was only deficient in the Dentist, Pediatric category in Apache County. HCA ACC continues to work on identifying and recruiting providers to help address the health workforce shortages in this medically underserved county. This includes recruiting IHS/638 locations and out-of-state providers in contiguous counties.

In Provider Categories where a Compliance Mismatch was reported, it was determined that the Average Difference Mismatch was less than 1%. This analysis considers a year-over-year comparison of CYE 2021 Q4 compared to CYE 2022 Q4, in the areas where there was a Compliance Mismatch for the ACC Program.

The Average Difference Mismatch was less than 1% in all the following areas.

| A. Time Period | Average Difference Mismatch | |
|---|---|---|
| | CYE 2021 Q4 | CYE 2022 Q4 |
| **D. Provider Category** | | |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 0.14% | 0.20% |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 0.33% | 0.10% |
| Behavioral Health Residential Facility (Only Maricopa and Pima Counties) | 0.10% | N/A |
| Cardiologist, Adult | 0.00% | -0.10% |
| Cardiologist, Pediatric | -0.10% | 0.20% |
| Dentist, Pediatric | 0.10% | -0.70% |
| Hospital | 32.87% | -0.20% |
| PCP, Adult | -0.76% | -2.67% |
| PCP, Pediatric | -2.28% | 0.30% |

There were 2 instances that the Average Difference Mismatch was greater than 1% in CYE 2022 Q4 but resolved to be less than a 1% Average Difference Mismatch in CYE 2022 Q4.

| A. Time Period | Average Difference Mismatch | |
|---|---|---|
| | CYE 2021 Q4 | CYE 2022 Q4 |
| **D. Provider Category** | | |
| Hospital | 32.8 | -0.2 |

| A. Time Period | Average Difference Mismatch | |
|---|---|---|
| | CYE 2021 Q4 | CYE 2022 Q4 |
| **D. Provider Category** | | |
| PCP, Pediatric | -2.2 | 0.3 |

**Prior Year's Recommendation from the EQR Technical Report for NAV**

There were 2 instances that the Average Difference Mismatch was greater than 1% in CYE 2022 Q4.

| A. Time Period | Average Difference Mismatch | |
|---|---|---|
| | CYE 2021 Q4 | CYE 2022 Q4 |
| **D. Provider Category** | | |
| Pharmacy | 5.1 | 2.4 |

| A. Time Period | Average Difference Mismatch | |
|---|---|---|
| | CYE 2021 Q4 | CYE 2022 Q4 |
| **D. Provider Category** | | |
| PCP, Adult | -0.7 | -2.6 |

HCA ACC worked diligently to achieve the improvements detailed above. Per the CYE2024 Network Development and Management Plan submitted to AHCCCS in Q1 of CYE 2024:

"*Earlier this year our network reported a Pediatric Dental gap in Apache County. HCA ACC worked in coordination with a pediatric dental office in Northern Arizona to provide mobile dentistry, added tele-dentistry and provided transportation to neighboring counties.*

*HCA ACC is actively working to increase capacity in the identified county by recruiting new providers including IHS and 638 Tribal Providers. Medically underserved communities and Provider Shortages continue to be network issue. Focus on tele, mobile, to assist in covering service needs. Although HCA ACC only had 1 gap, HCA ACC will still balance needs of members in their communities.*"

The plan further states:

"*In coordination with a pediatric dental office in Northern Arizona, HCA ACC has mobilized to provide mobile dentistry, added tele-dentistry, and provided transportation to neighboring counties.*"

"*The challenges of meeting the pediatric dental network adequacy in Apache [county] relate to the rural areas where dental services are not available, or practices will not contract with an MCO. Existing dental practices have challenges retaining and locating qualified dentists who are interested in serving rural communities. In communication with Midwestern University Dental School, leaders report fewer dental students interested in practicing in rural communities. HCA ACC continues to review updates from the Arizona Dental Board where annually, they provide statistics on the number of licensed Dentists, Dental Hygienist, Denturist and Dental Business entities in Arizona. In 2023 there was an increase in dentists and dental businesses entities, however, most of these new businesses are in urban areas and does not address the continued deficiencies of new dental practices and dentists in rural areas.*"

**Prior Year's Recommendation from the EQR Technical Report for NAV**

| Arizona Dental Board Licenses: | 2021 | 2022 | 2023 | Difference between 2022 2023 |
|---|---|---|---|---|
| # Dentists | 5,464 | 5,476 | 5,547 | 71 |
| # Dental Hygienists | 5,124 | 5,217 | 5,228 | 11 |
| # Denturists | 12 | 9 | 11 | 2 |
| # Business Entities | 356 | 356 | 476 | 120 |

"*HCA ACC's efforts to maintain and improve the dental network includes increasing overall reimbursement in 2022 and for some Northern AZ counties in 2023. In 2024, HCA ACC is evaluating implementation of a dental Value Based Program (VBP) that ensures members receive a higher level of oral health care. Providers who meet established quality thresholds are incentivized with increased revenue to their practices. This increased reimbursement will help dental group entities attract and retain dentists within their communities. In Arizona, dental providers in non-urban areas have expressed concerns of staffing shortages, high costs of business operations and challenges in retaining or attracting quality professionals. Arizona Alliance for Community Health Centers has sponsored forums on recruitment and retention, however, FQHCs/RHCs continue to struggle with maintaining an adequate staff of dentist in rural communities. ADHS monitors workforce challenges to identify solutions for Arizona medically underserved areas such a school loan repayment program. Furthermore, HCA ACC seeks opportunities with the Arizona Dental Board, Arizona Dental Association and ADHS to cover northern Arizona counties through services that include teledentistry, field clinics, virtual clinics and mobile dental services that incorporate the use of telemedicine, teleconferencing among providers, and an Integrated Medical Record to provide multi- specialty, interdisciplinary care when needed within various areas of the state.*

*In Apache County, HCA ACC is contracted with three unique dental group practices representing three unique service locations and three unique dentists. Once a new dentist (currently in the contracting and credentialing process) is in contract, HCA ACC has validated that there are no other AHCCCS Registered providers available in Apache County that are not affiliated with Indian Health Services (IHS). HCA ACC has contracted with Tuba City a Tribally Operated 638 Program.*

*Additionally, San Juan Regional Medical Center and their affiliated dental practitioner in Farmington, NM is in the process of contracting and credentialing. Network Services is also pursuing contracts with providers in the following service areas: Gallup, NM and Ft. Defiance, AZ.*"

When HSAG data becomes available, HCA ACC analyzes the detail as illustrated above, to ensure discrepancies are identified and corrected as applicable.

**HSAG's Assessment:**

HSAG has determined that HCA ACC has satisfactorily addressed this prior year's recommendation.

# Mercy Care ACC-RBHA

## *Validation of Performance Measures*

### Results for Information Systems Standards Review

During CYE 2023, HSAG evaluated Mercy Care ACC-RBHA's data system for processing of each data type used for reporting the Contractor's CY 2022 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that Mercy Care ACC-RBHA followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-82 displays HSAG's PMV findings for each data type reviewed during CYE 2023 in alignment with the CMS EQR Protocol 2 audit requirements.

**Table 5-82—CYE 2023 PMV Findings**

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

### Results for Performance Measures

Table 5-83 presents the CY 2021 and CY 2022 Mercy Care ACC-RBHA performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and MY 2022. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and/or MY 2022. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

**Table 5-83—CY 2021 and CY 2022 Mercy Care ACC-RBHA Performance Measure Results**

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021-2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| ***Maternal and Perinatal Care*** | | | | |
| ***Prenatal and Postpartum Care*** | | | | |
| *Timeliness of Prenatal Care[#]* | 84.2%[+] | 84.9%[+] | → | ★★★ |
| *Postpartum Care* | 72.8%[+] | 78.1%[+] | → | ★★★ |
| ***Behavioral Health*** | | | | |
| ***Antidepressant Medication Management*** | | | | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | 56.7% | 53.8% | ↓ | ★ |
| *Effective Continuation Phase Treatment—Total (18+ Years)* | 39.3% | 35.2% | ↓ | ★ |
| ***Follow-Up After ED Visit for Substance Use*** | | | | |
| *7-Day Follow-Up—Total* | — | 33.1% | — | ★★★★ |
| *30-Day Follow-Up—Total* | — | 42.9% | — | ★★★★ |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 44.0% | 48.2% | ↑ | ★★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 59.6% | 65.5% | ↑ | ★★★★ |
| ***Follow-Up After ED Visit for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 51.5% | 52.1% | → | ★★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 61.0% | 63.0% | → | ★★★ |
| ***Use of Opioids at High Dosage*** | | | | |
| *18+ Years** | 9.3% | 9.1% | → | ★ |
| ***Initiation and Engagement of Substance Use Disorder (SUD) Treatment*** | | | | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | — | 54.5% | — | ★★★★ |
| *Engagement of SUD Treatment—Total—Total (13+ Years)* | — | 20.7% | — | ★★★★ |
| ***Adherence to Antipsychotic Medications for Individuals with Schizophrenia*** | | | | |
| *18+ Years* | — | 57.7% | — | ★★ |
| ***Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication*** | | | | |
| *18–64 Years* | — | 81.1% | — | ★★★ |
| ***Care of Acute and Chronic Conditions*** | | | | |
| ***Controlling High Blood Pressure*** | | | | |
| *18–85 Years* | 64.0%[+] | 59.9%[+] | → | ★★ |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | | | | |
| *HbA1c Control (<8.0 %)—Total (18–75 Years)* | — | 58.4[+]% | — | ★★★★ |

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021-2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)** | 40.6%+ | 34.8%+ | → | ★★★ |
| ***Pediatric Health*** | | | | |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotics*** | | | | |
| *Blood Glucose Testing—Total (1–17 Years)* | 61.2% | 65.1% | ↑ | ★★★★ |
| *Cholesterol Testing—Total (1–17 Years)* | 48.4% | 53.8% | ↑ | ★★★★★ |
| *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* | 47.6% | 52.9% | ↑ | ★★★★★ |
| ***Childhood Immunization Status***** | | | | |
| *Combination 3* | 62.3% | 56.9% | → | ★ |
| *Combination 7* | 56.9% | 52.8% | → | ★★ |
| *Combination 10* | 30.2% | 23.1% | ↓ | ★ |
| ***Developmental Screening in the First Three Years of Life*** | | | | |
| *Total (0–3 Years)* [N] | — | 51.8% | — | — |
| ***Immunizations for Adolescents*** | | | | |
| *Combination 1 (Meningococcal, Tdap)* | 84.4% | 89.1% | → | ★★★★★ |
| *Combination 2 (Meningococcal, Tdap, HPV)* | 40.9% | 40.1% | → | ★★★ |
| ***Oral Evaluation, Dental Services*** | | | | |
| *Total (0–20 Years)* [N] | — | 52.2% | — | — |
| ***Well-Child Visits in the First 30 Months of Life*** | | | | |
| *Six or More Well-Child Visits* | 64.3% | 65.1% | → | ★★★★ |
| *15 Months–30 Months—Two or More Well-Child Visits* | — | 63.1% | — | ★★ |
| ***Child and Adolescent Well-Care Visits*** | | | | |
| *Total (3–21 Years)* | 49.7% | 49.6% | → | ★★★ |
| ***Preventive Screening*** | | | | |
| ***Breast Cancer Screening*** | | | | |
| *Total (50–74 Years)* | 52.0% | 54.3% | ↑ | ★★★ |
| ***Cervical Cancer Screening*** | | | | |
| *21–64 Years* | 58.2%+ | 60.1%+ | → | ★★★ |
| ***Appropriate Utilization of Services*** | | | | |
| ***Ambulatory Care*** | | | | |
| *Emergency Department (ED) Visits—Total (0–85+ Years)* [F] | 498.0 | 519.6 | — | — |
| ***Plan All-Cause Readmissions*** | | | | |
| *Observed Readmissions—Total (18–64 Years)* | 9.4% | 9.7% | → | — |
| *Expected Readmissions—Total (18–64 Years)* | — | 9.6% | — | — |

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021-2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| *Outlier Rate—Total (18–64 Years)* | — | 59.6 | — | — |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)** | 0.9810 | 1.0103 | — | ★★ |

* A lower rate indicates better performance for this measure.
** Table A-1 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
+ Indicates the measure was reported using hybrid methodology.
# Caution should be considered when comparing CY 2021 to CY 2022 results as changes to the measure specifications occurred.
Cells shaded green indicate that the rate met or exceeded the MY 2021 and/or MY 2022 national Medicaid mean.
[1] Indicates a 2021–2022 comparison is not presented in the CYE 2023 Annual Technical Report because either the CY 2021 rate was not presented in the CYE 2022 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
↑ Indicates improvement of measure rates.
↓ Indicates decline of measure rates.
→ Indicates stable measure rates.
[2] Performance Levels for CY 2022 were based on comparisons of the HEDIS MY 2022 measure rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks.
Performance Levels for 2022 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile
[N] Measure has no NCQA Medicaid mean for comparison
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.

## Strengths, Opportunities for Improvement, and Recommendations

Table 5-84 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-84—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| In the Maternal and Perinatal Care measure group, Mercy Care ACC-RBHA's measure rates for *Timeliness of Prenatal Care* and *Postpartum Care* measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022, indicating members are receiving the recommended prenatal and postpartum care. **[Quality, Timeliness, Access]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| In the Behavioral Health measure group:<br>• Nine of 13 (69.2 percent) Mercy Care ACC-RBHA measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. **[Quality, Timeliness, Access]**<br>– *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*<br>– *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)*<br>– *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)*<br>– *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* and *Engagement of SUD Treatment—Total—Total (13+ Years)*<br>– *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years*<br>In the Care of Acute and Chronic Conditions measure group, Mercy Care ACC-RBHA measure rates for *HbA1c Control (<8.0 %)—Total (18–75 Years)* and *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)* met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. **[Quality]** |
| In the Pediatric Health measure group:<br>• Seven of 13 (53.8 percent) Mercy Care ACC-RBHA measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. **[Quality, Timeliness, Access]**<br>• Mercy Care ACC-RBHA's performance measure rates for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total (1–17 Years), Cholesterol Testing—Total (1–17 Years)*, and *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* were at or above the 75th percentile, indicating that most children and adolescents with ongoing antipsychotic medication use had metabolic testing performed. Metabolic monitoring (blood glucose and cholesterol testing) is an important component of ensuring appropriate management of children and adolescents on antipsychotic medications.[5-38] **[Quality]**<br>• Mercy Care ACC-RBHA's performance measure rates for *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022, indicating adolescents are receiving the recommended vaccinations. **[Quality]** |

[5-38] National Committee for Quality Assurance. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM). Available at: https://www.ncqa.org/hedis/measures/metabolic-monitoring-for-children-and-adolescents-on-antipsychotics/. Accessed on: Jan 31, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| • In the Preventive Screening measure group, all (100.0 percent) of Mercy Care ACC-RBHA's measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. **[Quality]** |
| **Opportunities for Improvement and Recommendations** |
| In the Behavioral Health measure group, Mercy Care ACC-RBHA's performance measure rate for *Use of Opioids at High Dosage—18+ Years* fell below the 25th percentile indicating an opportunity to identify trends leading to the opioid crisis. **[Quality]**<br><br>Recommendation: In 2016, opioid-related overdoses accounted for more than 42,000 deaths in the United States. Of those, 40 percent involved prescription opioids. Literature suggests there is a correlation between high dosages of prescription opioids and the risk of both fatal and nonfatal overdose. HSAG recommends that Mercy Care ACC-RBHA follow the CDC guidelines on opioid prescribing for chronic, nonmalignant pain, which recommend the use of "additional precautions" when prescribing dosages ≥50 MED and recommend providers avoid or "carefully justify" increasing dosages ≥90 mg MED. In 2019, the authors of the 2016 guidelines published commentary that cautioned providers, systems, payers and states from developing policies and practices that are "inconsistent with and go beyond" the guideline recommendations. The commentary included cautions regarding strict enforcement of dosage and duration thresholds, as well as abrupt tapering of opioids. The opioid dosage assessed in this measure is a reference point for health plans to identify members who may be at high risk for opioid overuse and misuse. HSAG recommends outreach to members who fall within this category to assess and schedule interventions as necessary.[5-39]<br><br>In the Behavioral Health measure group, Mercy Care ACC-RBHA's performance measure rates for *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total (18+Years)* fell below the 25th percentile, indicating an opportunity to identify trends leading to antidepressant medication mismanagement. **[Quality]**<br><br>Recommendation: Suicide is the 10th leading cause of death in the United States. Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy and self-esteem, and can lead to suicide. Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness and identifying and managing side effects.[5-44] HSAG recommends that Mercy Care ACC-RBHA conduct a root cause analysis or focus study to determine why some members with a diagnosis of major depression were not receiving continuous medication treatment. This could include conducting focus groups to identify |

[5-39] National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/ Accessed on: Jan 25, 2024

[5-44] National Committee for Quality Assurance. Antidepressant Medication Management. Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management. Accessed on: Feb 16, 2024

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, Mercy Care ACC-RBHA should implement appropriate interventions to improve performance related to antidepressant medication management. Educating staff and patients continuously to ensure consistent communication of the importance of medication adherence is highly suggested. |
| In the Pediatric Health measure group, Mercy Care ACC-RBHA's performance measure rate for *Childhood Immunization Status—Combination 3* and *Combination 10* fell below the 25th percentile, indicating that children were not always getting their immunizations by their second birthday. Vaccination coverage must be maintained to prevent a resurgence of vaccine-preventable diseases. **[Quality, Access]**<br><br>Recommendation: HSAG recommends that Mercy Care ACC-RBHA conduct a root cause analysis to determine why some children are not getting their immunizations by their second birthday. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services to implement appropriate interventions. Mercy Care ACC-RBHA should consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). Upon identification of a root cause, HSAG recommends that Mercy Care ACC-RBHA implement appropriate interventions to improve performance related to childhood immunizations. |

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

Table 5-85 presents performance measure recommendations made to Mercy Care ACC in the CYE 2022 Annual Technical Report[5-40] and Mercy Care ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 5-85—Mercy Care ACC-RBHA Follow-Up to CYE 2022 Performance Measure Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| **Recommendation 1:** |
| HSAG recommended that Mercy Care ACC continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. Additionally, HSAG recommended that Mercy Care ACC continue to conduct a formal review of its source code followed |

[5-40] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP). Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 1, 2024.

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| by a complete test plan, including live system validation of data, prior to reporting any performance measure data. |
| **Mercy Care ACC-RBHA's Response:**<br>Historically, Mercy Care ACC has followed the NCQA HEDIS guidelines regarding continuous enrollment, which is required by AHCCCS beginning in MY 2023. As a result, Mercy Care ACC is in compliance with the current requirements.<br>The National Medicaid Quality Data team ensures that necessary source code changes are made by the software vendor with the release of any changes to event data, and rates are reviewed monthly. Any anomalies/discrepancies/outliers that are found are reviewed, researched, and tested thoroughly before any data are reported to regulatory bodies. Additionally, monthly event checks using vendor resources are compared to any technical specifications to ensure that the vendor is accurately capturing the right reporting elements for all core and non-core activities, as well as higher monitoring of internal back-end system integrations to ensure that all data elements are within scope to be captured for reporting. |
| **HSAG's Assessment:** HSAG determined that Mercy Care ACC-RBHA satisfactorily addressed these prior year's recommendations. |
| **Recommendation 2:** |
| HSAG recommended that Mercy Care ACC explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratification related to race and ethnicity. Mercy Care ACC should continue working with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information. |
| **Mercy Care ACC-RBHA's Response:**<br>Mercy Care ACC is working in collaboration with the Aetna Medicaid Quality & Report team to update the 834 mapping to include all applicable data. Additionally, exploration of leveraging the CMS enrollment files and case/care management data for capturing additional data is planned for 2024. As part of this additional work, Mercy Care ACC and Aetna Medicaid are collaborating with the Health Equity Team to identify whether indirect data sources can be captured to supplement the direct data sources.<br><br>Finally, AHCCCS has implemented TI and DAP requirements to encourage providers to support data collection and is working with HIE to provide more information. Mercy Care ACC has been working with the HIE on receiving the A08 alerts for race and ethnicity data directly. |
| **HSAG's Assessment:** HSAG determined that Mercy Care ACC-RBHA satisfactorily addressed these prior year's recommendations. |
| **Recommendation 3:** |
| While Mercy Care ACC conducted root cause analyses and implemented interventions specific to the CY 2020 *Prenatal and Postpartum Care—Postpartum Care* rate, this rate remained low in CY 2021; therefore, HSAG recommended that Mercy Care ACC continue to implement appropriate |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| interventions to improve performance related to postpartum care. HSAG also recommended that Mercy Care ACC monitor and expand on interventions currently in place to improve performance for the *Prenatal and Postpartum Care—Postpartum Care* measure indicator. |
| **Mercy Care ACC-RBHA's Response:**<br>Mercy Care ACC continued the interventions that were reported in 2022, after completion of a root cause analysis. Those interventions include:<br>• Leveraging the ACOG data submitted to the perinatal Integrated Care Management (ICM) team for low-risk pregnancy identification, in addition to use by the perinatal Care Management team.<br>• Leveraging newborn notifications for identification of pregnant members.<br>• Implementation of a process to identify pregnant members through positive pregnancy tests in the HIE.<br>• Revision of the current process so that members who are referred to ICM but refuse care management or are unable to be reached are transitioned back to a low-risk outreach team.<br>• Workforce driver for additional staff to conduct postpartum outreach calls so that all members who appear on a call list receive an outreach call.<br>• Conducting digital outreach throughout the year to capture all postpartum members.<br>• Revising the outreach process so that the postpartum mailing is sent to the member regardless of whether or not the member's PCP or baby's PCP information is available (revise letter template and process).<br>• Expand education to OB/GYNs by MCH coordinators.<br>• Train two staff on the management of this measure to allow for knowledge and early intervention as well as supplying a backup in the event of staff resignations.<br>• Medical record vendor challenges—address through work locally at the health plan and nationally in partnership with Mercy Care ACC's National Medicaid Quality Management (NMQM) team.<br><br>Mercy Care ACC's MY 2022 rate of 78.10% exceeds the NCQA HEDIS MY 2022 Medicaid mean of 76.96% and meets the 50th percentile of 78.10%. |
| **HSAG's Assessment:**<br>Mercy Care ACC-RBHA identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that Mercy Care ACC-RBHA satisfactorily addressed these prior year's recommendations. |
| **Recommendation 4:** |
| While Mercy Care ACC conducted a root cause analysis and implemented interventions specific to the CY 2020 *Antidepressant Medication Management—Effective Continuation Phase Treatment* measure rate, this rate remained low in CY 2021; therefore, HSAG recommended that Mercy Care ACC continue to implement appropriate interventions to improve performance related to the *Antidepressant Medication Management—Effective Continuation Phase Treatment* rate. HSAG also recommended that Mercy Care ACC monitor and expand on interventions currently in place to |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| improve performance related to continuous medication treatment for members with a diagnosis of major depression. |
| **Mercy Care ACC-RBHA's Response:**<br>Mercy Care ACC conducted data review and best practice identification, conducted a presentation and distributed it to ACOs and Clinically Integrated Networks, and added the *Antidepressant Medication Management* measure in the Mercy Care ACC Value-Based Program for 2023 contracts. However, Mercy Care ACC's performance with the *Antidepressant Medication Management* measure continues to fall below the NCQA HEDIS Medicaid mean, resulting in Mercy Care ACC returning to the "plan" phase of the PDSA cycle, where additional interventions were developed for implementation:<br>• The Pharmacy Risk Prevention Report, which includes members at risk for non-compliance with medications, and includes gap in care data (measures: *AMM, HDO, SAA, SPD, SPC, SSD,* and *UOP*)<br>• Healthmine Application—Member Web portal to provide educational information regarding gaps in care along with digital and written member outreach (planned to be open for member access 11/01/2023)<br><br>Mercy Care ACC will continue to monitor performance with this measure through the additional phases of the PDSA cycle and modify existing interventions or implement additional interventions as necessary. |
| **HSAG's Assessment:**<br>Mercy Care ACC-RBHA identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that Mercy Care ACC-RBHA satisfactorily addressed these prior year's recommendations. |
| **Recommendation 5:** |
| HSAG recommended that Mercy Care ACC conduct a root cause analysis or focus study to determine why there was a higher proportion of members receiving prescriptions for opioids. Upon identification of a root cause, HSAG recommended that Mercy Care ACC implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse. |
| **Mercy Care ACC-RBHA's Response:**<br>As a result of a root cause analysis, Mercy Care ACC developed the following interventions aimed at reducing the number and percentage of members who are prescribed high dose opioids:<br>• The Pharmacy Risk Prevention Report, which includes members at risk for noncompliance with medications, and includes gap in care data (measures: *AMM, HDO, SAA, SPD, SPC, SSD,* and *UOP*).<br>• Opioid/SUD Best Practices Presentation to Mercy Care Value-Based Service (VBS) providers by Mercy Care's associate chief medical officer. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| • The Educational Outreach Program (EOP) with provider fax including targeted member information for providers identified as having members on > 90 MME (morphine milligram equivalents). This also includes an opioid prescriber report card.<br>• Telephonic one-on-one provider outreach to the top 10 high MME prescribers.<br>• SMS (PBM program): This program targets high-risk drug classes, focusing on controlled substances, and inappropriate use and misuse related indicators such as poly-pharmacy, provider shopping, and high total controlled substance claims volume. Quarterly, clinical pharmacists will evaluate controlled substance claims and any available supporting medical data to identify potential medication misuse and inappropriate claims for appropriate intervention. During subsequent quarters, pharmacists conduct follow-up activities utilizing physician responses and current claim activity. Situations identified as being potentially inappropriate may be referred to the client (plan) for further action.<br>• Creation and distribution of a report of members who are utilizing 50–89 MME for provider awareness and intervention prior to the member reaching 90 MME.<br>• Mercy Care ACC's associate chief medical officer outreaches to prescribing providers of members who are in the *HDO* measure numerator.<br>• Mercy Care ACC case managers will outreach members in the *HDO* measure for care coordination.<br><br>Mercy Care ACC will continue to monitor the plan's performance with this measure through the additional phases of the PDSA cycle and modify existing interventions or implement additional interventions as necessary. |
| **HSAG's Assessment:**<br>Mercy Care ACC-RBHA identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that Mercy Care ACC-RBHA satisfactorily addressed these prior year's recommendations. |

## *Validation of Performance Improvement Projects*

### Back to Basics PIP

In CYE 2023, Mercy Care ACC-RBHA continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 1, PIP validation activities focused on improvement from the baseline results. Mercy Care ACC-RBHA submitted Remeasurement 1 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes or discontinuation of the interventions.

HSAG conducted an annual validation of the first remeasurement year reflective of CY 2022 (January 1, 2022, through December 31, 2022) using AHCCCS-calculated and validated indicator rates. HSAG evaluated Mercy Care ACC-RBHA's performance indicator results based on an analysis of

improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

### *Validation Results*

Table 5-86 displays the overall confidence levels for the Mercy Care ACC-RBHA *Back to Basics* PIP.

**Table 5-86—Mercy Care ACC-RBHA *Back to Basics* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| Mercy Care ACC-RBHA | *High Confidence* | 100% | 100% | *Not Assessed* | *Not Assessed* | *Not Assessed* |

### *Measure Results*

Table 5-87 and Table 5-88 provide the *Back to Basics* PIP baseline and intervention year rates for each indicator for Mercy Care ACC-RBHA.

**Table 5-87—Mercy Care ACC-RBHA *Back to Basics* PIP Rates for PIP Indicator 1**

| Contractor | PIP Indicator 1: *W30 Rate 1* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| Mercy Care ACC-RBHA | 65.0% | 65.1% |

**Table 5-88—Mercy Care ACC-RBHA *Back to Basics* PIP Rates for PIP Indicator 2**

| Contractor | PIP Indicator 2: *WCV* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| Mercy Care ACC-RBHA | 52.9% | 49.6% |

### *Interventions*

Table 5-89 presents PIP interventions for Mercy Care ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 5-89—Mercy Care ACC-RBHA *Back to Basics* PIP Interventions**

| Contractor | Interventions |
|---|---|
| Mercy Care ACC-RBHA | *W30 (15 Months)*<br>During postpartum calls, the outreach staff reviews the baby's PCP information on file and assistance is offered if the parent has not made the baby's first appointment.<br>• Proactive reminder calls to parents/guardians of 6-, 9-, and 11-month-olds to remind them that their child is due for a well-child visit and immunizations (if appropriate) during the month. If the parent has not already made an appointment, a three-way call is placed to the provider's office to schedule an appointment.<br>• Mailing to parents/guardians of 1-month-olds that includes a well-child magnet listing the ages that children need well visits and a booklet on immunizations and debunking immunization myths.<br>• Incentive offer to parents of 3-month-olds - if the member has six well-child visits before they turn 15 months of age and all required immunizations prior to their second birthday, Mercy Care will send them a Target gift card.<br>• Immunization magnet mailing to parents of 6-month-olds listing the immunization schedule.<br>• Automated reminder calls to parents of 2- and 4-month-olds reminding them to schedule a well visit for their baby if they have not already done so and to make sure that their child's immunizations are up to date.<br>• EPSDT reminder cards, including information consistent with the AHCCCS periodicity schedule.<br>• EPSDT second reminder cards.<br>• Written reminders: member handbook, member newsletters, and newborn booklets to promote well-child visits; EPSDT reminder cards; and well-child reminder letters.<br>• A written provider outreach process which includes mailings to PCPs for members in need of an EPSDT visit; members 0–24 months of age in need of immunizations; adolescents in need of immunizations; a reminder on the requirement to conduct developmental screenings at the 9-, 18- and 24-month visits; information pertaining to the members' historical dental care and whether or not the member is due for dental care.<br>• Face-to-face contacts between the Mercy Care coordinators and providers encouraging outreach efforts on members lacking childhood immunizations and/or well-child visits. |

| Contractor | Interventions |
|---|---|
| | • Provider pay for performance to Primary Care Medical Home (PCMH)/ACO groups for improving performance in the measure.<br>• Mercy Care has established an internal workgroup to delve deeper into the decline in well-child rates and explore any possible correlation to EPSDT participation. The aim of the workgroup is to ensure that network capacity is keeping up with recent and continuing growth of Mercy Care membership.<br>• Text reminder messages to opt-in members;<br>– April-Dental Visits for Kids-Members or Parents of members <21 years of age<br>– June-EPSDT Visit-Members or Parents of members <21 years of age<br><br>*WCV*<br>• Telephone outreach to members turning 3–6 years of age during the measurement year. For members in need of an appointment, a three-way call with their provider to schedule the visit will be conducted.<br>• Automated reminder calls to parents/guardians of members 3–6 years of age.<br>• EPSDT reminder cards, including information consistent with the AHCCCS periodicity schedule.<br>• EPSDT second reminder cards.<br>• Written reminders to members including but not limited to a member handbook, member newsletters, and newborn booklets to promoting well-child visits; EPSDT reminder cards; and well-child reminder letters.<br>• Member financial incentive offered to parents/guardians of members who have not yet had a well-child exam during the contract year.<br>• Written provider outreach process which includes mailings to PCPs for members in need of an EPSDT visit and information pertaining to the members' historical dental care and whether or not the member is due for dental care.<br>• Identification of the largest provider groups and schedule face-to-face visits to encourage member outreach.<br>• Provider pay for performance to PCMH/ACO groups for improving performance in the measure.<br>• Mercy Care is changing the member outreach schedule for members ages 3–6 years of age from a "summer schedule," with calls beginning in April and ending in August, to a monthly schedule in an effort to increase well-child visit rates for this age group. Incentives will continue.<br>• Mercy Care has established an internal workgroup to delve deeper into the decline in well-child rates and explore any possible correlation to EPSDT participation. The aim of the workgroup is to ensure that network capacity is keeping up with recent and continuing growth of Mercy Care membership. |

| Contractor | Interventions |
|---|---|
| | • Text reminder messages to opt-in members:<br>– April-Dental Visits for Kids-Members or Parents of members <21 years of age<br>– May-Dental Sealant-Members or Parents of members ages 6–15 years<br>– June-EPSDT Visit-Members or Parents of members <21 years of age. |

### *Strengths, Opportunities for Improvement, and Recommendations*

Table 5-90 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA related to the *Back to Basics* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-90—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG noted that Mercy Care ACC-RBHA performed accurate statistical testing between the baseline and Remeasurement 1 results and had a slight non-statistically significant improvement for indicator 1. **[Quality, Access]**<br><br>Mercy Care ACC-RBHA developed and implemented measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 2. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| For indicator 1, Mercy Care ACC-RBHA had a non-statistically significant improvement of 0.12 percentage point in the indicator rate between the baseline year and Remeasurement Year 1. Mercy Care ACC-RBHA had a decline of 3.33 percentage points in the indicator rate between the baseline year and Remeasurement Year 1 for indicator 2. **[Quality, Access]**<br><br>Recommendations: As the PIP progresses, HSAG recommends that Mercy Care ACC-RBHA:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

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

Table 5-91 presents PIP recommendations made to Mercy Care ACC in the CYE 2022 Annual Technical Report[5-41] and Mercy Care ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 5-91—Mercy Care ACC-RBHA Follow-Up to CYE 2022 PIP Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| HSAG recommended that Marcy Care ACC:<br>• Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary.<br>• Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available.<br>• Develop and document a plan for sustaining the improvement for any demonstrated improvement in indicator rates. |
| **Mercy Care ACC-RBHA's Response:**<br>Mercy Care ACC continues to review the PIP rates at least quarterly, with an annual final measurement year evaluation once the data are finalized. When the health plan identifies declines in performance, or that the rates are not on track to reach the defined goal, we initiate or continue to the next step in the PDSA cycle. Best practices are identified, documented, and incorporated into the health plan's standard operating procedures.<br><br>The COVID-19 PHE continued to impact the rates of members' receipt of well-child visits through 2022; however, Mercy Care ACC data for MY 2023 demonstrate significant year-over-year improvements in the *Child and Adolescent Well-Care Visit (WCV)* and *Well Child Visits in the First 30 Months of Life* (Rate 1) rates.<br><br>*WCV* rate with claims through 09/30/2023: 41.90% (a 13.6 percent improvement over the 2022 rates for the same time period) |

[5-41] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP) Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 8, 2024.

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| *W30* (Rate 1) rate with claims through 09/30/2023: 64.55% (a 4.1 percent improvement over the 2022 rates for the same time period)<br><br>AHCCCS notified the health plans that the *Annual Dental Visit (ADV)* measure is being removed as an indicator within this PIP due to being retired by NCQA. |
| **HSAG's Assessment:** HSAG has determined that the Contractor has satisfactorily addressed these prior year's recommendations. |

## Prenatal and Postpartum Care PIP

In CYE 2023, Mercy Care ACC-RBHA submitted baseline measurement results for the *Prenatal and Postpartum Care* PIP, which was initiated in CY 2022. Mercy Care ACC-RBHA submitted baseline performance indicator results and interventions implemented.

HSAG conducted an annual validation of the baseline year reflective of CY 2022 (January 1, 2022, through December 31, 2022) using AHCCCS-calculated and validated indicator rates. HSAG evaluated Mercy Care ACC-RBHA's performance indicator results based on an analysis of improvement strategies implemented as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

### *Validation Results*

Table 5-92 displays the overall confidence levels for the Mercy Care ACC-RBHA *Prenatal and Postpartum Care* PIP.

**Table 5-92—Mercy Care ACC-RBHA *Prenatal and Postpartum Care* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| Mercy Care ACC-RBHA | *High Confidence* | 100% | 100% | *Not Assessed* | *Not Assessed* | *Not Assessed* |

### *Measure Results*

Table 5-93 and Table 5-94 provide the *Prenatal and Postpartum Care* PIP baseline rates for each indicator for Mercy Care ACC-RBHA.

**Table 5-93—Mercy Care ACC-RBHA *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 1**

| Contractor | PIP Indicator 1: *Timeliness of Prenatal Care* |
|---|---|
| | Baseline Year |
| | CY 2022 |
| Mercy Care ACC-RBHA | 84.9% |

**Table 5-94—Mercy Care ACC-RBHA *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 2**

| Contractor | PIP Indicator 2: *Postpartum Care* |
|---|---|
| | Baseline Year |
| | CY 2022 |
| Mercy Care ACC-RBHA | 78.1% |

### *Interventions*

Table 5-95 presents PIP interventions for Mercy Care ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 5-95—Mercy Care ACC-RBHA *Prenatal and Postpartum Care* PIP Interventions**

| Contractor | Interventions |
|---|---|
| Mercy Care ACC-RBHA | • Written member outreach activities which may include but are not limited to the "You and Your Baby" magazine.<br>• Written member outreach on postpartum depression.<br>• Educational outreach information is available on the Mercy Care website.<br>• Text messaging, email, and IVR outreach to close gaps in care.<br>• Outreach telephone calls to members who delivered a baby encouraging them to schedule a postpartum visit which includes offering transportation assistance.<br>• OB case management/care coordination to high-risk members who delivered and follow-up on postpartum needs. As member contact allows, OB Case Management performs postpartum depression screenings for eligible members.<br>• Coordinate referral and reporting of pregnant members with Mercy Care's ICM Perinatal Care Management program. |

### *Strengths, Opportunities for Improvement, and Recommendations*

Table 5-96 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA related to the *Prenatal and Postpartum Care* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-96—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to the *Prenatal and Postpartum Care* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| Mercy Care ACC-RBHA developed and implemented measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 1. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| For indicator 1, 84.9 percent of women had a prenatal care visit in the first trimester and 78.1 percent had a postpartum visit between seven and 84 days after delivery during CYE 2022. **[Quality, Access]**<br><br>Recommendations: As the PIP progresses, HSAG recommends that Mercy Care ACC-RBHA:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

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

The *Prenatal and Postpartum Care* PIP was initiated in CY 2022; therefore, this section is not applicable.

## *Compliance Reviews*

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

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

AHCCCS stated that it views the readiness review process as an ongoing series of activities to monitor and ensure Contractor progress. AHCCCS initiates the readiness review process roughly six months prior to the contract effective date. These readiness activities are essential to establishing the capacity of the awarded Contractors to function in a number of critical areas, including operations and administration, service delivery, financial management, and systems management. The Mercy Care ACC-RBHA contract began October 1, 2022. The compliance review for the ACC-RBHA Program will be conducted in CYE 2024 and will therefore be included in the CYE 2024 annual technical report.

## *Network Adequacy Validation*

### Results

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

- Central GSA: Gila, Maricopa,[5-42] and Pinal counties

Each region-specific table summarizes semiannual validation results containing the percentage of members meeting each time/distance standard by quarter and county, with color-coding to identify whether or not the time/distance standard was "Met" or "Not Met."

The value "NA" is shown for time/distance standards that do not apply to the county or program.

The value "NR" is shown for time/distance standards in which no members met the network requirement denominator for the program and county; therefore, HSAG calculated no corresponding time/distance result.

Yellow color-coding identifies instances in which HSAG's time/distance results met the minimum network requirement but differed from the ACOM 436 results.

Red color-coding identifies instances in which HSAG's time/distance results did not meet the compliance standard, regardless of the ACOM 436 results.

An asterisk (*) indicates that fewer than 10 members were included in the denominator of HSAG's results.

A carat (^) indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

[5-42] Maricopa County includes the 85342, 85358, and 85390 ZIP Codes; these ZIP Codes are physically located in both Maricopa and Yavapai counties.

**Table 5-97—Mercy Care ACC-RBHA Time/Distance Validation Results for Central GSA—Percentage of Members Meeting Minimum Network Requirements**

| Minimum Network Requirement | Gila | | Maricopa | | Pinal | |
|---|---|---|---|---|---|---|
| | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0^ | 100.0^ | 98.7^ | 98.8^ | 100.0^ | 100.0^ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 100.0^ | 100.0^ | 98.7^ | 98.8^ | 100.0^ | 100.0^ |
| BHRF | NA | NA | 99.5 | 99.5 | NA | NA |
| Cardiologist, Adult | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| Cardiologist, Pediatric | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| Dentist, Pediatric | 100.0 | 99.4 | 99.4 | 99.4 | 100.0 | 100.0 |
| Hospital | 100.0 | 100.0 | 99.9 | 99.9 | 100.0 | 100.0 |
| OB/GYN | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 100.0 | 100.0 | 99.2 | 99.1 | 100.0 | 100.0 |
| PCP, Adult | 100.0^ | 100.0^ | 99.8^ | 99.8^ | 100.0^ | 100.0^ |
| PCP, Pediatric | 100.0^ | 100.0^ | 99.7^ | 99.7^ | 100.0^ | 100.0^ |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
^indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county

## Strengths, Opportunities for Improvement, and Recommendations

Table 5-98 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-98—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to NAV**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths:<br>• Mercy Care ACC-RBHA met all time/distance network standards in all assigned counties for both quarters in CYE 2023. **[Access]**<br>Note: Mercy Care ACC-RBHA provides coverage in the following counties: Gila, Maricopa, and Pinal. |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Opportunities for Improvement and Recommendations** |
| HSAG identified no opportunities for improvement for Mercy Care ACC-RBHA.<br><br>Recommendation While HSAG did not have any recommendations specific to its existing provider network coverage, Mercy Care ACC-RBHA should continue to maintain current compliance with network standards. |

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

Table 5-99 presents NAV recommendations made to Mercy Care ACC in the CYE 2022 Annual Technical Report[5-43] and Mercy Care ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 5-99—Mercy Care ACC-RBHA Follow-Up to CYE 2022 NAV Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for NAV |
|---|
| While HSAG did not have any recommendations specific to Mercy Care ACC's existing provider network coverage, HSAG recommended that Mercy Care ACC-RBHA continue to maintain current compliance with network standards. |
| **Mercy Care ACC-RBHA's Response:**<br>Mercy Care ACC continues existing processes to ensure that the plan maintains compliance with the AHCCCS network coverage requirements. |
| **HSAG's Assessment:**<br>HSAG has determined that Mercy Care ACC-RBHA has satisfactorily addressed this prior year's recommendation. |

[5-43] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP) Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 8, 2024.

# Molina ACC

## *Validation of Performance Measures*

### Results for Information Systems Standards Review

During CYE 2023, HSAG evaluated Molina ACC's data system for processing of each data type used for reporting the Contractor's CY 2022 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that Molina ACC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-100 displays HSAG's PMV findings for each data type reviewed during CYE 2023 in alignment with the CMS EQR Protocol 2 audit requirements.

**Table 5-100—CYE 2023 PMV Findings**

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

### Results for Performance Measures

Table 5-101 presents the CY 2021 and CY 2022 Molina ACC performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and MY 2022. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and/or MY 2022. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

**Table 5-101—CY 2021 and CY 2022 Molina ACC Performance Measure Results**

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| ***Maternal and Perinatal Care*** | | | | |
| ***Prenatal and Postpartum Care*** | | | | |
| *Timeliness of Prenatal Care*[#] | 75.4%[+] | 83.7%[+] | ↑ | ★★ |
| *Postpartum Care* | 66.2%[+] | 64.2%[+] | → | ★ |
| ***Behavioral Health*** | | | | |
| ***Antidepressant Medication Management*** | | | | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | 61.3% | 63.7% | → | ★★★ |
| *Effective Continuation Phase Treatment—Total (18+ Years)* | 43.9% | 48.1% | → | ★★★ |
| ***Follow-Up After ED Visit for Substance Use*** | | | | |
| *7-Day Follow-Up—Total* | — | 30.8% | — | ★★★★ |
| *30-Day Follow-Up—Total* | — | 40.5% | — | ★★★ |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 33.2% | 34.3% | → | ★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 51.0% | 54.2% | → | ★★ |
| ***Follow-Up After ED Visit for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 52.3% | 46.3% | → | ★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 59.5% | 56.3% | → | ★★★ |
| ***Use of Opioids at High Dosage*** | | | | |
| *18+ Years** | 5.5% | 1.6% | ↑ | ★★★★ |
| ***Initiation and Engagement of Substance Use Disorder (SUD) Treatment*** | | | | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | — | 56.6% | — | ★★★★★ |
| *Engagement of SUD Treatment—Total—Total (13+ Years)* | — | 21.8% | — | ★★★★ |
| ***Adherence to Antipsychotic Medications for Individuals with Schizophrenia*** | | | | |
| *18+ Years* | — | 31.3% | — | ★ |
| ***Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication*** | | | | |
| *18–64 Years* | — | 75.3% | — | ★ |
| ***Care of Acute and Chronic Conditions*** | | | | |
| ***Controlling High Blood Pressure*** | | | | |
| *18–85 Years* | 54.7%[+] | 39.7%[+] | ↓ | ★ |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | | | | |
| *HbA1c Control (<8.0 Percent)—Total (18–75 Years)* | — | 44.3%[+] | — | ★ |

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| *HbA1c Poor Control (>9.0 Percent)—Total (18–75 Years)** | 43.3%+ | 49.1%+ | → | ★ |
| ***Pediatric Health*** | | | | |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotics*** | | | | |
| *Blood Glucose Testing—Total (1–17 Years)* | 53.5% | 53.8% | → | ★★ |
| *Cholesterol Testing—Total (1–17 Years)* | 40.2% | 43.2% | → | ★★★★ |
| *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* | 37.8% | 40.9% | → | ★★★ |
| ***Childhood Immunization Status***** | | | | |
| *Combination 3* | 56.2%+ | 61.1%+ | → | ★★ |
| *Combination 7* | 49.6%+ | 55.2%+ | → | ★★ |
| *Combination 10* | 25.1%+ | 26.3%+ | → | ★★ |
| ***Developmental Screening in the First Three Years of Life*** | | | | |
| *Total (0–3 Years)* [N] | — | 48.4%+ | — | — |
| ***Immunizations for Adolescents*** | | | | |
| *Combination 1 (Meningococcal, Tdap)* | 82.2%+ | 78.6%+ | → | ★★ |
| *Combination 2 (Meningococcal, Tdap, HPV)* | 30.7%+ | 31.4%+ | → | ★★ |
| ***Oral Evaluation, Dental Services*** | | | | |
| *Total (0–20 Years)* [N] | — | 6.4% | — | — |
| ***Well-Child Visits in the First 30 Months of Life*** | | | | |
| *Six or More Well-Child Visits* | 44.8% | 56.0% | ↑ | ★★ |
| *15 Months–30 Months—Two or More Well-Child Visits* | — | 54.6% | — | ★ |
| ***Child and Adolescent Well-Care Visits*** | | | | |
| *Total (3–21 Years)* | 34.2% | 39.6% | ↑ | ★ |
| ***Preventive Screening*** | | | | |
| ***Breast Cancer Screening*** | | | | |
| *Total (50–74 Years)* | 39.6% | 47.3% | ↑ | ★★ |
| ***Cervical Cancer Screening*** | | | | |
| *21–64 Years* | 38.0%+ | 37.7%+ | → | ★ |
| ***Appropriate Utilization of Services*** | | | | |
| ***Ambulatory Care*** | | | | |
| *Emergency Department (ED) Visits—Total (0–85+ Years)* [F] | 479.1 | 544.2 | — | — |
| ***Plan All-Cause Readmissions*** | | | | |
| *Observed Readmissions—Total (18–64 Years)* | 8.4% | 11.7% | ↓ | — |
| *Expected Readmissions—Total (18–64 Years)* | — | 9.3% | — | — |

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| *Outlier Rate—Total (18–64 Years)* | — | 72.1 | — | — |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)** | 0.8568 | 1.2529 | — | ★ |

* A lower rate indicates better performance for this measure.
** Table A-1 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
+ Indicates the measure was reported using hybrid methodology.
# Caution should be considered when comparing CY 2021 to CY 2022 results as changes to the measure specifications occurred.
Cells shaded green indicate that the rate met or exceeded the MY 2021 and/or MY 2022 national Medicaid mean.
[1] Indicates a 2021–2022 comparison is not presented in the CYE 2023 Annual Technical Report because either the CY 2021 rate was not presented in the CYE 2022 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
↑ Indicates improvement of measure rates.
↓ Indicates decline of measure rates.
→ Indicates stable measure rates.
[2] Performance Levels for CY 2022 were based on comparisons of the HEDIS MY 2022 measure rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks.
Performance Levels for 2022 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile
[N] Measure has no NCQA Medicaid mean for comparison
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.

## Strengths, Opportunities for Improvement, and Recommendations

Table 5-102 presents strengths, opportunities for improvement, and recommendations for Molina ACC related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-102—Molina ACC Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| In the Behavioral Health Care measure group:<br>• Nine out of 13 (69.2 percent) of Molina ACC's measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 **[Quality, Timeliness, Access]**.<br>– *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total (18+ Years)* |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| – *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up–Total*<br>– *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)*<br>– *Use of Opioids at High Dosage*<br>– *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* and *Engagement of SUD Treatment—Total—Total (13+ Years).* |
| In the Pediatric Health measure group, Molina ACC's performance measure rates for *Metabolic Monitoring for Children and Adolescents on Antipsychotic—Cholesterol Testing—Total (1–17 Years)* was at or above the 75th percentile, indicating children and adolescents with ongoing antipsychotic medication use had metabolic testing during the year. **[Quality]** |
| **Opportunities for Improvement and Recommendations** |
| In the Maternal and Perinatal Care measure group, Molina ACC's performance measure rates for *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, indicating an opportunity to increase access to timely postpartum care. Timely and adequate postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.[5-44] **[Quality, Timeliness, Access]**<br><br>Recommendation: While Molina ACC conducted a root cause analysis and implemented interventions specific to the *Prenatal and Postpartum Care—Postpartum Care* measure indicator, this rate remained low in CY 2022; therefore, HSAG recommends that Molina ACC continue to implement appropriate interventions to improve performance related to postpartum care. HSAG also recommends that Molina ACC monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care* measure, submitting the results of interventions as required by AHCCCS.<br><br>In the Behavioral Health Care measure group, Molina ACC's performance measure rate for *Adherence to Antipsychotic Medications for Individuals with Schizophrenia—18+ Years* fell below the 25th percentile, indicating adults 18 years of age and older who have schizophrenia or schizoaffective disorder who were dispensed and did not remain on an antipsychotic medication did not remain on the medication for at least 80 percent of their treatment period. **[Quality]**<br><br>Recommendation: Schizophrenia is a chronic and disabling psychiatric disorder that requires ongoing treatment and monitoring. Symptoms include hallucinations, illogical thinking, memory impairment, and incoherent speech. Medication non-adherence is common and a major concern in |

[5-44] National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/. Accessed on: Jan 31, 2024

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| the treatment of schizophrenia. Using antipsychotic medications as prescribed reduces the risk of relapse or hospitalization.[5-45]HSAG recommends that Molina ACC conduct a root cause analysis to determine why members with a diagnosis of schizophrenia were not always receiving continuous medication treatment. Upon identification of a root cause, Molina ACC should continue to implement appropriate interventions to improve performance related to the *Adherence to Antipsychotic Medications for Individuals with Schizophrenia—18+ Years* measure rate. HSAG also recommends that Molina ACC monitor and expand on interventions currently in place to improve performance related to continuous medication treatment for members with a diagnosis of schizophrenia.<br><br>In the Behavioral Health measure group, Molina ACC's performance measure rate for *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication—18–64 Years* fell below the 25th percentile, indicating an opportunity for diabetes screening testing to be done. **[Quality]**<br><br>Recommendation: Heart disease and diabetes are among the top 10 leading causes of death in the United States. Because persons with SMI who use antipsychotics are at increased risk of cardiovascular diseases and diabetes, screening and monitoring of these conditions is important. Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health, quality of life, and economic outcomes downstream.[5-46] |
| In the Preventive Screening measure group, Molina ACC's performance measure rate for *Cervical Cancer Screening—21–64 Years* fell below the 25th percentile, indicating that women were not always receiving timely screening for cervical cancer. Early detection reduces the risk of dying from this type of cancer and can lead to a greater range of treatment options and lower healthcare costs. Prolonged delays in screening may lead to delayed diagnoses, poor health consequences, and an increase in cancer disparities among women already experiencing health inequities.[5-47] **[Quality]**<br><br>Recommendation: While Molina ACC conducted a root cause analysis and implemented interventions specific to the *Cervical Cancer Screening—21–64 Years* measure rate, this rate remained low in CY 2022; therefore, HSAG recommends that Molina ACC continue to monitor |

[5-45] National Committee for Quality Assurance. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA). Available at: https://www.ncqa.org/hedis/measures/adherence-to-antipsychotic-medications-for-individuals-with-schizophrenia/. Accessed on: Jan 31, 2024

[5-46] National Committee for Quality Assurance. Diabetes and Cardiovascular Screening Disease Screening and Monitoring for People With Schizophrenia or Bipolar Disorder (SSD) Available at: https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/. Accessed on: Feb 21, 2024.

[5-47] Centers for Disease Control and Prevention. Sharp Declines in Breast and Cervical Cancer Screening. https://www.cdc.gov/media/releases/2021/p0630-cancer-screenings.html. Accessed on: Jan 25, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| and expand on interventions currently in place to improve performance related to the *Cervical Cancer Screening—21–64 Years* measure, submitting the results of interventions to AHCCCS in its QM/PI. |
| In the Pediatric Health measure group:<br>• Molina ACC's performance measure rate for *Child and Adolescent Well-Care Visits—Total (3–21 Years)* fell below the 25th percentile, indicating that children and adolescents were not always receiving their well-care visits. Assessing physical, emotional, and social development is important at every stage of life, particularly for children and adolescents. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[5-48] **[Quality, Access]**<br><br>Recommendation: While Molina ACC conducted a root cause analysis and implemented interventions specific to *Child and Adolescent Well-Care Visits—Total (3–21 Years)*, this rate remained low in CY 2022; therefore, HSAG recommends that Molina ACC continue to identify best practices to support children in receiving well-care visits according to recommended schedules. HSAG also recommends that Molina ACC monitor and expand on interventions currently in place to improve performance related to well-care visits.<br><br>• Molina ACC's performance measure rate for *Well-Child Visits in the First 30 Months of Life—15 Month–-30 Months—Two or More Well-Child Visits* fell below the 25th percentile, indicating that children and adolescents were not always accessing well-care visits with a PCP. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[5-49] **[Quality, Access]**<br><br>Recommendation: While Molina ACC conducted a root cause analysis and implemented interventions specific to the *Well-Child Visits in the First 30 Months of Life—15 Months–30 Months—Two or More Well-Child Visits* measure indicator, this rate remained low in CY 2022; therefore, HSAG recommends that Molina ACC continue to identify best practices to support children in receiving well-care visits according to recommended schedules. HSAG also recommends that Molina ACC monitor and expand on interventions currently in place to improve performance related to well-care visits. |
| In the Care of Acute and Chronic Conditions measure group, Molina ACC's *Controlling High Blood Pressure—18–85 Years* measure rate fell below the 25th percentile, indicating that some members are not adequately controlling their blood pressure. **[Quality]** |

[5-48] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Jan 31, 2024.
[5-49] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Jan 31, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| Recommendation: Controlling high blood pressure is an important step in preventing heart attacks, stroke and kidney disease, and in reducing the risk of developing other serious conditions. Healthcare providers and plans can help individuals manage their high blood pressure by prescribing medications and encouraging low-sodium diets, increased physical activity, and smoking cessation. HSAG therefore recommends that Molina ACC monitor and expand on interventions currently in place to improve performance related to members' high blood pressure control. Molina ACC should submit updated barrier assessments and interventions as required by AHCCCS. |
| In the Care of Acute and Chronic Conditions measure group, Molina ACC's *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 %)—Total (18-75 Years)* and *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)* measure rates fell below the 25th percentile, indicating poor control over diabetes. |
| Recommendation: Diabetes is a complex group of diseases marked by high blood glucose (blood sugar) due to the body's inability to make or use insulin. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life. With support from healthcare providers, patients can manage their diabetes with self-care, taking medications as instructed, eating a healthy diet, being physically active and quitting smoking.5-50 HSAG therefore recommends that Molina ACC monitor and expand on interventions currently in place to improve performance related to members' HbA1c control. Molina ACC should submit updated barrier assessments and interventions as required by AHCCCS. |

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

Table 5-103 presents performance measure recommendations made to Molina ACC in the CYE 2022 Annual Technical Report[5-51] and Molina ACC's follow-up to the recommendations, as well as an assessment of the degree to which Molina ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

[5-50] National Committee for Quality Assurance. Comprehensive Diabetes Care. Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on Feb 21, 2024.

[5-51] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP). Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 1, 2024.

**Table 5-103—Molina ACC Follow-Up to CYE 2022 Performance Measure Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| **Recommendation 1:** |
| HSAG recommended that Molina ACC update its data mapping to include tooth numbers to support future valid rate reporting of the *Sealant Receipt on Permanent First Molars* (*SFM-CH*) measure. |
| **Molina ACC's Response:** |
| Molina ACC IT implemented logic to capture Tooth Number and Tooth Surface in order to calculate the *SFM-CH* measure numerators appropriately as recommended. |
| **HSAG's Assessment:** |
| HSAG determined that Molina ACC satisfactorily addressed this prior year's recommendation. |
| **Recommendation 2:** |
| HSAG recommended that Molina ACC continue to explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratifications related to race and ethnicity. Molina ACC should continue working with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information. |
| **Molina ACC's Response:**<br>Molina ACC is working to improve member data collection. Below are current activities and recommendations.<br><br>Molina Healthcare Inc. Cultural Competency Data Management Project (CCDMP)<br>Purpose: To address new data collection requirements.<br><br>Molina ACC kicked off CCDMP in 2022, aimed to build the systems and processes for data collection. CCDMP is a two-phase project.<br>1. Phase I scope: Build out road map and start data collection/storage in Salesforce/Member Portal/Mobile App for race and ethnicity, pronouns, sexual orientation, and gender identity.<br>2. Phase II scope: Continue data collection as noted above and begin system integration to all Molina ACC downstream applications.<br><br>Timeline:<br>• Phase I took place September–October 2022, resulting in successful data collection of the new data fields (race and ethnicity, pronouns, sexual orientation, and gender identity) on Salesforce, Mobile App, and Member Portal.<br>• Phase II took place June–October 2023, resulting in integrating the data collected on Salesforce, Mobile App, and Member Portal to all downstream systems. The integration allows for visibility, application, and identification of areas of opportunity to move closer to health equity. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| At this time, Molina ACC does not actively collect race and ethnicity data, members are only self-reporting through the Member Portal and Mobile App. There are scenarios where members need help to enter this information and call Member Services for assistance. In that case, Member Services updates fields in Salesforce. Through frequent data analysis of Molina ACC's membership, the cultural competency coordinator recognizes the 834 file is a primary source specific to member race and ethnicity data collection. One of Molina ACC's internal challenges is regarding member race and ethnicity identification. For example, the majority of Molina ACC members report no ethnicity, which presents a barrier for targeted interventions. Specifically, for American Indian members, identifying tribal affiliation is critical to navigating services and culturally responsive resources. Furthermore, accuracy of data collected via the 834 file and member engagement is not representative of the member's voiced identification on engagement. Molina ACC would like the opportunity to explore methods to augment enrollment data to support future performance measures and member engagement functions. |
| **HSAG's Assessment:** HSAG determined that Molina ACC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 3:** |
| While Molina ACC conducted a root cause analysis and implemented interventions specific to the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators, these rates remained low in CY 2021; therefore, HSAG recommended that Molina ACC continue to implement appropriate interventions to improve performance related to prenatal and postpartum care. HSAG also recommended that Molina ACC monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care* measure. |
| **Molina ACC's Response:**<br>Molina ACC repeated root cause analyses to continue to understand members' access to prenatal and postpartum care. As result of this causal barrier analysis, Molina ACC focuses interventions on improving members' access to timely maternity care due to members' lack of awareness, transportation issues, socioeconomic factors, language and cultural barriers, stigma or fear, provider administrative burden, reporting complexity, and data completeness challenges.<br><br>2021 was still greatly impacted by COVID-19, which is why the rates continued to be low; however, the teams continued to press forward with existing interventions in addition to layering on additional interventions and planned activities that will improve Molina ACC's self-identified goals and objectives to improve performance by 6%. The activities include a pregnancy notification dashboard to outreach to all pregnant members educating them on the importance of prenatal and postpartum care. In addition, Molina ACC has dedicated staff that conduct outreach to remind members of timely prenatal and postpartum care. If members confirm they have completed their visit, the member's OB, date, and location of visit are sent to the clinical data acquisition team for supplemental data collection. Additionally, Molina ACC has gained success with its goal in identifying top providers who send pregnancy notifications along with medical records. Molina ACC will continue to |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| proactively monitor for new barriers and opportunities for improvement where performance can be enhanced to achieve better results. |
| **HSAG's Assessment:** Molina ACC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that Molina ACC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 4:** |
| While Molina ACC conducted a root cause analysis and implemented interventions specific to *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*, this rate remained low in CY 2021; therefore, HSAG recommended that Molina ACC continue to implement appropriate interventions to improve performance related to follow-up care following a hospitalization. HSAG also recommended that Molina ACC monitor and expand on interventions currently in place to improve performance related to the *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total* measure. |
| **Molina ACC's Response:**<br>Molina ACC continued to conduct root cause analyses to understand members' barriers to accessing timely behavioral health appointments and continue progress toward completing the plan's self-identified goals and objectives as this has remained a significant challenge. Molina ACC continued to focus interventions on improving performance on follow-up after hospitalization due to discharge planning challenges, stigma and mental health perception, difficulty in scheduling appointments, and providers' lack of awareness. COVID-19 was still a factor in 2021, and for this reason, the rates remained low. So, Molina ACC continued with its existing interventions and created a hospital follow-up program to layer on other planned activities to include additional barrier analyses to explore other interventions to further improve the seven-day follow-up rate.<br><br>Therefore, the plan started educating facilities on the importance of scheduling follow-up appointments within seven days and care managers on the seven-day follow-up HEDIS measure. A goal was established for care managers to offer every member discharged a Care Connections referral for a telehealth appointment within seven days of being discharged from the hospital. Additionally, Molina ACC contracted with a behavioral health vendor to engage with members admitted to the hospital and ED to connect members with services and complete follow-up visits as needed within seven days of discharge. The goal of this program focused on removing barriers to care, improve the member's health and quality of life, and increase treatment and medication compliance. As a result of this program, the follow-up after hospitalization rate improved to 43%. This means that 43% of members discharged from the hospital completed a visit with a provider within seven days after discharge. Specifically, the *FUH* rate met the high-performing benchmark and statistically and significantly showed improvement from the prior year. |
| **HSAG's Assessment:** Molina ACC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that Molina ACC satisfactorily addressed these prior year's recommendations. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| **Recommendation 5:** |
| While Molina ACC conducted a root cause analysis and implemented interventions specific to *Child and Adolescent Well-Care Visits*, this rate remained low in CY 2021; therefore, HSAG recommended that Molina ACC continue to identify best practices to support children in receiving well-care visits according to recommended schedules. HSAG also recommended that Molina ACC monitor and expand on interventions currently in place to improve performance related to well-care visits. |
| **Molina ACC's Response:**<br>Molina ACC repeated a root cause analysis to address and improve the rate of *Child and Adolescent Well-Care Visits*. Although the rate remained low, self-identified goals and objectives included increasing the rate of child and adolescent well-care visits. Therefore, Molina ACC continued to focus interventions on reasons for member noncompliance with care due to lack of awareness, fear or misconceptions, transitions to adult care, and the ability to discuss care needs for members 18–20 years of age with the parent/guardian without the member's consent.<br><br>While COVID-19 was still a factor in 2021, Molina ACC continued with existing interventions and incorporated other planned activities to include a clinic day for members in need of a well-child visit. The plan also conducted a text message campaign in addition to the "Happy Birthday" Member Outreach wherein members in the *WCV* denominator who need a visit, along with any other siblings, receive a reminder call to complete a well-child visit. Molina ACC will continue with its planned activities that will improve Molina ACC's self-identified goals and objectives to improve performance by 2%. The plan will continue to explore best practices that will support children receiving well-care visits according to the recommended schedules. In addition, the plan will improve the health of the child population through the EPSDT Program and interventions as this offers a way to ensure that children birth to age 21 years receive appropriate physical, dental, developmental, and mental health services from prevention to treatment. |
| **HSAG's Assessment:** Molina ACC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that Molina ACC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 6:** |
| While Molina ACC conducted a root cause analysis and implemented interventions specific to the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator, this rate remained low in CY 2021; therefore, HSAG recommended that Molina ACC continue to identify best practices to support children in receiving well-care visits according to recommended schedules. HSAG also recommended that Molina ACC monitor and expand on interventions currently in place to improve performance related to well-care visits. |
| **Molina ACC's Response:**<br>Molina ACC repeated a root cause analysis to address and improve the *Well-Child Visits in the First 30 Months of Life* rate. Although the rate remained low, self-identified goals and objectives included |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| increasing the rate. Therefore, Molina ACC conducted a barrier analysis to determine reasons for member noncompliance with care and focused interventions that showed a fear of vaccinations, lack of awareness, scheduling conflicts, forgetfulness, and parental anxiety or fear.<br><br>Although, COVID-19 continued to negatively affect parents' willingness and/or ability to access well-child visits in the first 30 months of life, it also affected appointments, availability, and resources for members and providers. Therefore, Molina ACC continued with its existing interventions in addition to other planned activities that will improve Molina ACC's self-identified goals and objectives to improve performance by 6%. Molina ACC will continue to explore best practices that will support children receiving well-child visits according to the recommended schedules. The plan will improve the health of the child population through the EPSDT Program and interventions as this offers a way to ensure that children birth to age 21 years receive appropriate physical, dental, developmental, and mental health services from prevention to treatment. Lastly, Molina ACC will continue to expand provider interventions to increase practitioner awareness of new and current members in need of well-child visits along with interventions to encourage parents to make and keep needed appointments for the newborn child. |
| **HSAG's Assessment:** Molina ACC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that Molina ACC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 7:** |
| HSAG recommended that Molina ACC conduct a root cause analysis to determine why some children were not always getting their immunizations by their second birthday. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Molina ACC should consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). Additionally, Molina ACC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, HSAG recommended that Molina ACC implement appropriate interventions to improve performance related to childhood immunizations. |
| **Molina ACC's Response:**<br>Molina ACC conducted a root cause analysis and determined the following reasons for member noncompliance with care:<br>1. Communication and awareness<br>2. Healthcare disparities<br>3. Parental choice<br>4. Vaccine hesitancy<br>5. Belief in natural immunity<br><br>COVID-19 continued to negatively affect parents' willingness and/or ability to access immunizations for their children in 2021, and rates remained low. Nonetheless, Molina ACC continued its existing |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| interventions with the EPSDT program, which sends member-recommended immunization schedules within the child's milestones along with education and follow-up reminders. The plan continued with self-identified goals and objectives to improve the health of the child population and ensure staff had more intentional discussions with providers around engagement, which included educating providers to recommend immunizations to parents as they are more likely to agree with vaccinations when supported by their provider. Additionally, Molina ACC leveraged provider fax blast reminders, webinars, newsletters, and the provider manual to remind providers of the importance of members' timely receipt of their immunizations. These activities improve the quality of services, the continuum of care, and healthcare outcomes by improving provider awareness regarding the importance of timely access to care. |
| **HSAG's Assessment:** Molina ACC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that Molina ACC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 8:** |
| While Molina ACC implemented interventions specific to the CY 2020 *Breast Cancer Screening* and *Cervical Cancer Screening* rates, these rates remained low in CY 2021; therefore, HSAG recommended that Molina ACC conduct a root cause analysis for these measures and continue to implement appropriate interventions to improve performance related to the *Breast Cancer Screening* and *Cervical Cancer Screening* rates. HSAG also recommended that Molina ACC monitor and expand on interventions currently in place to improve performance related to these screenings. |
| **Molina ACC's Response:**<br>Molina ACC continued to conduct root cause analyses to understand members' barriers to receiving breast and cervical cancer screenings. As a result of this analysis, Molina ACC focuses interventions on improving members' access to timely preventive care due to members' lack of awareness, fear of the unknown, anxiety about the results, discomfort and pain, embarrassment, previous negative experiences, fear of radiation, cultural or societal factors, and transportation constraints.<br><br>With COVID-19 still serving as a factor in 2021, the rates remained low; therefore, Molina ACC continued with the existing interventions and layered on more planned activities to include a dedicated team member who conducts outreach to remind members to get their screenings in a timely manner. To meet the plan's self-identified goals and objectives and improve the rate by 4%, Molina ACC partnered with radiology vendors for a provider incentive program to outreach and engage members for mammogram screenings completed and claims received. This activity improves the quality of services, the continuum of care, and healthcare outcomes by supporting members to complete this critical screening through financial provider incentives. |
| **HSAG's Assessment:** Molina ACC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that Molina ACC satisfactorily addressed these prior year's recommendations. |

## Validation of Performance Improvement Projects

### Back to Basics PIP

In CYE 2023, Molina ACC continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 1, PIP validation activities focused on improvement from the baseline results. Molina ACC submitted Remeasurement 1 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes or discontinuation of the interventions.

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

#### *Validation Results*

Table 5-104 displays the overall confidence levels for the Molina ACC *Back to Basics* PIP.

**Table 5-104—Molina ACC *Back to Basics* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| Molina ACC | *High Confidence* | 100% | 100% | *High Confidence* | 100% | 100% |

#### *Measure Results*

Table 5-105 and Table 5-106 provide the *Back to Basics* PIP baseline, intervention, and Remeasurement Year 1 rates for each indicator for Molina ACC.

**Table 5-105—Molina ACC *Back to Basics* PIP Rates for PIP Indicator 1**

| Contractor | PIP Indicator 1: *W30 Rate 1* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2020* | CY 2022 |
| Molina ACC | 49.1% | 56.0% |

*In CYE 2019, the Molina ACC performance measure rate for indicator 1 had a small denominator, which did not allow for reporting of the measure. CY 2020 served as baseline for indicator 1 for Molina ACC.

**Table 5-106—Molina ACC *Back to Basics* PIP Rates for PIP Indicator 2**

| Contractor | PIP Indicator 2: *WCV* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| Molina ACC | 33.9% | 39.6% |

### *Interventions*

Table 5-107 presents PIP interventions for Molina ACC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 5-107—Molina ACC *Back to Basics* PIP Interventions**

| Contractor | Interventions |
|---|---|
| Molina ACC | • Contact Center member outreach: Uses live call agents to outreach to members and assist with connection to preventive care services and programs including scheduling appointments, member check-in calls, and inbound support for program referrals.<br>• Supplemental data sources: Remote access to provider EMRs, EMR data feeds, and medical record requests for visits completed but not reported.<br>• Comprehensive HEDIS Measures Training Program: Designed to equip all Molina employees with the knowledge and skills necessary to understand and effectively implement the HEDIS measures. By training all employees, from frontline staff to management, to support consistent adherence to HEDIS standards, these activities will improve the quality of services, the continuum of care, and healthcare outcomes. Training will include the following objectives:<br>• Understand HEDIS Measures: Introduce employees to the purpose and significance of HEDIS measures in evaluating healthcare quality and performance. |

| Contractor | Interventions |
|---|---|
| | • Familiarize with HEDIS Domains: Provide an overview of the various domains covered by HEDIS, such as preventive care, chronic conditions management, and member experience.<br>• Interpret Measure Requirements: Enable employees to comprehend the high-level technical details of each HEDIS measure, including the numerator, denominator, and exclusions.<br>• Compliance and Best Practices: Emphasize the importance of compliance with HEDIS guidelines and promote best practices for achieving high-quality delivery of care and services.<br>• Quality Improvement Initiatives: Encourage employees to identify opportunities for quality improvement based on HEDIS results.<br>• SpectraMedix: Web-based portal for providers in a VBP contract or the Pay for Quality (P4Q) program to access their HEDIS performance scores and gaps in care.<br>• The success of all VBP arrangements rely on data sharing and quality improvement support. Providers need timely and easy-to-understand reporting. VBP partners are provided scorecards outlining the contractual benchmarks and their current performance relative to the established targets. Moving forward, Molina will have this dedicated system to ensure providers have the tools, information, and transparency needed to be successful in a VBP arrangement.<br>• Implementation delayed from May 2023 due to vendor challenges; to ensure there are no declines in quality efforts, delivery of provider HEDIS scorecards and gap in care reporting continues via the current process discussed in the existing interventions above.<br>• Website updates: Annually reevaluate and update provider- and member-facing Molina website quality content to ensure appropriateness, accuracy, and relevance of information. Over time, some content on the website may become outdated or irrelevant. Regular evaluations give the opportunity to review and update content, ensuring it remains accurate, valuable, and aligned with current recommendations and guidance.<br>• WCV Back-to-School member incentive: Molina Healthy Rewards program allows members to earn gift card rewards for completing a comprehensive annual wellness visit.<br>• WCV and ADV Happy Birthday member outreach: For members with gaps in care, send relay text messages and mailed postcards to parents of children and adolescents, as well as young adults, during the member's birth month to wish the member a happy birthday and a reminder to complete a comprehensive wellness exam and dental visit each year. |

| Contractor | Interventions |
|---|---|
| | • Newborn member outreach: Highly collaborative and coordinated approach with real-time provider feedback and follow-ups, supportive scheduling, claims verifications, exclusions, and handling of member issues.<br>• These activities improve the quality of services, the continuum of care, and healthcare outcomes by improving member awareness about the importance of timely access to care through strength-based health promotion, supportive scheduling, and appointment reminders.<br>• Culturally and Linguistically Appropriate Services (CLAS): Language access services (oral interpreting by trained and qualified interpreters, American Sign Language, access to telephonic interpreter services, member materials translated into alternative languages and made available in alternate formats); member materials written using Plain Language guidelines and content at a sixth-grade reading level or lower; and ongoing cultural competency staff and provider trainings. Members who have access to culturally competent healthcare providers and staff are more likely to attend their appointments and comply with the providers' orders. These interventions help members understand the conversations happening between them and their providers in the clinical setting, improving health literacy, clinical outcomes, member satisfaction, and member compliance.<br>• Provider clinic days: Scheduled days with PCPs and dental providers for Molina members to access services. During a clinic day, providers see a scheduled roster of Molina members, address their medical concerns, provide diagnoses, prescribe medications, perform procedures, and offer medical advice. Clinic days are an essential part of healthcare delivery, allowing for efficient and focused patient care in a more relaxed and less intense environment compared to when Molina members access care outside the clinic day period. |

### *Strengths, Opportunities for Improvement, and Recommendations*

Table 5-108 presents strengths, opportunities for improvement, and recommendations for Molina ACC related to the *Back to Basics* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-108—Molina ACC Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG noted that Molina ACC performed accurate statistical testing between the baseline and Remeasurement 1 results and demonstrated statistically significant improvement for both indicators. **[Quality, Access]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| Molina ACC developed and implemented measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 2. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| For indicator 1, Molina ACC had a statistically significant increase of 6.94 percentage points in the indicator rate between the baseline year and Remeasurement Year 1. Molina ACC had a statistically significant increase of 5.66 percentage points in the indicator rate between the baseline year and Remeasurement Year 1 for indicator 2. **[Quality, Access]**<br><br>Recommendations: As the PIP progresses, HSAG recommends that Molina ACC:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions as necessary.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention. |

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

Table 5-109 presents PIP recommendations made to Molina ACC in the CYE 2022 Annual Technical Report[5-52] and Molina ACC's follow-up to the recommendations, as well as an assessment of the degree to which Molina ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 5-109—Molina ACC Follow-Up to CYE 2022 PIP Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| HSAG recommended that Molina ACC:<br>• Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary.<br>• Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available.<br>• Develop and document a plan for sustaining the improvement for any demonstrated improvement in indicator rates. |

[5-52] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP). Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 8, 2024.

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
| --- |
| **Molina ACC's Response:**<br>Molina ACC Healthcare develops PIPs to improve compliance rates for specific performance measures and to address trends identified through monitoring activities. Whenever possible, a target population with treatment disparities for each performance measure is identified by analyzing member demographic data such as race and ethnicity, age, and diagnosis. After the population is identified, interventions are specifically designed to develop Molina ACC's self-identified goals and objectives to improve compliance rates. Therefore, Molina ACC continues to develop and implement interventions, assess the impact, and measure the effectiveness of the interventions quarterly to ensure Molina ACC meets the goals and objectives that Molina ACC identified or AHCCCS-required areas of focus.<br><br>As a result of these activities, Molina ACC now tracks key performance indicators (KPIs) by intervention during Molina ACC's monthly operating meetings. |
| **HSAG's Assessment:** HSAG has determined that the Contractor has satisfactorily addressed these prior year's recommendations. |

### Prenatal and Postpartum Care PIP

In CYE 2023, Molina ACC submitted baseline measurement results for the *Prenatal and Postpartum Care* PIP, which was initiated in CY 2022. Molina ACC submitted baseline performance indicator results and interventions implemented.

HSAG conducted an annual validation of the baseline year reflective of CY 2022 (January 1, 2022, through December 31, 2022) using AHCCCS-calculated and validated indicator rates. HSAG evaluated Molina ACC's performance indicator results based on an analysis of improvement strategies implemented as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

### *Validation Results*

Table 5-110 displays the overall confidence levels for the Molina ACC *Prenatal and Postpartum Care* PIP.

**Table 5-110—Molina ACC *Prenatal and Postpartum Care* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| Molina ACC | *High Confidence* | 100% | 100% | *Not Assessed* | *Not Assessed* | *Not Assessed* |

### *Measure Results*

Table 5-111 and Table 5-112 provide the *Prenatal and Postpartum Care* PIP baseline rates for each indicator for Molina ACC.

**Table 5-111—Molina ACC *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 1**

| Contractor | PIP Indicator 1: *Timeliness of Prenatal Care* |
|---|---|
| | Baseline Year |
| | CY 2022 |
| Molina ACC | 83.7% |

**Table 5-112—Molina ACC *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 2**

| Contractor | PIP Indicator 2: *Postpartum Care* |
|---|---|
| | Baseline Year |
| | CY 2022 |
| Molina ACC | 64.2% |

### *Interventions*

Table 5-113 presents PIP interventions for Molina ACC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 5-113—Molina ACC *Prenatal and Postpartum Care* PIP Interventions**

| Contractor | Interventions |
|---|---|
| Molina ACC | • Increased engagement with providers with the support of additional Molina staffing. Molina supplied performance measure reporting tip sheets, medical record review and feedback, one-on-one medical record documentation coaching and guidance, improved coordination and communication, in-office provider visits, best practice facilitation, and improved coordination and communication.<br>• Comprehensive HEDIS Measures Training Program: Designed to equip all Molina employees with the knowledge and skills necessary to understand and effectively implement the HEDIS measures. By training all employees, from frontline staff to management, to support consistent adherence to HEDIS standards, these activities will improve the quality of services, the continuum of care, and healthcare outcomes. Training will include the following objectives:<br>• Understand HEDIS Measures: Introduce employees to the purpose and significance of HEDIS measures in evaluating healthcare quality and performance.<br>• Familiarize with HEDIS Domains: Provide an overview of the various domains covered by HEDIS, such as preventive care, chronic conditions management, and member experience.<br>• Interpret Measure Requirements: Enable employees to comprehend the high-level technical details of each HEDIS measure, including the numerator, denominator, and exclusions.<br>• Compliance and Best Practices: Emphasize the importance of compliance with HEDIS guidelines and promote best practices for achieving high-quality delivery of care and services.<br>• Quality Improvement Initiatives: Encourage employees to identify opportunities for quality improvement based on HEDIS results.<br>• SpectraMedix: Web-based portal for providers in a VBP contract or P4Q program to access their HEDIS performance scores and gaps in care.<br>• The success of all VBP arrangements rely on data sharing and quality improvement support. Providers need timely and easy-to-understand reporting. VBP partners are provided scorecards outlining the contractual benchmarks and their current performance relative to the established targets. Moving forward, Molina will have this dedicated system to ensure providers |

| Contractor | Interventions |
|---|---|
| | have the tools, information, and transparency needed to be successful in a VBP arrangement.<br>• Implementation delayed from May 2023 due to vendor challenges; to ensure there are no declines in quality efforts, delivery of provider HEDIS scorecards and gap in care reporting continues via the current process discussed in the existing interventions above.<br>• Website updates: Annually reevaluate and update provider- and member-facing Molina website quality content to ensure appropriateness, accuracy, and relevance of information. Over time, some content on the website may become outdated or irrelevant. Regular evaluations give the opportunity to review and update content, ensuring it remains accurate, valuable, and aligned with current recommendations and guidance.<br>• Cultural Competency Plan: Delivery of culturally competent services and the provision of language and disability-related access to all enrollees, including limited English proficiency (LEP) persons.<br>• Cultural Competency Workgroup: Comprise representatives of all health plans and programs from various departments, such as Quality Improvement, Provider Services, Member Services, Healthcare Services, and Human Resources. The workgroup meets quarterly to assess CLAS needs, such as trainings and employee communication.<br>• Implementation of CLAS Evaluation: Delivery of culturally competent services and the provision of language and disability-related access to all enrollees, including LEP persons. |

### *Strengths, Opportunities for Improvement, and Recommendations*

Table 5-114 presents strengths, opportunities for improvement, and recommendations for Molina ACC related to the *Prenatal and Postpartum Care* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-114—Molina ACC Strengths, Opportunities for Improvement, and Recommendations Related to the *Prenatal and Postpartum Care* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| Molina ACC developed and implemented measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 1. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| For indicator 1, 83.7 percent of women had a prenatal care visit in the first trimester and 64.2 percent had a postpartum visit between seven and 84 days after delivery during CYE 2022. **[Quality, Access]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| Recommendations: As the PIP progresses, HSAG recommends that Molina ACC:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

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

The *Prenatal and Postpartum Care* PIP was initiated in CY 2022; therefore, this section is not applicable.

## Compliance Reviews

### Results

AHCCCS conducted a compliance review of Molina ACC from April 11, 2022, through April 14, 2022. On June 24, 2022, AHCCCS finalized the report findings, provided Molina ACC with a CAP submission matrix, and required a CAP for any standard with a total score of less than 95 percent. On October 31, 2022, AHCCCS accepted Molina ACC's proposed CAPs and required the Contractor to submit updated policies, manuals, desktop procedures, and other vital documents to provide evidence of CAP completion. On September 1, 2023, AHCCCS reviewed Molina ACC's CAP status update and determined that not all CAPs had been completed for closure. AHCCCS required the Contractor to reassess the CAPs and resubmit information demonstrating compliance by September 15, 2023. Remaining CAP items were under review by AHCCCS at the time this report was being written. Additional results of the CAP update will be included in the CYE 2024 annual technical report. Table 5-115 presents the compliance review results for Molina ACC.

**Table 5-115—Molina ACC Compliance Review Results**

| Compliance Focus Areas | CYE 2022 Molina ACC Scores | CYE 2022 Program-Level Average | CYE 2023 Molina ACC CAP Update |
|---|---|---|---|
| CC | 100% | 99% | NA |
| CIS | 92% | 96% | PM |
| DS | 84% | 91% | PM |
| GA | 93% | 92% | M |

| Compliance Focus Areas | CYE 2022 Molina ACC Scores | CYE 2022 Program-Level Average | CYE 2023 Molina ACC CAP Update |
|---|---|---|---|
| GS | 99% | 99% | NA |
| MCH | 76% | 82% | PM |
| MM | 93% | 94% | M |
| MI | 95% | 96% | NA |
| QM | 69% | 77% | PM |
| QI | 89% | 92% | M |
| RI | 100% | 100% | NA |
| TPL | 100% | 100% | NA |
| ISOC | 97% | 96% | NA |

NA = "not applicable." A CAP was not required as the CYE 2022 score was 95% or above.
PM = "partially met." AHCCCS approved the Contractor's proposed CAP. The Contractor must submit evidence of compliance.
M = "met." AHCCCS accepted and closed the Contractor's CAP.

## Strengths, Opportunities for Improvement, and Recommendations

Table 5-116 presents strengths, opportunities for improvement, and recommendations for Molina ACC based on compliance activities conducted in CYE 2023, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-116—Molina ACC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| Molina ACC successfully closed CAPs in the following Focus Areas:<br>• General Administration (GA) **[Timeliness, Access]**<br>• Medical Management (MM) **[Timeliness, Access]**<br>• Quality Improvement (QI) **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| Molina ACC has remaining CAPs in the following Focus Areas:<br>• Claims and Information Standards (CIS) **[Access]**<br>• Delivery Systems (DS) **[Timeliness, Access]**<br>• Adult, EPSDT and Maternal Child Health (MCH) **[Quality, Timeliness, Access]**<br>• Quality Management (QM) **[Quality]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| Recommendation: HSAG recommends that Molina ACC continue to work on outstanding CAP items and submit to AHCCCS in the approved time frame. |

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

Table 5-117 presents compliance recommendations made to Molina ACC in the CYE 2022 Annual Technical Report[5-53] and Molina ACC's follow-up to the recommendations, as well as an assessment of the degree to which Molina ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 5-117—Molina ACC Follow-Up to CYE 2022 Compliance Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for Compliance |
|---|
| HSAG recommends that Molina ACC consider conducting a self-assessment of the CIS, DS, GA, MCH, MM, QM, and QI Focus Area requirements. |
| **Molina ACC's Response:**<br>Self-identified goals and objectives include Molina ACC's Compliance Department conducting an Annual Risk Assessment of its clinical and operational areas to assess and determine key risk areas that could negatively affect the organization and developing an Audit Plan as the year closes out in order to prepare an Audit Schedule for the following year.<br>• Based on the recent 2022 Operational Review (OR) results, the Claims and Information Standards (CIS), Delivery Systems (DS), General Administration (GA), Maternal Child Health (MCH), Medical Management (MM), Quality Management (QM), and Quality Improvement (QI) focus areas will be the areas that Molina ACC will audit in 2024.<br>• Molina ACC (in 2024) will review and validate the 41 deficiencies for which CAPs were developed by Molina ACC and approved by AHCCCS for the 2022 OR along with contract requirements.<br>• Molina ACC will also look at other focus areas in which deficiencies were not identified during the OR but could still be a risk, as time and resources allow.<br>• The Audit Schedule/Calendar will be modified as needed throughout the year.<br><br>Additionally, Molina ACC's Contract Compliance department has developed a tracking mechanism to ensure that as regulatory updates come down the pipeline (policy and MEMO changes/updates |

[5-53] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP) Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 8, 2024.

| Prior Year's Recommendation from the EQR Technical Report for Compliance |
|---|
| received), Contract Compliance will ensure prompt implementation and require documentation to demonstrate compliance from respective business owners (BOs) and/or areas. |
| **HSAG's Assessment:**<br>Based on CAP closure for the GA, MM, and QI Focus Areas; CAP acceptance for the CIS, DS, MCH, and QM Focus Areas; and the response provided, HSAG determined that Molina ACC has satisfactorily addressed this prior year's recommendation. |

## *Network Adequacy Validation*

### Results

HSAG evaluated Molina ACC's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents semiannual validation findings specific to the ACC Program, with one results table for the following GSA:

- Central GSA: Gila, Maricopa,[5-54] and Pinal counties

Each region-specific table summarizes semiannual validation results containing the percentage of members meeting each time/distance standard by quarter and county, with color-coding to identify whether or not the time/distance standard was "Met" or "Not Met."

The value "NA" is shown for time/distance standards that do not apply to the county or program.

The value "NR" is shown for time/distance standards in which no members met the network requirement denominator for the program and county; therefore, HSAG calculated no corresponding time/distance result.

Yellow color-coding identifies instances in which HSAG's time/distance results met the minimum network requirement but differed from the ACOM 436 results.

Red color-coding identifies instances in which HSAG's time/distance results did not meet the compliance standard, regardless of the ACOM 436 results.

An asterisk (*) indicates that fewer than 10 members were included in the denominator of HSAG's results.

A carat (^) indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

[5-54] Maricopa County includes the 85342, 85358, and 85390 ZIP Codes; these ZIP Codes are physically located in both Maricopa and Yavapai counties.

**Table 5-118—Molina ACC Time/Distance Validation Results for Central GSA—Percentage of Members Meeting Minimum Network Requirements**

| Minimum Network Requirement | Gila | | Maricopa | | Pinal | |
|---|---|---|---|---|---|---|
| | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0^ | 100.0^ | 98.7^ | 98.9^ | 100.0^ | 100.0^ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 100.0^ | 100.0^ | 98.5^ | 98.8^ | 100.0^ | 100.0^ |
| BHRF | NA | NA | 98.1 | 98.2 | NA | NA |
| Cardiologist, Adult | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| Cardiologist, Pediatric | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| Dentist, Pediatric | 100.0 | 58.5 | 99.2 | 99.2 | 99.9 | 99.8 |
| Hospital | 100.0 | 100.0 | 99.8 | 99.8 | 100.0 | 100.0 |
| OB/GYN | 100.0 | 100.0 | 99.9 | 99.9 | 100.0 | 100.0 |
| Pharmacy | 100.0 | 100.0 | 99.1 | 99.1 | 100.0 | 100.0 |
| PCP, Adult | 100.0^ | 100.0^ | 99.8^ | 99.7^ | 100.0^ | 100.0^ |
| PCP, Pediatric | 100.0^ | 100.0^ | 99.6^ | 99.6^ | 100.0^ | 100.0^ |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
represents time/distance standard results that do not meet the compliance standard based on HSAG's results.
^indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.

## Strengths, Opportunities for Improvement, and Recommendations

Table 5-119 presents strengths, opportunities for improvement, and recommendations for Molina ACC related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-119—Molina ACC Strengths, Opportunities for Improvement, and Recommendations Related to NAV**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths:<br>• Molina ACC met all time/distance network standards for both quarters in CYE 2023 in Maricopa and Pinal counties. **[Access]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| • Molina ACC met all time/distance network standards for BHRF; Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; Cardiologist, Adult and Pediatric; Hospital; OB/GYN; PCP, Adult and Pediatric; and Pharmacy. **[Access]**<br>Note: Molina ACC provides coverage in the following counties: Gila, Maricopa, and Pinal. |
| **Opportunities for Improvement and Recommendations** |
| HSAG identified the following opportunities for improvement.<br>• Molina ACC failed to meet the time/distance standard for at least one quarter and/or county for Dentist, Pediatric. **[Access]**<br><br>Recommendation: HSAG recommends that Molina ACC maintain current compliance with network standards but continue to address network gaps, as applicable. |

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

Table 5-120 presents NAV recommendations made to Molina ACC in the CYE 2022 Annual Technical Report[5-55] and Molina ACC's follow-up to the recommendations, as well as an assessment of the degree to which Molina ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 5-120—Molina ACC Follow-Up to CYE 2022 NAV Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for NAV |
|---|
| HSAG recommended that Molina ACC continue to monitor its processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS. |
| **Molina ACC's Response:**<br>Self-identified goals and objectives include Molina ACC conducting frequent reviews of provider demographic/data repositories as part of the health plan's continuous improvement efforts surrounding the PAT file submission, which has proven effective with the most recent successful submission in October 2023. |
| **HSAG's Assessment:**<br>HSAG has determined that the Molina ACC has satisfactorily addressed these prior year's recommendations. |

[5-55] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP) Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 8, 2024.

# UHCCP ACC

## *Validation of Performance Measures*

### Results for Information Systems Standards Review

During CYE 2023, HSAG evaluated UHCCP ACC's data system for processing of each data type used for reporting the Contractor's CY 2022 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that UHCCP ACC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-121 displays HSAG's PMV findings for each data type reviewed during CYE 2023 in alignment with the CMS EQR Protocol 2 audit requirements:

**Table 5-121—CYE 2023 PMV Findings**

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

### Results for Performance Measures

Table 5-122 presents the CY 2021 and CY 2022 UHCCP ACC performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and MY 2022. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and/or MY 2022. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

**Table 5-122—CY 2021 and CY 2022 UHCCP ACC Performance Measure Results**

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| ***Maternal and Perinatal Care*** | | | | |
| ***Prenatal and Postpartum Care*** | | | | |
| *Timeliness of Prenatal Care*[#] | 86.4%[+] | 82.5%[+] | → | ★★ |
| *Postpartum Care* | 68.4%[+] | 67.6%[+] | → | ★ |
| ***Behavioral Health*** | | | | |
| ***Antidepressant Medication Management*** | | | | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | 60.8% | 61.0% | → | ★★★ |
| *Effective Continuation Phase Treatment—Total (18+ Years)* | 43.1% | 42.0% | → | ★★ |
| ***Follow-Up After ED Visit for Substance Use*** | | | | |
| *7-Day Follow-Up—Total* | — | 32.5% | — | ★★★★ |
| *30-Day Follow-Up—Total* | — | 41.9% | — | ★★★ |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 44.8% | 48.0% | ↑ | ★★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 61.4% | 64.5% | ↑ | ★★★ |
| ***Follow-Up After ED Visit for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 44.7% | 45.4% | → | ★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 54.8% | 56.9% | → | ★★★ |
| ***Use of Opioids at High Dosage*** | | | | |
| *18+ Years** | 11.9% | 11.0% | ↑ | ★ |
| ***Initiation and Engagement of Substance Use Disorder (SUD) Treatment*** | | | | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | — | 53.3% | — | ★★★★ |
| *Engagement of SUD Treatment—Total—Total (13+ Years)* | — | 20.6% | — | ★★★★ |
| ***Adherence to Antipsychotic Medications for Individuals with Schizophrenia*** | | | | |
| *18+ Years* | — | 47.3% | — | ★ |
| ***Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication*** | | | | |
| *18–64 Years* | — | 77.4% | — | ★★ |
| ***Care of Acute and Chronic Conditions*** | | | | |
| ***Controlling High Blood Pressure*** | | | | |
| *18–85 Years* | 67.4%[+] | 65.2%[+] | → | ★★★ |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | | | | |
| *HbA1c Control (<8.0 Percent)—Total (18–75 Years)* | — | 54.5% | — | ★★★ |

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| *HbA1c Poor Control (>9.0 Percent)—Total (18–75 Years)** | 34.3% | 33.3% | → | ★★★★ |
| ***Pediatric Health*** | | | | |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotics*** | | | | |
| *Blood Glucose Testing—Total (1–17 Years)* | 58.1% | 59.1% | → | ★★★ |
| *Cholesterol Testing—Total (1–17 Years)* | 49.3% | 50.6% | → | ★★★★ |
| *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* | 46.7% | 48.2% | → | ★★★★ |
| ***Childhood Immunization Status***** | | | | |
| *Combination 3* | 65.7%+ | 62.0%+ | → | ★★ |
| *Combination 7* | 59.4%+ | 55.0%+ | → | ★★ |
| *Combination 10* | 37.5%+ | 28.2%+ | ↓ | ★★ |
| ***Developmental Screening in the First Three Years of Life*** | | | | |
| *Total (0–3 Years)*[N] | — | 48.9%+ | — | — |
| ***Immunizations for Adolescents*** | | | | |
| *Combination 1 (Meningococcal, Tdap)* | 85.6%+ | 87.8%+ | → | ★★★★ |
| *Combination 2 (Meningococcal, Tdap, HPV)* | 41.4%+ | 41.4%+ | → | ★★★★ |
| ***Oral Evaluation, Dental Services*** | | | | |
| *Total (0–20 Years)*[N] | — | 48.2% | — | — |
| ***Well-Child Visits in the First 30 Months of Life*** | | | | |
| *Six or More Well-Child Visits* | 63.3% | 61.8% | → | ★★★ |
| *15 Months–30 Months—Two or More Well-Child Visits* | — | 63.6% | — | ★★ |
| ***Child and Adolescent Well-Care Visits*** | | | | |
| *Total (3–21 Years)* | 47.9% | 47.4% | ↓ | ★★ |
| ***Preventive Screening*** | | | | |
| ***Breast Cancer Screening*** | | | | |
| *Total (50–74 Years)* | 55.6% | 55.8% | → | ★★★ |
| ***Cervical Cancer Screening*** | | | | |
| *21–64 Years* | 58.9%+ | 58.9%+ | → | ★★★ |
| ***Appropriate Utilization of Services*** | | | | |
| ***Ambulatory Care*** | | | | |
| *Emergency Department (ED) Visits—Total (0–85+ Years)*[F] | 469.8 | 478.8 | — | — |
| ***Plan All-Cause Readmissions*** | | | | |
| *Observed Readmissions—Total (18–64 Years)* | 9.5% | 8.7% | ↑ | — |
| *Expected Readmissions—Total (18–64 Years)* | — | 9.5% | — | — |

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| *Outlier Rate—Total (18–64 Years)* | — | 56.0 | — | — |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)** | 1.0051 | 0.9117 | — | ★★★ |

* A lower rate indicates better performance for this measure.
** Table A-1 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
+ Indicates the measure was reported using hybrid methodology.
# Caution should be considered when comparing CY 2021 to CY 2022 results as changes to the measure specifications occurred.
Cells shaded green indicate that the rate met or exceeded the MY 2021 and/or MY 2022 national Medicaid mean.
[1] Indicates a 2021–2022 comparison is not presented in the CYE 2023 Annual Technical Report because either the CY 2021 rate was not presented in the CYE 2022 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
↑ Indicates improvement of measure rates.
↓ Indicates decline of measure rates.
→ Indicates stable measure rates.
[2] Performance Levels for CY 2022 were based on comparisons of the HEDIS MY 2022 measure rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks.
Performance Levels for 2022 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile
[N] Measure has no NCQA Medicaid mean for comparison
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.

## Strengths, Opportunities for Improvement, and Recommendations

Table 5-123 presents strengths, opportunities for improvement, and recommendations for UHCCP ACC related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-123—UHCCP ACC Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| In the Behavioral Health measure group:<br>• Nine out of 13 (69.23 percent) UHCCP ACC measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. **[Quality, Timeliness, Access]**<br>– *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| – *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*<br>– *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)*<br>– *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)*<br>– *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* and *Engagement of SUD Treatment—Total—Total (13+ Years)* |
| In the Care of Acute and Chronic Conditions group:<br>• All of the measure indicators for UHCCP ACC's rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. **[Quality]**<br>• UHCCP ACC's performance measure rate for *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)—Total (18–75 Years)* was at or above the 75th percentile, indicating that most members with diabetes had controlled HbA1c levels most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[5-56] **[Quality]** |
| In the Pediatric Health measure group:<br>• UHCCP ACC's rates for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total (1–17 Years)* and *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* were at or above the 75th percentile, indicating that most children and adolescents with ongoing antipsychotic medication use had metabolic testing performed. Metabolic monitoring (blood glucose and cholesterol testing) is an important component of ensuring appropriate management of children and adolescents on antipsychotic medications.[5-57] **[Quality]**<br>• Performance measure rates for *Immunizations for Adolescents—Combination 1(Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* were at or above the 75th percentile, indicating that most adolescents were receiving one dose of meningococcal vaccine, one Tdap vaccine, and the complete HPV vaccine series by their 13th birthday. Receiving recommended vaccinations is the best defense against serious vaccine-preventable diseases, including meningococcal meningitis, tetanus, diphtheria, pertussis (whooping cough), and HPV.[5-58] **[Quality]** |

[5-56] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 31, 2024.
[5-57] National Committee for Quality Assurance. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM). Available at: https://www.ncqa.org/hedis/measures/metabolic-monitoring-for-children-and-adolescents-on-antipsychotics/. Accessed on: Jan 31, 2024.
[5-58] National Committee for Quality Assurance. Immunizations for Adolescents (IMA). Available at: https://www.ncqa.org/hedis/measures/immunizations-for-adolescents/. Accessed on: Jan 31, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Opportunities for Improvement and Recommendations** |
| In the Behavioral Health measure group, UHCCP ACC's performance measure rate for *Use of Opioids at High Dosage—18+ Years* fell below the 25th percentile indicating an opportunity to identify trends leading to the opioid crisis. **[Quality]**<br><br>Recommendation: In 2016, opioid-related overdoses accounted for more than 42,000 deaths in the United States. Of those, 40 percent involved prescription opioids. Literature suggests there is a correlation between high dosages of prescription opioids and the risk of both fatal and nonfatal overdose. HSAG recommends that UHCCP ACC follow the CDC guidelines on opioid prescribing for chronic, nonmalignant pain, which recommend the use of "additional precautions" when prescribing dosages ≥50 MED and recommend providers avoid or "carefully justify" increasing dosages ≥90 mg MED. In 2019, the authors of the 2016 guidelines published commentary that cautioned providers, systems, payers, and states from developing policies and practices that are "inconsistent with and go beyond" the guideline recommendations. The commentary included cautions regarding strict enforcement of dosage and duration thresholds, as well as abrupt tapering of opioids. The opioid dosage assessed in this measure is a reference point for health plans to identify members who may be at high risk for opioid overuse and misuse. HSAG recommends outreach to members who fall within this category to assess and schedule interventions as necessary.[5-59] |
| In the Maternal and Perinatal Health measure group, UHCCP ACC's performance measure rate for *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, indicating an opportunity to increase access to timely postpartum care. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.[5-60] **[Quality, Timeliness, Access]**<br><br>Recommendation: While UHCCP ACC conducted a root cause analysis and implemented interventions specific to the CY 2021 *Prenatal and Postpartum Care—Postpartum Care* rate, this rate remained low in CY 2022; therefore, HSAG recommends that UHCCP ACC continue to implement appropriate interventions to improve performance related to postpartum care. HSAG also recommends that UHCCP ACC monitor and expand on interventions currently in place to improve performance for the *Prenatal and Postpartum Care—Postpartum Care* measure indicator. |

[5-59] National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/ Accessed on: Jan 25, 2024

[5-60] National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/. Accessed on: Jan 31, 2024.

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

Table 5-124 presents performance measure recommendations made to UHCCP ACC in the CYE 2022 Annual Technical Report[5-61] and UHCCP ACC's follow-up to the recommendations, as well as an assessment of the degree to which UHCCP ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 5-124—UHCCP ACC Follow-Up to CYE 2022 Performance Measure Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| **Recommendation 1:** |
| HSAG recommended that UHCCP ACC ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. Additionally, HSAG recommended that UHCCP ACC continue to conduct a formal review of its source code followed by a complete test plan, including live system validation of data, prior to reporting any performance measure data. |
| **UHCCP ACC's Response:** |
| UHCCP ACC follows the NCQA/CMS guidance on continuous enrollment requirements for measure calculation. Source code for HEDIS measures is reviewed by NCQA, which is confirmed by the certificate received. For non-HEDIS measures, there are multiple audit firms that annually review and approve the performance measure vendor's source code (including HSAG). UHCCP ACC compares prior year results to current year results to confirm any significant discrepancies. UHCCP ACC and HSAG discussed the topic during UHCCP ACC's virtual PMV audit review with HSAG. |
| **HSAG's Assessment:** HSAG determined that UHCCP ACC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 2:** |
| HSAG recommended that UHCCP ACC explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratifications related to race and ethnicity. UHCCP ACC should continue working with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information. |
| **UHCCP ACC's Response:** |
| UHCCP ACC is reporting race and ethnicity data on all NCQA HEDIS performance measures requiring race and ethnicity stratification. |

[5-61] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP) Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 1, 2024.

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| To improve the completion and accuracy of race and ethnicity data, UHCCP ACC has added some functionality to gather race, ethnicity, and language (REL) information from multiple sources under the Health Care Needs Identifier (HCNI) effort. In terms of collaborative efforts, UHCCP ACC has been working with AHCCCS on expanding data feeds. |
| **HSAG's Assessment:** HSAG determined that UHCCP ACC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 3:** |
| While UHCCP ACC conducted a root cause analysis and implemented interventions specific to the CY 2020 *Prenatal and Postpartum Care—Postpartum Care* rate, this rate remained low in CY 2021; therefore, HSAG recommended that UHCCP ACC continue to implement appropriate interventions to improve performance related to postpartum care. HSAG also recommended that UHCCP ACC monitor and expand on interventions currently in place to improve performance for the *Prenatal and Postpartum Care—Postpartum Care* measure indicator. |
| **UHCCP ACC's Response:**<br>UHCCP ACC did not meet the 2022 NCQA Medicaid Mean (MY 2021) rates for the *Prenatal and Postpartum Care—Postpartum Care (PPC-PPC)* submeasure. As a result, UHCCP ACC implemented a CAP for the submeasure in July 2023. The submeasure is also included in UHCCP ACC's 2023 and 2024 QI Work Plans.<br><br>UHCCP ACC also has an AHCCCS-mandated PIP in place for the *PPC* measure. The UHCCP ACC PPC PIP workgroup performs an annual review of the initial root cause analysis (RCA) for the PPC PIP. The workgroup evaluates whether the root causes are still relevant/applicable and if any new root causes have been identified.<br><br>UHCCP ACC identified the following root causes impacting *PPC-PPC* rate performance:<br>1. Providers may not be aware of UHCCP ACC services provided to high-risk pregnancy members.<br>2. Prenatal and postpartum care disparities exist among Black, Indigenous, and People of Color (BIPOC) (non-White) members.<br>3. Providers may not submit Current Procedural Terminology (CPT) II codes to close gaps in care via administrative claims.<br><br>To address the identified root cause deficiencies, UHCCP ACC implemented the following interventions in 2022 and 2023:<br>• Clinical practice consultants (CPCs) to inform groups that if there is a high-risk pregnancy on the report, UHCCP ACC has high-risk care managers assigned to the members as well.<br>• Health Equity Provider Incentive (HEPi) Program offered to providers for closing PPC-timeliness of prenatal care (TOPC) and PPC-postpartum care gaps in care for BIPOC members.<br>• UHCCP ACC rolled out a CPT II code dashboard. CPCs will be able to share dashboard results with provider groups and reiterate the importance of submitting CPT II codes. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| The COVID-19 pandemic presented numerous challenges which impacted access to postpartum care, including limited in-person visits, the transition to telehealth services, and overwhelmed resources. At the time of this review, the COVID-19 pandemic access to care factors impacting this measure have largely been resolved, although 2023 rates could still be slightly impacted due to this measure's lookback period. |
| **HSAG's Assessment:** UHCCP ACC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that UHCCP ACC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 4:** |
| HSAG recommended that UHCCP ACC conduct a root cause analysis or focus study to determine why there was a higher proportion of members receiving prescriptions for opioids. Upon identification of a root cause, HSAG recommended that UHCCP ACC implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse. |
| **UHCCP ACC's Response:**<br>UHCCP ACC spent much of 2021 doing a deep dive analysis of the *Use of Opioids at High Dosage* (*HDO*) measure. Ultimately, the findings revealed very little actionable information. Here is an overview of the activities and findings:<br><br>1. Early in 2021, UHCCP ACC met with several other UHC community and state Medicaid plans that perform well in the measure to learn more about what they were doing to impact their rates. All the plans felt their performance was a result of their states' robust public health campaigns on opioids and OUD rather than anything they were doing.<br>2. UHCCP ACC also conducted a two-phased medical records review audit in 2021–2022 of prescribers who accounted for most members in the measure numerator to identify the root causes of UHCCP ACC's poor performance in the measure. The UHCCP ACC medical director reviewed the findings with the top 17 pain management provider groups identified in the audit and educated them on opioid prescribing best practices and *HDO* measure technical specifications. The following were the key takeaways from the audit:<br>i. All prescribers were pain management providers, and the top providers are generally the same month over month.<br>ii. A couple of pain management providers were unaware the measure requires members to be below 90 MME/day. Many providers thought members could be at 90 MME/day and not be included in the measure numerator. The audit provided an opportunity to educate those providers on the *HDO* maximum MME requirement.<br>iii. Members have usually been taking high dose opioids for many years for chronic pain. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| UHCCP ACC did not meet the 2022 NCQA Medicaid Mean (MY 2021) rates for the *HDO* performance measure. As a result, UHCCP ACC implemented a CAP for the *HDO* measure in July 2023. The measure is also included in UHCCP ACC's 2023 and 2024 QI Work Plans.<br><br>UHCCP ACC identified the following root causes impacting *HDO* rate performance for LTC:<br>1. Members may not be aware behavioral health telehealth services are available.<br>2. Financial incentives not motivating providers to outreach members to close gaps in care.<br>3. Demographic and SDOH factors might impact members' ability to reduce or discontinue high-dose opioids.<br><br>To address the identified root cause deficiencies, UHCCP ACC implemented the following new interventions in 2022 and 2023:<br>• Annual Virtual Visit email campaign sent to members, which included messaging about behavioral health telehealth services.<br>• Adapted the provider incentive program for 2022 by increasing participating provider incentive payment amounts.<br>• Subpopulation, demographic, and SDOH analyses of compliant members to identify trends for targeted interventions.<br><br>Although UHCCP ACC has not met the NCQA national average rates since 2019, the plan has achieved year-over-year improvement in measure rates. UHCCP ACC's 2022 rate was three points better than its 2019 rate. |
| **HSAG's Assessment:** UHCCP ACC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that UHCCP ACC satisfactorily addressed these prior year's recommendations. |

## *Validation of Performance Improvement Projects*

### Back to Basics PIP

In CYE 2023, UHCCP ACC continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 1, PIP validation activities focused on improvement from the baseline results. UHCCP ACC submitted Remeasurement 1 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes or discontinuation of the interventions.

HSAG conducted an annual validation of the first remeasurement year reflective of CY 2022 (January 1, 2022, through December 31, 2022) using AHCCCS-calculated and validated indicator rates. HSAG evaluated UHCCP ACC's performance indicator results based on an analysis of improvement strategies

implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

### *Validation Results*

Table 5-125 displays the overall confidence levels for the UHCCP ACC *Back to Basics* PIP.

**Table 5-125—UHCCP ACC *Back to Basics* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| UHCCP ACC | *High Confidence* | 100% | 100% | *No Confidence* | 33% | 100% |

### *Measure Results*

Table 5-126 and Table 5-127 provide the *Back to Basics* PIP baseline, intervention, and Remeasurement Year 1 rates for each indicator for UHCCP ACC.

**Table 5-126—UHCCP ACC *Back to Basics* PIP Rates for PIP Indicator 1**

| Contractor | PIP Indicator 1: *W30 Rate 1* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| UHCCP ACC | 65.6% | 61.9% |

**Table 5-127—UHCCP ACC *Back to Basics* PIP Rates for PIP Indicator 2**

| Contractor | PIP Indicator 2: *WCV* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| UHCCP ACC | 52.7% | 47.4% |

### *Interventions*

Table 5-128 presents PIP interventions for UHCCP ACC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 5-128—UHCCP ACC *Back to Basics* PIP Interventions**

| Contractor | Interventions |
|---|---|
| UHCCP ACC | • Include dollar amount in the provider-specific Missed Opportunities reports shared with providers. The reports list members who have had a sick visit with the provider and have not had a well visit.<br>• The Provider Tip Sheet provides best practices for improving well-care visit rates. Tips will include information on how providers can make practice changes to incorporate well-care visits with sick visits. The CPCs will share the document with providers, along with the Missed Opportunities report, and provide one-to-one education.<br>• Collaborate with Arizona Family Health Partnership (AFHP) on its Adolescent Champion Model pilot program.<br>• Myth vs Fact member letter is mailed to guardians of children in the *WCV* measure.<br>• T1015 Audit.<br>• Wellness Reimbursement Campaign.<br>• Health Disparity: Black or African American Babies (W30 Rate 1) CPC Monthly Talking Points (September 2022). Targeted intervention for Black babies due to health disparity analysis and finding.<br>• Health Disparity: Black or African American Babies (W30 Rate 1) QM Team: Targeted Member Outreach (September and October 2022) due to health disparity analysis and finding. |

### *Strengths, Opportunities for Improvement, and Recommendations*

Table 5-129 presents strengths, opportunities for improvement, and recommendations for UHCCP ACC related to the *Back to Basics* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-129—UHCCP ACC Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG noted that UHCCP ACC performed accurate statistical testing between the baseline and Remeasurement 1 results. **[Quality, Access]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| UHCCP ACC developed and implemented measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 2. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| For indicator 1, UHCCP ACC had a decline of 3.75 percentage points in the indicator rate between the baseline year and Remeasurement Year 1. UHCCP ACC had a decline of 5.26 percentage points in the indicator rate between the baseline year and Remeasurement Year 1 for indicator 2. **[Quality, Access]**<br><br>Recommendations: As the PIP progresses, HSAG recommends that UHCCP ACC:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

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

Table 5-130 presents PIP recommendations made to UHCCP ACC in the CYE 2022 Annual Technical Report[5-62] and UHCCP ACC's follow-up to the recommendations, as well as an assessment of the degree to which UHCCP ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 5-130—UHCCP ACC Follow-Up to CYE 2022 PIP Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| HSAG recommended that UHCCP ACC:<br>• Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary.<br>• Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available. |

[5-62] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP). Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 16, 2024.

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| • Develop and document a plan for sustaining the improvement for any demonstrated improvement in indicator rates. |

**UHCCP ACC's Response:**

The UHCCP ACC quality manager monitors the *Back to Basics* (B2B) PIP performance measure rates monthly and reviews them with the B2B PIP workgroup quarterly (at a minimum). The B2B PIP workgroup is composed of various stakeholders and subject matter experts from within the plan. The workgroup meets regularly to review PIP performance measure rates, evaluate the effectiveness of current PIP interventions, and identify root causes of performance deficiencies as well as new opportunities for improvement.

The B2B PIP workgroup collaborates on adjusting interventions for continued improvement, as needed, based on root cause analysis intervention success. The workgroup utilizes the PDSA method to evaluate interventions and determine next steps: adopt, adapt, or abandon. Many interventions have been revamped/improved to meet the changing needs for member health outcomes and rate improvement. Some interventions undergo an effectiveness analysis to evaluate their impact by comparing members with open gaps in care to those with closed gaps in care after the completion of the intervention.

The PIP workgroup continues the PDSA process and collaborating to improve the B2B performance measure rates. A few examples of UHCCP ACC 2022 (Remeasurement Year 1) and 2023 (Remeasurement Year 2) interventions are provided below:

- During 2022, UHCCP ACC identified a racial health disparity in the *Well-Child Visit in the First 30 Months of Life—Six Visits in the First 15 Months* (W30 Rate 1) performance measure and addressed it by performing member and provider outreach for Black or African American babies that still needed well-child visits. An effectiveness analysis was completed which concluded that a 28% improvement was achieved by the end of MY 2022.
- A Myth vs. Fact letter and flyer were distributed to 11,012 parents, guardians, and members to educate them on the importance of getting a WCV, even during sick visits. By the end of 2022, 55.9% had obtained a WCV.
- During 2023, UHCCP ACC added/incorporated outreach phone calls to over 2,000 members assigned to select provider groups to raise member awareness of the Back-to-School gift card incentive campaign implemented to improve *WCV* rates.
- To incent providers, UHCCP ACC increased claims payment allowed amounts for well-care visits occurring between 10/1/2022 through 12/31/2022.

UHCCP ACC's plans for sustaining improvement for any demonstrated improvement in indicator rates are outlined above. Detailed plans are documented in the B2B PIP workgroup's meeting minutes, the intervention analysis template, and the annual PIP report. The PIP measure plans are also tracked in the UHCCP ACC QI Workplans.

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| **HSAG's Assessment:** HSAG has determined that the Contractor has satisfactorily addressed these recommendations. |

## Prenatal and Postpartum Care PIP

In CYE 2023, UHCCP ACC submitted baseline measurement results for the *Prenatal and Postpartum Care* PIP, which was initiated in CY 2022. UHCCP ACC submitted baseline performance indicator results and interventions implemented.

HSAG conducted an annual validation of the baseline year reflective of CY 2022 (January 1, 2022, through December 31, 2022) using AHCCCS-calculated and validated indicator rates. HSAG evaluated UHCCP ACC's performance indicator results based on an analysis of improvement strategies implemented described in the Validation of Performance Improvement Project section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

### *Validation Results*

Table 5-131 displays the overall confidence levels for the UHCCP ACC *Prenatal and Postpartum Care* PIP.

**Table 5-131—UHCCP ACC *Prenatal and Postpartum Care* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| UHCCP ACC | *High Confidence* | 100% | 100% | *Not Assessed* | *Not Assessed* | *Not Assessed* |

### *Measure Results*

Table 5-132 and Table 5-133 provide the *Prenatal and Postpartum Care* PIP baseline rates for each indicator for UHCCP ACC.

**Table 5-132—UHCCP ACC *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 1**

| Contractor | PIP Indicator 1: *Timeliness of Prenatal Care* |
|---|---|
| | Baseline Year |
| | CY 2022 |
| UHCCP ACC | 82.5% |

**Table 5-133—UHCCP ACC *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 2**

| Contractor | PIP Indicator 2: *Postpartum Care* |
|---|---|
| | Baseline Year |
| | CY 2022 |
| UHCCP ACC | 67.6% |

### *Interventions*

Table 5-134 presents PIP interventions for UHCCP ACC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 5-134—UHCCP ACC *Prenatal and Postpartum Care* PIP Interventions**

| Contractor | Interventions |
|---|---|
| UHCCP ACC | • HFS 2.0 Modernization: Rising Risk BIPOC Population<br>• CPC Monthly Talking Points/Provider Education and PCOR Review<br>• Virgin Pulse IVR calls to members: Prenatal Welcome, Pre-postpartum Tips, Postpartum (Initial and Follow-up)<br>• Healthy First Steps<br>• Community Plan Primary Care Provider Incentive (CP-PCPi) includes OB providers (PPC-TOPC)<br>• Arizona State-Specific Provider Training: OB-GYN Care Provider Toolkit |

### *Strengths, Opportunities for Improvement, and Recommendations*

Table 5-135 presents strengths, opportunities for improvement, and recommendations for UHCCP ACC related to the *Prenatal and Postpartum Care* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-135—UHCCP ACC Strengths, Opportunities for Improvement, and Recommendations Related to the *Prenatal and Postpartum Care* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| UHCCP ACC developed and implemented measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 1. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| For indicator 1, 82.5 percent of women had a prenatal care visit in the first trimester and 67.6 percent had a postpartum visit between seven and 84 days after delivery during CYE 2022. **[Quality, Access]**<br><br>Recommendations: As the PIP progresses, HSAG recommends that UHCCP ACC:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

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

The *Prenatal and Postpartum Care* PIP was initiated in CY 2022; therefore, this section is not applicable.

## *Compliance Reviews*

### Results

AHCCCS conducted a compliance review of UHCCP ACC from September 12, 2022, through September 15, 2022. On November 29, 2022, AHCCCS finalized the report findings, provided UHCCP ACC with a CAP submission matrix, and required a CAP for any standard with a total score of less than 95 percent. After the Contractor's first CAP submission, AHCCCS accepted some of the proposed CAPs but required additional information. On February 24, 2023, AHCCCS accepted UHCCP ACC's proposed CAPs and required the Contractor to submit updated policies, manuals, desktop procedures, and other vital documents to provide evidence of CAP completion by August 24, 2023. Remaining CAP items were under review by AHCCCS at the time this report was being written. Additional results of the CAP update will be included in the CYE 2024 annual technical report. Table 5-136 presents the compliance review results for UHCCP ACC.

**Table 5-136—UHCCP ACC Compliance Review Results**

| Focus Areas | CYE 2022 UHCCP ACC Scores | CYE 2022 Program-Level Average | CYE 2023 UHCCP ACC CAP Update |
|---|---|---|---|
| CC | 93% | 99% | PM |
| CIS | 99% | 96% | NA |
| DS | 98% | 91% | NA |
| GA | 100% | 92% | NA |
| GS | 100% | 99% | NA |
| MCH | 95% | 82% | NA |
| MM | 97% | 94% | NA |
| MI | 95% | 96% | NA |
| QM | 84% | 77% | PM |
| QI | 100% | 92% | NA |
| RI | 100% | 100% | NA |
| TPL | 100% | 100% | NA |
| ISOC | 86% | 96% | PM |

NA = "not applicable." A CAP was not required as the CYE 2022 score was 95% or above.
PM = "partially met." AHCCCS approved the Contractor's proposed CAP. The Contractor must submit evidence of compliance.
M = "met." AHCCCS accepted and closed the Contractor's CAP.

## Strengths, Opportunities for Improvement, and Recommendations

Table 5-137 presents strengths, opportunities for improvement, and recommendations for UHCCP ACC based on compliance activities conducted in CYE 2023, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-137—UHCCP ACC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| AHCCCS approved UHCCP ACC's proposed CAPs for all Focus Areas with scores less than 95 percent. UHCCP ACC will provide evidence of CAP completion in CYE 2024. |
| **Opportunities for Improvement and Recommendations** |
| UHCCP ACC has remaining CAPs in the following Focus Areas:<br>• Corporate Compliance (CC) **[Quality, Access]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| • Quality Management (QM) **[Quality]**<br>• Integrated Systems of Care (ISOC) **[Quality, Access]**<br><br>Recommendation: HSAG recommends that UHCCP ACC continue to work on outstanding CAP items and submit to AHCCCS in the approved time frame. |

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

Table 5-138 presents compliance recommendations made to UHCCP ACC in the CYE 2022 Annual Technical Report[5-63] and UHCCP ACC's follow-up to the recommendations, as well as an assessment of the degree to which UHCCP ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 5-138—UHCCP ACC Follow-Up to CYE 2022 Compliance Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for Compliance |
|---|
| HSAG did not have recommendations for UHCCP ACC in CYE 2022, as UHCCP ACC compliance results were unavailable for the CYE 2022 Annual Technical Report. |
| **UHCCP ACC's Response:**<br>Not applicable. |
| **HSAG's Assessment:**<br>Not applicable. |

## *Network Adequacy Validation*

### Results

HSAG evaluated UHCCP ACC's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents semiannual validation findings specific to the ACC Program, with one results table for each of the following GSAs:

- Central GSA: Gila, Maricopa,5-64 and Pinal counties

[5-63] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP) Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 8, 2024.

[5-64] Maricopa County includes the 85342, 85358, and 85390 ZIP Codes; these ZIP Codes are physically located in both Maricopa and Yavapai counties.

- South GSA: Pima County

Each region-specific table summarizes semiannual validation results containing the percentage of members meeting each time/distance standard by quarter and county, with color-coding to identify whether or not the time/distance standard was "Met" or "Not Met."

The value "NA" is shown for time/distance standards that do not apply to the county or program.

The value "NR" is shown for time/distance standards in which no members met the network requirement denominator for the program and county; therefore, HSAG calculated no corresponding time/distance result.

Yellow color-coding identifies instances in which HSAG's time/distance results met the minimum network requirement but differed from the ACOM 436 results.

Red color-coding identifies instances in which HSAG's time/distance results did not meet the compliance standard, regardless of the ACOM 436 results.

An asterisk (*) indicates that fewer than 10 members were included in the denominator of HSAG's results.

A carat (^) indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

**Table 5-139—UHCCP ACC Time/Distance Validation Results for Central GSA—Percentage of Members Meeting Minimum Network Requirements**

| | Gila | | Maricopa | | Pinal | |
|---|---|---|---|---|---|---|
| Minimum Network Requirement | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0^ | 100.0^ | 98.9^ | 99.3^ | 100.0^ | 100.0^ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 100.0^ | 100.0^ | 99.0^ | 99.4^ | 100.0^ | 100.0^ |
| BHRF | NA | NA | 98.2 | 98.1 | NA | NA |
| Cardiologist, Adult | 100.0^ | 100.0^ | 100.0^ | 99.9^ | 100.0^ | 100.0^ |
| Cardiologist, Pediatric | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| Dentist, Pediatric | 100.0 | 58.8 | 99.5 | 99.3 | 100.0 | 100.0 |
| Hospital | 100.0 | 100.0 | 99.9 | 99.9 | 100.0 | 100.0 |
| OB/GYN | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 100.0 | 100.0 | 99.0 | 99.1 | 100.0 | 100.0 |

| Minimum Network Requirement | Gila | | Maricopa | | Pinal | |
|---|---|---|---|---|---|---|
| | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| PCP, Adult | 100.0^ | 100.0^ | 99.7^ | 99.7^ | 100.0^ | 100.0^ |
| PCP, Pediatric | 100.0^ | 100.0^ | 99.7^ | 99.7^ | 100.0^ | 100.0^ |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
represents time/distance standard results that do not meet the compliance standard based on HSAG's results.
^indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.

**Table 5-140—UHCCP ACC Time/Distance Validation Results for South GSA—Percentage of Members Meeting Minimum Network Requirements**

| Minimum Network Requirement | Pima | |
|---|---|---|
| | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 97.0^ | 97.0^ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 97.2^ | 97.2^ |
| BHRF | 92.6 | 92.5 |
| Cardiologist, Adult | 99.3^ | 99.8^ |
| Cardiologist, Pediatric | 99.9^ | 100.0^ |
| Dentist, Pediatric | 98.8 | 98.8 |
| Hospital | 99.5 | 99.5 |
| OB/GYN | 100.0 | 99.8 |
| Pharmacy | 98.5 | 98.5 |
| PCP, Adult | 99.9^ | 99.8^ |
| PCP, Pediatric | 99.8^ | 99.8^ |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
^indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

## Strengths, Opportunities for Improvement, and Recommendations

Table 5-141 presents strengths, opportunities for improvement, and recommendations for UHCCP ACC related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 5-141—UHCCP ACC Strengths, Opportunities for Improvement, and Recommendations Related to NAV**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths:<br>• UHCCP ACC met all time/distance network standards for both quarters in CYE 2023 in Maricopa, Pima, and Pinal counties. **[Access]**<br>• UHCCP ACC met all time/distance network standards for BHRF; Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; Cardiologist, Adult and Pediatric; Hospital; OB/GYN; PCP, Adult and Pediatric; and Pharmacy. **[Access]**<br><br>Note: UHCCP ACC provides coverage in the following counties: Gila, Maricopa, Pima, and Pinal. |
| **Opportunities for Improvement and Recommendations** |
| HSAG identified the following opportunities for improvement:<br>• UHCCP ACC failed to meet the time/distance standard for at least one quarter and/or county for Dentist, Pediatric. **[Access]**<br><br>Recommendation: HSAG recommends that UHCCP ACC maintain current compliance with network standards but continue to address network gaps, as applicable. |

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

Table 5-142 presents NAV recommendations made to UHCCP ACC in the CYE 2022 Annual Technical Report[5-65] and UHCCP ACC's follow-up to the recommendations, as well as an assessment of the degree to which UHCCP ACC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 5-142—UHCCP ACC Follow-Up to CYE 2022 NAV Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for NAV |
|---|
| While HSAG did not have recommendations specific to UHCCP ACC's existing provider network coverage, HSAG recommended that UHCCP ACC continue to maintain current compliance with network standards. |

[5-65] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP) Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Feb 8, 2024.

| Prior Year's Recommendation from the EQR Technical Report for NAV |
| --- |
| **UHCCP ACC's Response:**<br>UHCCP ACC will continue to maintain current network standards in all assigned counties. |
| **HSAG's Assessment:**<br>HSAG has determined that UHCCP ACC has satisfactorily addressed this prior year's recommendations. |

# 6. RBHA/ACC-RBHA SMI-Designated Population Program-Level Comparative Results

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

This section includes RBHA and ACC-RBHA program-level comparative results for the SMI-Designated population, organized by EQR-related activity, which includes strengths, opportunities for improvement, and HSAG's recommendations for program-level performance improvement. This section also includes information about the extent to which each Contractor was able to address the prior year's recommendations for each activity.

## Validation of Performance Measures

The RBHA/ACC-RBHA Program-Level results include all validated and aggregated RBHA/ACC-RBHA data, however HCA RBHA's contract terminated as of October 1, 2022. This resulted in reduced denominators and minimal contributions by HCA RBHA to overall statewide average rates for the following performance measures: *Use of Opioids at High Dosage, Adherence to Antipsychotic Medications for Individuals with Schizophrenia, Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication, Controlling High Blood Pressure, Hemoglobin A1c Control for Patients With Diabetes, Oral Evaluation, Dental Services, Breast Cancer Screening,* and *Cervical Cancer Screening.*

### *Results for Information Systems Standards Review*

During CYE 2023, HSAG evaluated each RBHA/ACC-RBHA SMI-Designated Population Program Contractor's data system for processing of each data type used for reporting the Contractor's CY 2022 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. A summary of these findings by RBHA Program Contractor is provided in Table 6-1. Table 6-1 also displays whether or not each RBHA Program Contractor met the assessed IS standards, which demonstrates whether or not the Contractor has effective IS practices and control procedures for data reporting. Additional information about each RBHA Program Contractor's general findings for each data type reviewed can be found in Section 7. RBHA/ACC-RBHA SMI-Designated Population Program Contractor-Specific Results. Additional information regarding the CMS EQR Protocol 2[6-1] audit

[6-1] The Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: January 26, 2024.

requirements, including more information about the levels of scoring, can be found in the Validation of Performance Measures section in Appendix A. Methodology.

**Table 6-1—Performance Measures Validation Contractor Comparison: CMS EQR Protocol 2 Validation Results for RBHA/ACC-RBHA SMI-Designated Population Program Contractors**

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

## Results for Performance Measures

Table 6-2 presents the CY 2022 aggregate performance measure results for the RBHA/ACC-RBHA SMI-Designated Population Program Contractors. Performance measure rate cells shaded green indicate that aggregate performance met or exceeded NCQA's Quality Compass national Medicaid HMO mean for HEDIS MY 2022. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the national Medicaid mean are shaded green. Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

**Table 6-2—CY 2022 Aggregate Performance Measure Results for the RBHA or RBHA/ACC-RBHA SMI-Designated Population Program Contractors**

| Measure | AzCH–CCP ACC-RBHA | HCA RBHA | Mercy Care ACC-RBHA | RBHA / ACC-RBHA Program Aggregate |
|---|---|---|---|---|
| ***Maternal and Perinatal Care*** | | | | |
| ***Prenatal and Postpartum Care*** | | | | |
| *Timeliness of Prenatal Care*[#] | 71.4%[+] | 79.5%[+] | 78.6%[+] | 76.6%[+] |
| *Postpartum Care* | 54.1%[+] | 61.4%[+] | 73.6%[+] | 66.1%[+] |
| ***Behavioral Health*** | | | | |
| ***Antidepressant Medication Management*** | | | | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | 60.5% | 56.9% | 48.7% | 53.4% |

| Measure | AzCH–CCP ACC-RBHA | HCA RBHA | Mercy Care ACC-RBHA | RBHA / ACC-RBHA Program Aggregate |
|---|---|---|---|---|
| *Effective Continuation Phase Treatment—Total (18+ Years)* | 44.1% | 41.8% | 34.0% | 38.1% |
| ***Follow-Up After ED Visit for Substance Use*** | | | | |
| *7-Day Follow-Up—Total* | 61.9% | 52.9% | 55.1% | 56.8% |
| *30-Day Follow-Up—Total* | 73.4% | 71.3% | 74.1% | 73.5% |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 61.3% | 70.3% | 69.3% | 67.4% |
| *30-Day Follow-Up—Total (6+ Years)* | 79.3% | 84.9% | 83.6% | 82.6% |
| ***Follow-Up After ED Visit for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 54.0% | 57.1% | 58.5% | 57.1% |
| *30-Day Follow-Up—Total (6+ Years)* | 70.9% | 73.6% | 72.1% | 72.0% |
| ***Use of Opioids at High Dosage*** | | | | |
| *18+ Years** | 12.3% | NA++ | 9.7% | 10.6% |
| ***Initiation and Engagement of Substance Use Disorder (SUD) Treatment*** | | | | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | 54.2% | 44.6% | 49.3% | 50.2% |
| *Engagement of SUD Treatment—Total—Total (13+ Years)* | 17.0% | 12.4% | 12.4% | 13.7% |
| ***Adherence to Antipsychotic Medications for Individuals with Schizophrenia*** | | | | |
| *18+ Years* | 58.5% | NA++ | 56.2% | 56.9% |
| ***Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*** | | | | |
| *18–64 Years* | 82.7% | NA++ | 86.3% | 85.3% |
| ***Care of Acute and Chronic Conditions*** | | | | |
| ***Controlling High Blood Pressure*** | | | | |
| *18–85 Years* | 64.5%+ | NA++ | 65.0%+ | 64.8%+ |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | | | | |
| *HbA1c Control (<8.0 Percent)—Total (18–75 Years)* | 57.7%+ | NA++ | 65.2%+ | 62.7%+ |
| *HbA1c Poor Control (>9.0 Percent)—Total (18–75 Years)** | 35.8%+ | NA++ | 27.0%+ | 29.9%+ |
| ***Pediatric Health*** | | | | |
| ***Oral Evaluation, Dental Services*** | | | | |
| *Total (0–20 Years)* N | 24.1% | NA++ | 19.8% | 20.8% |
| ***Preventive Screening*** | | | | |
| ***Breast Cancer Screening*** | | | | |
| *Total (50–74 Years)* | 39.1% | NA++ | 41.1% | 40.3% |

| Measure | AzCH–CCP ACC-RBHA | HCA RBHA | Mercy Care ACC-RBHA | RBHA / ACC-RBHA Program Aggregate |
|---|---|---|---|---|
| ***Cervical Cancer Screening*** | | | | |
| *Total (21–64 Years)* | 49.9%+ | NA++ | 49.9%+ | 49.9%+ |
| ***Appropriate Utilization of Services*** | | | | |
| ***Ambulatory Care*** | | | | |
| *Emergency Department (ED) Visits—Total (0–85+ Years)* F | 1,161.0 | 1,139.2 | 1,189.6 | 1,175.8 |
| ***Plan All-Cause Readmissions*** | | | | |
| *Observed Readmissions—Total (18–64 Years)* | 19.6% | 13.4% | 15.6% | 16.3% |
| *Expected Readmissions—Total (18–64 Years)* | 14.6% | 11.3% | 11.8% | 12.4% |
| *Outlier Rate—Total (18–64 Years)* | 115.6 | 41.4 | 123.7 | 114.4 |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)** | 1.3425 | 1.1839 | 1.3245 | 1.3174 |

* A lower rate indicates better performance for this measure.
+ Indicates the measure was reported using hybrid methodology.
++ NA indicates the denominator was too small to report a valid rate, based on the applicable measure specifications.
# Caution should be considered when comparing CY 2021 to CY 2022 results as changes to the measure specifications occurred.
Cells shaded green indicate that the rate met or exceeded the MY 2022 national Medicaid mean.
N Measure has no NCQA Medicaid mean for comparison
F NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months.

Table 6-3 presents the CY 2021 and CY 2022 RBHA/ACC-RBHA SMI-Designated Population Program Aggregate for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

**Table 6-3—CY 2022 Performance Measure Aggregate Results for RBHA/ACC-RBHA SMI-Designated Population Program Contractors**

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| ***Maternal and Perinatal Care*** | | | | |
| ***Prenatal and Postpartum Care*** | | | | |
| *Timeliness of Prenatal Care*[#] | 74.8%[+] | 76.6%[+] | → | ★ |
| *Postpartum Care* | 57.1%[+] | 66.1%[+] | ↑ | ★ |
| ***Behavioral Health*** | | | | |
| ***Antidepressant Medication Management*** | | | | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | 57.2% | 53.4% | ↓ | ★ |
| *Effective Continuation Phase Treatment—Total (18+ Years)* | 43.3% | 38.1% | ↓ | ★★ |
| ***Follow-Up After ED Visit for Substance Use*** | | | | |
| *7-Day Follow-Up—Total* | — | 56.8% | — | ★★★★★ |
| *30-Day Follow-Up—Total* | — | 73.5% | — | ★★★★★ |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 64.3% | 67.4% | ↑ | ★★★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 81.2% | 82.6% | ↑ | ★★★★★ |
| ***Follow-Up After ED Visit for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 53.9% | 57.1% | → | ★★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 70.1% | 72.0% | → | ★★★★ |
| ***Use of Opioids at High Dosage*** | | | | |
| *18+ Years** | 10.8% | 10.6% | → | ★ |
| ***Initiation and Engagement of Substance Use Disorder (SUD) Treatment*** | | | | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | — | 50.2% | — | ★★★★ |
| *Engagement of SUD Treatment—Total—Total (13+ Years)** | — | 13.7% | — | ★★ |
| ***Adherence to Antipsychotic Medications for Individuals with Schizophrenia*** | | | | |
| *18+ Years* | 57.6% | 56.9% | → | ★★ |
| ***Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication*** | | | | |
| *18–64 Years* | 80.8% | 85.3% | ↑ | ★★★★ |
| ***Care of Acute and Chronic Conditions*** | | | | |
| ***Controlling High Blood Pressure*** | | | | |
| *18–85 Years* | 54.3%[+] | 64.8%[+] | ↑ | ★★★ |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | | | | |
| *HbA1c Control (<8.0 %)—Total (18–75 Years)* | — | 62.7%[+] | — | ★★★★★ |

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)** | 38.0%+ | 29.9%+ | ↑ | ★★★★ |
| ***Pediatric Health*** | | | | |
| ***Oral Evaluation, Dental Services*** | | | | |
| *Total (0–20 Years)* [N] | — | 20.8% | — | — |
| ***Preventive Screening*** | | | | |
| ***Breast Cancer Screening*** | | | | |
| *Total (50–74 Years)* | 34.3% | 40.3% | ↑ | ★ |
| ***Cervical Cancer Screening*** | | | | |
| *Total (21–64 Years)* | 44.4%+ | 49.9%+ | ↑ | ★ |
| ***Appropriate Utilization of Services*** | | | | |
| ***Ambulatory Care*** | | | | |
| *Emergency Department (ED) Visits—Total (0–85+ Years)* [F] | 1,207.2 | 1,175.8 | — | — |
| ***Plan All-Cause Readmissions*** | | | | |
| *Observed Readmissions—Total (18–64 Years)* | 14.6% | 16.3% | ↓ | — |
| *Expected Readmissions—Total (18–64 Years)* | — | 12.4% | — | — |
| *Outlier Rate—Total (1–-64 Years)* | — | 114.4 | — | — |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)** | 1.2764 | 1.3174 | — | ★ |

* A lower rate indicates better performance for this measure.
+ Indicates the measure was reported using hybrid methodology.
# Caution should be considered when comparing CY 2021 to CY 2022 results as changes to the measure specifications occurred
Cells shaded green indicate that the rate met or exceeded the MY 2021 and/or MY 2022 and/or national Medicaid mean.
— Indicates a 2021–2022 comparison is not presented in the CYE 2023 Annual Technical Report because either the CY 2021 rate was not presented in the CYE 2022 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
[1] Aggregated rates were calculated and compared from CY 2021 to CY 2022, and comparisons were based on a Chi-square test of statistical significance with a p value of <0.01 due to large denominators.
↑ Indicates improvement of measure rates.
↓ Indicates decline of measure rates.
→ Indicates stable measure rates.
[2] Performance Levels for CY 2022 were based on comparisons of the HEDIS MY 2022 measure rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks.
Performance Levels for 2022 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile
[N] Measure has no NCQA Medicaid mean for comparison
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.

Table 6-4 highlights the RBHA/ACC-RBHA SMI-Designated Population Program Contractors' performance for the current year by measure group. The table illustrates the Contractors' CY 2022 measure rates and their performance relative to the NCQA national Medicaid Quality Compass HEDIS MY 2022 percentiles, where applicable. The performance level star ratings are defined as follows:

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

**Table 6-4—CY 2022 National Percentiles Comparison for the RBHA/ACC-RBHA SMI-Designated Population Program Contractors**

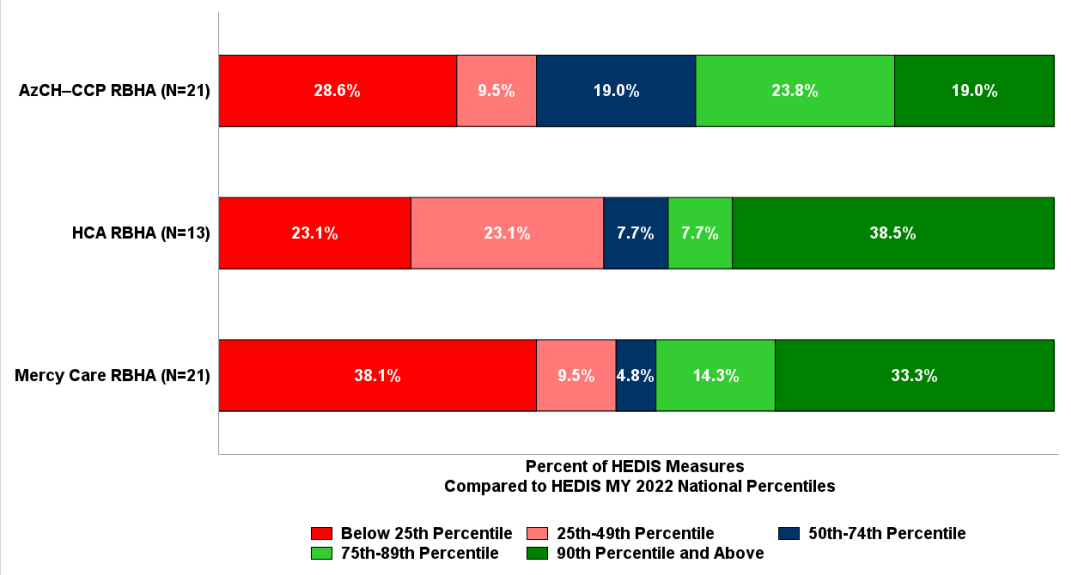
| Measure | AzCH–CCP ACC-RBHA | HCA RBHA | Mercy Care ACC-RBHA | ACC-RBHA Program Aggregate |
|---|---|---|---|---|
| ***Maternal and Perinatal Care*** | | | | |
| ***Prenatal and Postpartum Care*** | | | | |
| *Timeliness of Prenatal Care* | ★ | ★ | ★ | ★ |
| *Postpartum Care* | ★ | ★ | ★ | ★ |
| ***Behavioral Health*** | | | | |
| ***Antidepressant Medication Management*** | | | | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | ★★ | ★★ | ★ | ★ |
| *Effective Continuation Phase Treatment—Total (18+ Years)* | ★★★ | ★★ | ★ | ★★ |
| ***Follow-Up After ED Visit for Substance Use*** | | | | |
| *7-Day Follow-Up—Total* | ★★★★★ | ★★★★★ | ★★★★★ | ★★★★★ |
| *30-Day Follow-Up—Total* | ★★★★★ | ★★★★★ | ★★★★★ | ★★★★★ |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | ★★★★★ | ★★★★★ | ★★★★★ | ★★★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | ★★★★★ | ★★★★★ | ★★★★★ | ★★★★★ |
| ***Follow-Up After ED Visit for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | ★★★★ | ★★★★ | ★★★★ | ★★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | ★★★★ | ★★★★★ | ★★★★ | ★★★★ |
| ***Use of Opioids at High Dosage*** | | | | |
| *18+ Years* | ★ | NA++ | ★ | ★ |
| ***Initiation and Engagement of Substance Use Disorder (SUD)*** | | | | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | ★★★★ | ★★★ | ★★★★ | ★★★★ |

| Measure | AzCH–CCP ACC-RBHA | HCA RBHA | Mercy Care ACC-RBHA | ACC-RBHA Program Aggregate |
|---|---|---|---|---|
| *Engagement of SUD Treatment—Total—Total (13+ Years)* | ★★★ | ★★ | ★★ | ★★ |
| ***Adherence to Antipsychotic Medications for Individuals with Schizophrenia*** | | | | |
| *18+ Years* | ★★ | NA++ | ★★ | ★★ |
| ***Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*** | | | | |
| *18–64 Years* | ★★★★ | NA++ | ★★★★★ | ★★★★ |
| ***Care of Acute and Chronic Conditions*** | | | | |
| ***Controlling High Blood Pressure*** | | | | |
| *18–85 Years* | ★★★ | NA++ | ★★★ | ★★★ |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | | | | |
| *HbA1c Control (<8.0 %)—Total (18–75 Years)* | ★★★★ | NA++ | ★★★★★ | ★★★★★ |
| *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)* | ★★★ | NA++ | ★★★★★ | ★★★★ |
| ***Preventive Screening*** | | | | |
| ***Breast Cancer Screening*** | | | | |
| *Total (50–74 Years)* | ★ | NA++ | ★ | ★ |
| ***Cervical Cancer Screening*** | | | | |
| *Total (21–64 Years)* | ★ | NA++ | ★ | ★ |
| ***Appropriate Utilization of Services*** | | | | |
| ***Plan All-Cause Readmissions*** | | | | |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)* | ★ | ★ | ★ | ★ |

++ NA indicates the denominator was too small to report a valid rate, based on the applicable measure specification.

Figure 6-1 displays the RBHA/ACC-RBHA SMI-Designated Population Program Contractors' HEDIS MY 2022 performance compared to NCQA MY 2022 National Percentiles. HSAG analyzed results from 15 performance measures for HEDIS MY 2022 for a total of 21 measure rates.

**Figure 6-1—Comparison of Measure Rates to HEDIS Medicaid National Percentiles for RBHA/ACC-RBHA SMI-Designated Population Program Contractors**




## *Strengths and Opportunities for Improvement*

Table 6-5 presents program-level strengths and opportunities for improvement for RBHA/ACC-RBHA SMI-Designated Population Program as related to performance measures.

**Table 6-5—RBHA and ACC-RBHA Program Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| In the Behavioral Health measure group:<br>• The *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure rates for the Contractors (serving the SMI-Designated Population in CYE 2022) and the Program Aggregate rate met or exceeded the NCQA national Medicaid Quality Compass HEDIS MY 2022 90th percentile. These results may indicate that members enrolled with these Contractors may be receiving timely follow-up visits for substance use abuse or dependence after an ED visit. Timely follow-up care for individuals with substance use abuse or dependence who were seen in the ED is associated with a reduction in substance use and future ED use and hospital admissions, as well as a decrease in bed days.[6-2] **[Quality, Timeliness, Access]** |

[6-2] National Committee for Quality Assurance. Follow-Up After ED Visit for AOD Abuse or Dependence. Available at: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-alcohol-and-other-drug-abuse-or-dependence/. Accessed on: Feb 5, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| • The *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* measure rates for the Contractors (serving the SMI-Designated Population in CYE 2022) and the Program Aggregate rate met or exceeded the national Medicaid Quality Compass HEDIS MY 2022 75th percentile. These results may indicate that members may be receiving timely follow-up visits for mental illness after an ED visit. Research suggests that follow-up care for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function, and increased compliance with follow-up instructions.[6-3] **[Quality, Timeliness, Access]**<br>• The *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* measure rates for the Contractors (serving the SMI-Designated Population in CYE 2022) and the Program Aggregate rate met or exceeded NCQA national Medicaid Quality Compass HEDIS MY 2022 90th percentile. These results may indicate that members enrolled with these Contractors may be receiving timely follow-up visits with a mental health provider after inpatient discharge for a diagnosis of mental illness or intentional self-harm. Providing follow-up care to patients after a psychiatric hospitalization can improve patient outcomes and decrease the likelihood of rehospitalization and the overall cost of outpatient care.[6-4] **[Quality, Timeliness, Access]**<br>• For the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years* measure, the rates for two of the Contractors (serving the SMI-Designated Population in CYE 2022) and the Program Aggregate rate met or exceeded the NCQA national Medicaid Quality Compass HEDIS MY 2022 75th percentile. This performance indicates that members receiving antipsychotic medications for schizophrenia who were enrolled with these Contractors may be receiving diabetes screenings. Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health, quality of life, and economic outcomes downstream.[6-5] **[Quality, Timeliness, Access]** |
| In the Care of Acute and Chronic Conditions measure group:<br>• The rates for two of the Contractors (serving the SMI-Designated Population in CYE 2022) and the Program Aggregate rate met or exceeded the NCQA national Medicaid Quality Compass HEDIS MY 2022 75th percentile for the *Hemoglobin A1c Control for Patients With Diabetes —HbA1c Control (<8.0 %)—Total (18–75 Years)* measure rate. Based on evidence-based guidelines, high |

[6-3] National Committee for Quality Assurance Follow-Up After ED Visit for Mental Illness. Available at: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/. Accessed on: Feb 5, 2024.

[6-4] National Committee for Quality Assurance. Follow-Up After Hospitalization for Mental Illness. Available at https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/. Accessed on: Feb 5, 2024.

[6-5] National Committee for Quality Assurance. Diabetes and Cardiovascular Disease Screening and Monitoring for People With Schizophrenia or Bipolar Disorder. Available at: https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/. Accessed on: Feb 5, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| performance on this measure rate may indicate that members with diabetes may be able to manage their condition through the appropriate use of medications, diet and nutrition, or physical activity. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[6-6] **[Quality]** |
| **Opportunities for Improvement** |
| In the Maternal and Perinatal Care measure group, the rates for the Contractors (serving the SMI-Designated Population in CYE 2022) and the Program Aggregate rate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and also fell below the 25th percentile, indicating that not all women were having timely prenatal and postpartum care visits. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.[6-7] **[Quality, Timeliness, Access]**<br><br>Recommendation: While two of the Contractors (serving the SMI-Designated Population in CYE 2022) conducted a root cause analysis and implemented targeted interventions specific to their CY 2020 *Prenatal and Postpartum Care* rates, both of their *Timeliness of Prenatal Care* and *Postpartum Care* rates were low for CY 2021 and CY 2022. HSAG therefore recommends that these Contractors continue to implement appropriate interventions to improve performance relative to prenatal and postpartum care. HSAG also recommends that the Contractors continue to monitor and expand upon interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measures. |
| In the Behavioral Health measure group, two Contractors' (serving the SMI-Designated Population in CYE 2022) performance measure rates for *Use of Opioids at High Dosage—18+ Years* and the Program Aggregate rate remained below the 25th percentile. This result indicates a continued opportunity for these Contractors to monitor prescribing and utilization data and to implement interventions to improve care and services around opioid prescribing. The CDC guidelines on opioid prescribing for chronic, nonmalignant pain recommend the use of "additional precautions" when prescribing dosages ≥50 MED and recommend providers avoid or "carefully justify" increasing dosages ≥90 mg MED.[6-8] **[Quality]**<br><br>Recommendation: While two of the Contractors (serving the SMI-Designated Population in CYE 2022) conducted a root cause analysis and implemented interventions to determine why there was a higher proportion of members receiving prescriptions for opioids, their performance remained low |

[6-6] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Feb 5, 2024.
[6-7] National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/. Accessed on: Feb 5, 2024.
[6-8] National Committee for Quality Assurance. Use of Opioids at High Dosage (HDO). Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/. Accessed on: Jan 30, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| in CY 2022. HSAG therefore recommends that these Contractors continue to implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse. HSAG also recommends that Contractors (serving the SMI-Designated Population in CYE 2022) monitor and expand on interventions currently in place to improve performance related to the *Use of Opioids at High Dosage—18+ Years* measure. |
| In the Preventive Screening measure group:<br>• The rates for two Contractors (serving the SMI-Designated Population in CYE 2022) and the Program Aggregate rate for *Breast Cancer Screening—Total (50–74 Years)* fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and fell below the 25th percentile, indicating that not all women were receiving timely screening for breast cancer. Early detection reduces the risk of dying from this type of cancer and can lead to a greater range of treatment options and lower healthcare costs.[6-9] **[Quality]**<br>• The rates for two Contractors (serving the SMI-Designated Population in CYE 2022) and the Program Aggregate rate for *Cervical Cancer Screening—Total (21–64 Years)* fell below both the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and the 25th percentile, indicating that not all women were receiving timely screening for cervical cancer. Cervical cancer is one of the most common causes of cancer death for American women; effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate.[6-10] **[Quality]**<br><br>Recommendation: While these Contractors conducted a root cause analysis and implemented interventions specific to their CY 2020 *Breast Cancer Screening—Total (21–64 Years)* and *Cervical Cancer Screening—Total (21–64 Years)* rates, these rates remained low for both CY 2021 and CY 2022. HSAG therefore recommends that the Contractors (serving the SMI-Designated Population in CYE 2022) leverage the current PIP activities to continue to implement appropriate interventions to improve performance related to preventive screenings. HSAG also recommends that these Contractors monitor and expand on interventions currently in place to improve performance related to these measures. |
| In the Appropriate Utilization of Services measure group, the *Plan All-Cause Readmissions—O/E Ratio—Total—18-64 Years* measure rates for the Contractors (serving the SMI-Designated Population in CYE 2022) and the Program Aggregate rate fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022, indicating that some members experienced unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay. [**Quality**] |

[6-9] National Committee for Quality Assurance. Breast Cancer Screening (BCS). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Feb 5, 2024.
[6-10] National Committee for Quality Assurance. Cervical Cancer Screening (CCS). Available at: https://www.ncqa.org/hedis/measures/cervical-cancer-screening/. Accessed on: Feb 5, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| Recommendation: While these Contractors initiated efforts to identify best practices for reducing unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay, their rates remained below the 25th percentile for CY 2022. The Contractors also followed the recommendation of conducting a root cause analysis to identify factors contributing to members experiencing unplanned acute readmissions, which should include evaluating that appropriate follow-up care is available to members upon discharge from an acute inpatient admission or observation. However, HSAG recommends that these Contractors continue to follow through on these performance improvement strategies in order to increase provider and member outreach and improve follow-up care after discharge from an acute inpatient admission or observation. |
| For CY 2022 performance measure reporting, race and ethnicity stratifications (RES) were required based on NCQA HEDIS specifications. While HSAG did not identify Contractor-specific opportunities to improve RES, all Contractors (serving the SMI-Designated population in CYE 2022) could benefit from continuing to focus on refining RES reporting where required per measure specifications. **[Quality]**<br><br>Recommendation: HSAG recommends that the Contractors (serving the SMI-Designated population in CYE 2022) explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratifications related to RES. The Contractors should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information. |

# Validation of Performance Improvement Projects

## Preventive Screening PIP

Breast cancer is the most common female cancer in the United States for every major ethnic group, the second most common cause of cancer death in women,[6-11] and accounts for 15 percent of all new cancer diagnoses in the U.S.[6-12] Ensuring that all women receive regular breast cancer screening is critically important in disease prevention, early detection, and treatment. In 2019, an estimated 268,600 new cases of invasive breast cancer will be diagnosed among women.[6-13] Breast cancer screening for women is aimed at identifying breast abnormalities as early as possible, and ideally, before warning signs or symptoms are present when the chances of survival are the highest. Approximately 1 in 8 women (13

[6-11] Jemal A, Siegel R, Ward E, et al. Cancer Statistics, 2009. *CA: A Cancer Journal for Clinicians*. 2009 Jul-Aug;59(4):225-49. Epub 2009 May 27.
[6-12] Howlader N, Noone AM, Krapcho M, Miller D, Brest A, Yu M, Ruhl J, Tatalovich Z, Mariotto A, Lewis DR, Chen HS, Feuer EJ, Cronin KA (eds). SEER Cancer Statistics Review, 1975-2016, National Cancer Institute. Bethesda, MD; 2016.
[6-13] American Cancer Society. Breast Cancer Facts & Figures 2019-2020. Atlanta: American Cancer Society, Inc. 2019.

percent) will be diagnosed with invasive breast cancer in their lifetime and 1 in 39 women (3 percent) will die from breast cancer.[6-14]

Breast cancer is most frequently diagnosed among women ages 55–64 with the median age of diagnosis at 62 years of age[6-11] While there are other factors that affect a woman's risk of developing breast cancer, age is a primary risk factor. By age 40, the chances are 1 in 68; by age 50 it becomes 1 in 43; by age 60, it is 1 in 29.[6-15] Even if breast cancer incidences cannot be substantially reduced for some women who are at high risk for developing the disease, the risk of death from breast cancer can be reduced by regular screening.

Cervical cancer is a type of cancer that occurs in the cells of the cervix. All women are at risk for cervical cancer; however, it occurs most often in women over age 30.[6-16] According to the American Cancer Society, in the United States for 2020, about 13,800 new cases of invasive cervical cancer will be diagnosed and about 4,290 women will die from the disease.[6-17] The risk of developing cervical cancer can be reduced by having screening tests and receiving a vaccine that protects against human papillomavirus (HPV) infection. Women who smoke, had many children, used birth control pills for a long time, or have a human immunodeficiency virus (HIV) infection are at higher risk. Cervical cancer used to be the leading cause of cancer death for women in the United States. However, in the past 40 years, the number of cases and the number of deaths from cervical cancer have decreased significantly due to women getting screened regularly. The HPV vaccine protects against the types of HPV that most often cause cervical, vaginal, and vulvar cancers. However, the most important thing someone can do to help prevent cervical cancer is to have regular screenings starting at the age of 21.

Between 30–50 percent of all cancer cases are preventable.[6-18] Breast and cervical cancer screenings increase the chances of detecting certain cancers early, when they might be easier to treat. Prevention offers the most cost effective long-term strategy for the control of cancer. Policies, programs, and projects should be implemented to raise awareness, to reduce exposure to cancer risk factors, and to ensure that individuals are provided with the information and support needed to participate in preventive screenings.

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

[6-14] Howlader N, Noone AM, Krapcho M, et al., eds. SEER Cancer Statistics Review, 1975-2016. Bethesda, MD: National Cancer Institute; 2019.
[6-15] National Business Group on Health. 2011. "Pathways to Managing Cancer in the Workplace." (May 8, 2012).
[6-16] Centers for Disease Control and Prevention. (2019, October 18). National Breast and Cervical Cancer Early Detection Program. Available at: https://www.cdc.gov/cancer/nbccedp/about.htm. Accessed on: Feb 8, 2024.
[6-17] Fontham ETH, Wolf AMD, Church TR, et al. Cervical Cancer Screening for Individuals at Average Risk: 2020 Guideline Update from the American Cancer Society. *CA Cancer J Clin*. 2020. Available at: https://doi.org/10.3322/caac.21628. Accessed on: Feb 8, 2024.
[6-18] World Health Organization. (2007). Cancer. Available at: https://www.who.int/cancer/prevention/en/. Accessed on: Feb 8, 2024.

## RBHA/ACC-RBHA Program-Level Validation Results

Table 6-6 displays the overall confidence levels for the RBHA/ACC-RBHA Program *Preventive Screening* PIP.

**Table 6-6—RBHA/ACC-RBHA Program *Preventive Screening* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| AzCH-CCP ACC-RBHA | *High Confidence* | 100% | 100% | *Low Confidence* | 33% | 100% |
| HCA RBHA | *High Confidence* | 100% | 100% | *Not Assessed* | *Not Assessed* | *Not Assessed* |
| Mercy Care ACC-RBHA | *High Confidence* | 100% | 100% | *Moderate Confidence* | 33% | 100% |

## RBHA/ACC-RBHA Program-Level Measure Results

Table 6-7 and Table 6-8 provide the *Preventive Screening* PIP baseline, intervention, and Remeasurement Year 1 rates for each RBHA/ACC-RBHA Program Contractor.

**Table 6-7—RBHA/ACC-RBHA Program Contractor' *Preventive Screening* PIP Comparative Rates for Indicator 1**

| Contractor | PIP Indicator 1: *Breast Cancer Screening* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| AzCH-CCP ACC-RBHA | 38.5% | 39.1% |
| HCA RBHA | 36.6% | Not Applicable |
| Mercy Care ACC-RBHA | 35.8% | 41.1% |

**Table 6-8—RBHA/ACC-RBHA Program Contractor' *Preventive Screening* PIP Comparative Rates for Indicator 2**

| Contractor | PIP Indicator 2: *Cervical Cancer Screening* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| AzCH-CCP ACC-RBHA | 43.9% | 36.7% |
| HCA RBHA | 41.0% | Not Applicable |
| Mercy Care ACC-RBHA | 43.5% | 37.4% |

## RBHA/ACC-RBHA Program-Level Interventions

For the *Preventive Screening* PIP, all Contractors provided lists of interventions that were in place for this validation cycle. These lists detailed the identified population, the intervention(s) in place, and whether or not the intervention(s) will be continued. The most common interventions across the RBHA/ACC-RBHA Program Contractors included targeting members and providers for outreach and education related to breast cancer screenings and cervical cancer screenings. Outreach methods included IVR, person-to-person, and automated phone calls; text message campaigns; emails; and letters and other mailing materials. Provider and member incentives were used as well as mobile services. Gap in care reports including supplemental data for providers identified members in need of screenings. These interventions may impact indicator performance, which will be evaluated during the next validation cycle. For further descriptions of each Contractor's interventions, see Section 7. RBHA/ACC-RBHA SMI-Designated Population Program Contractor-Specific Results.

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

Table 6-9 presents program-level strengths, opportunities for improvement, and recommendations for the RBHA/ACC-RBHA Program related to the *Preventive Screening* PIP.

**Table 6-9—RBHA/ACC-RBHA Program Strengths, Opportunities for Improvement, and Recommendations Related to the *Preventive Screening* PIPs**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG noted that at the program-level, each of the Contractors (serving the SMI-Designated Population in CYE 2022) performed accurate statistical testing between the baseline and Remeasurement 1 results. **[Quality, Access]**<br><br>RBHA/ACC-RBHA Program Contractors developed and implemented measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 2. **[Quality, Access]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Opportunities for Improvement and Recommendations** |
| Contractor's (serving the SMI-Designated Population in CYE 2022) indicator 2 rates demonstrated a decline compared to baseline indicator rates at Remeasurement 1. **[Quality, Access]**<br><br>Recommendation: To support successful progression of the PIPs in the next calendar year, HSAG recommends that the Contractors:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

## *Prenatal and Postpartum Care PIP*

According to the CDC, at least 50,000 women in the United States are affected by severe morbidity due to unexpected pregnancy-related health problems. In addition, more than 700 women die each year from pregnancy-related problems or delivery complications. Racial disparities exist among pregnancy-related deaths, as the CDC reports, "American Indian, Alaska Native, and Black women are two to three times more likely to die of pregnancy-related causes than White women."[6-19] Every death related to pregnancy is a tragedy, especially considering the CDC found that four in five of the deaths are preventable.[6-20]

According to Healthy People 2030, "women's health before, during, and after pregnancy can have a major impact on infants' health and well-being."[6-21] Strategies, such as maintaining a healthy lifestyle, receiving proper health care, and adopting healthy habits before and during pregnancy help prevent pregnancy complications and improve health outcomes for women and their babies. In addition, these strategies may assist in promoting infant health, development, and overall well-being.

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Prenatal and Postpartum Care* PIP for the ACC-RBHA population. The objective of the *Prenatal and Postpartum Care* PIP is to improve health outcomes for members and infants. This PIP focuses on increasing the number and percentage of members with live birth deliveries that 1) received a prenatal care visit, and 2) received a postpartum visit.

[6-19] Centers for Disease Control and Prevention. Hear Her Campaign. Pregnancy-Related Deaths in the United States. Available at: Pregnancy-Related Deaths in the United States | CDC. Accessed on: Feb 7, 2024.
[6-20] Ibid.
[6-21] U.S. Department of Health and Human Services. Healthy People 2030. Pregnancy and Childbirth. Available at: https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth#:~:text=Women's%20health%20before%2C%20during%2C%20and%20after%20pregnancy%20can%20have%20a,and%20to%20have%20healthy%20babies. Accessed on: Feb 7, 2024.

## ACC-RBHA Program-Level Validation Results

Table 6-10 displays the overall confidence levels for the ACC-RBHA Program for the *Prenatal and Postpartum Care* PIP.

**Table 6-10—ACC-RBHA Program *Prenatal and Postpartum* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| AzCH-CCP ACC-RBHA | *High Confidence* | 100% | 100% | *Not Assessed* | *Not Assessed* | *Not Assessed* |
| Mercy Care ACC-RBHA | *High Confidence* | 100% | 100% | *Not Assessed* | *Not Assessed* | *Not Assessed* |

## ACC-RBHA Program-Level Measure Results

Table 6-11 and Table 6-12 present indicator rates for each Contractor for the *Prenatal and Postpartum Care* PIP during the baseline year, intervention years, and Remeasurement Year 1.

**Table 6-11—ACC-RBHA Program Contractor *Prenatal and Postpartum Care* PIP Comparative Rates for Indicator 1**

| Contractor | PIP Indicator 1: *Timeliness of Prenatal Care* |
|---|---|
| | Baseline Year |
| | CY 2022 |
| AzCH-CCP ACC-RBHA | 71.4% |
| Mercy Care ACC-RBHA | 78.6% |

**Table 6-12—ACC-RBHA Program Contractor *Prenatal and Postpartum Care* PIP Comparative Rates for Indicator 2**

| Contractor | PIP Indicator 2: *Postpartum Care* |
|---|---|
| | Baseline Year |
| | CY 2022 |
| AzCH-CCP ACC-RBHA | 54.1% |
| Mercy Care ACC-RBHA | 73.6% |

## ACC-RBHA Program-Level Interventions

For the Prenatal and Postpartum Care PIP, all Contractors provided lists of interventions that were in place for this validation cycle. These lists detailed the identified population, the intervention(s) in place, and whether or not the intervention(s) will be continued. The most common interventions across the ACC-RBHA Program Contractors included targeting members and providers for outreach and education related to prenatal and postpartum visits. Outreach methods included person-to-person phone calls; text message campaigns; a mobile application; a Web portal; emails; and letters and other mailing materials. Provider and member incentives were used. Gap in care and notification of pregnancy reports for providers/strategic partners identified members in need of prenatal and postpartum visits. These interventions may impact indicator performance, which will be evaluated during the next validation cycle. For further descriptions of each Contractor's interventions, see Section 7. RBHA/ACC-RBHA SMI-Designated Population Program Contractor-Specific Results.

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

Table 6-13 presents program-level strengths, opportunities for improvement, and recommendations for the ACC-RBHA Program related to the *Prenatal and Postpartum Care* PIP.

**Table 6-13—ACC-RBHA Program Strengths, Opportunities for Improvement, and Recommendations Related to *Prenatal and Postpartum Care* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| Each of the Contractors (serving the SMI-Designated Population in CYE 2022) developed and implemented measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 1. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| There were no opportunities for improvement identified for the ACC-RBHA Program Contractors.<br><br>Recommendations: Although there were no opportunities for improvement identified for the Contractors (serving the SMI-Designated Population in CYE 2022), as the PIP progresses, HSAG recommends that the Contractors:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

## Compliance Reviews

AHCCCS includes the following Focus Areas in its compliance review activity. Table 6-14 presents the Focus Areas, including each associated acronym, used by AHCCCS during its compliance review.

**Table 6-14—Focus Areas and Associated Acronyms**

| Focus Area | Acronym |
|---|---|
| Corporate Compliance | CC |
| Claims and Information Standards | CIS |
| Delivery Systems | DS |
| General Administration | GA |
| Grievance Systems Focus Area | GS |
| Adult, EPSDT, and Maternal Child Health | MCH |
| Medical Management | MM |
| Member Information | MI |
| Quality Management | QM |
| Quality Improvement | QI |
| Division of Grant Administration | DGA |
| Reinsurance | RI |
| Third-Party Liability | TPL |
| Integrated Systems of Care | ISOC |

### *RBHA/ACC-RBHA Program-Level Results*

AHCCCS conducts a full compliance review for each Contractor every three years. In CYE 2021, AHCCCS conducted a compliance review for HCA RBHA. In CYE 2023, AHCCCS approved and closed HCA RBHA's CAPs. Results and CAP updates for HCA RBHA are available in Section 7. RBHA/ACC-RBHA SMI-Designated Population Program Contractor-Specific Results. In November 2021, AHCCCS awarded ACC-RBHA contracts to AzCH-CCP, Care 1st, and Mercy Care, expanding the current RBHA contract. As a result, AHCCCS conducted an extensive readiness review process during CYE 2022. Table 6-15 presents results for HCA RBHA for compliance reviews based on the review of all Focus Areas conducted in CYE 2021. The ACC-RBHA contracts went into effect on October 1, 2022. Compliance reviews will be conducted in CYE 2024 and will therefore be included in the CYE 2024 annual technical report.

**Table 6-15—RBHA/ACC-RBHA Program-Level Compliance Review Results**

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

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

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

Table 6-16 presents program-level strengths, opportunities for improvement, and recommendations for the RBHA/ACC-RBHA Program related to compliance.

**Table 6-16—RBHA/ACC-RBHA Program Strengths, Opportunities for Improvement, and Recommendations Related to Compliance**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| The compliance reviews for ACC-RBHA Program Contractors are scheduled for CYE 2024. |
| **Opportunities for Improvement and Recommendations** |
| The RBHA Program ended September 30, 2022. The compliance reviews for ACC-RBHA Program Contractors are scheduled for CYE 2024. |

# Network Adequacy Validation

## ACC-RBHA Program-Level Results

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

Table 6-17 summarizes HSAG's assessment of each ACC-RBHA Program Contractor's compliance with AHCCCS' minimum time/distance network standards. A check mark indicates that the ACC-RBHA Program Contractor met the minimum network standard for all assigned counties during the biannual assessment, and an "X" indicates that the ACC-RBHA Program Contractor failed to meet one or more minimum network standards in any assigned county or quarter. Section 7. RBHA/ACC-RBHA SMI-Designated Population Program Contractor-Specific Results contains NAV results specific to each Contractor and semiannual validation period.

**Table 6-17—Summary of CYE 2023 Compliance with Minimum Time/Distance Network Requirements for ACC-RBHA Program Contractors**

| Minimum Network Requirement | AzCH-CCP ACC-RBHA | Care 1st ACC-RBHA | Mercy Care ACC-RBHA |
|---|---|---|---|
| Behavioral Health Outpatient and Integrated Clinic, Adult | ✓ | ✓ | ✓ |
| BHRF (Only Maricopa and Pima Counties) | ✓ | NA | ✓ |
| Cardiologist, Adult | ✓ | ✓ | ✓ |
| Cardiologist, Pediatric | ✓ | ✓ | ✓ |
| Crisis Stabilization Facility | ✓ | ✓ | ✓ |
| Dentist, Pediatric | X | ✓ | X |
| Hospital | ✓ | ✓ | ✓ |
| OB/GYN | ✓ | ✓ | ✓ |
| Pharmacy | ✓ | ✓ | ✓ |
| PCP, Adult | ✓ | ✓ | ✓ |
| PCP, Pediatric | X | ✓ | ✓ |

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

The ACC-RBHA Program Contractors met the Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult and Pediatric; Crisis Stabilization Facility; Hospital; OB/GYN; PCP, Adult; and Pharmacy standards while not consistently meeting standards for Dentist, Pediatric and PCP, Pediatric.

Isolated data issues may have contributed to specific instances affecting Contractors' (serving the SMI-Designated Population in CYE 2023) compliance with time/distance standards. Specific examples include the following:

- In CYE 2023 Q4, one of the Contractor's data included substantially increased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; Cardiologist, Adult and Pediatric; Crisis Stabilization Facility; OB/GYN; and PCP, Adult and Pediatric. This potentially influenced the validated compliance for these provider types. The Contractor reported the increase was due to revisions in its extract file creating the PAT file that included all active provider addresses.
- In CYE 2023 Q2, one of the Contractor's data included decreased numbers of providers used to measure the Dentist, Pediatric standard. This influenced the validated compliance for this provider type. The error occurred because this Contractor's file from its dental benefit's manager was not correctly reporting the entire network for its ACC-RBHA Program. The Contractor identified the cause and successfully tested the solution.

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

Overall, the applicable ACC-RBHA Program Contractors met all minimum time/distance network standards during both quarters in Apache, Cochise, Coconino, Greenlee, La Paz, Maricopa, Mohave, Navajo, Pima, Pinal, Yavapai, and Yuma counties. Based on the semiannual NAV results, none of the ACC-RBHA Program Contractors met all requirements for all standards and quarters in their respective counties.

Each ACC-RBHA Program Contractor should continue to monitor and maintain its existing provider network as of CYE 2023 Q4, with specific attention to ensuring the availability of the following provider types among the applicable ACC-RBHA Program Contractors:

- Dentist, Pediatric in Santa Cruz County

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

Table 6-18 presents program-level strengths, opportunities for improvement, and recommendations for the ACC-RBHA Program related to NAV.

**Table 6-18—ACC-RBHA Program Strengths, Opportunities for Improvement, and Recommendations Related to NAV**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths:<br>• Each of the applicable Contractors (serving the SMI-Designated Population in CYE 2023) met all minimum time/distance network standards during both quarters in Apache, Cochise, Coconino, Greenlee, La Paz, Maricopa, Mohave, Navajo, Pima, Pinal, Yavapai, and Yuma counties. **[Access]**<br>• Each of the Contractors (serving the SMI-Designated Population in CYE 2023) consistently met the Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult and Pediatric; Crisis Stabilization Facility; Hospital; OB/GYN; PCP, Adult; and Pharmacy standards. **[Access]** |
| **Opportunities for Improvement and Recommendations** |
| HSAG identified the following opportunities for improvement:<br>• Isolated data issues may have contributed to specific instances affecting ACC-RBHA Program Contractors' compliance with time/distance standards. **[Access]**<br>• Not all ACC-RBHA Program Contractors consistently met the standards for Dentist, Pediatric in Santa Cruz County. **[Access]**<br><br>Recommendations:<br>• HSAG recommends that AHCCCS support the Contractors (serving the SMI-Designated Population in CYE 2023) in continuing to monitor their processes for creating the PAT file and to review the PAT file for accuracy prior to submitting to AHCCCS.<br>• HSAG recommends that AHCCCS support each Contractor (serving the SMI-Designated Population in CYE 2023) in continuing to monitor and maintain its existing provider network coverage as of CYE 2023 Q4, with specific attention to ensuring the availability of the following provider types among the applicable ACC-RBHA Program Contractors:<br>– Dentist, Pediatric in Santa Cruz County |

# 7. RBHA/ACC-RBHA SMI-Designated Population Program Contractor-Specific Results

RBHA and ACC-RBHA Contractors are responsible for the provision of services for the SMI-Designated Population.

This section provides, by RBHA and ACC-RBHA Contractor, activity-specific strengths, opportunities for improvement, and HSAG's recommendations for performance improvement. This section also includes information about the extent to which each Contractor was able to address the prior year's recommendations for each activity, as applicable. Since the HCA RBHA contract ended September 30, 2022, recommendations for improvement and follow-up to prior year's recommendations for HCA RBHA are not provided.

## AzCH-CCP ACC-RBHA

### *Validation of Performance Measures*

#### Results for Information Systems Standards Review

During CYE 2023, HSAG evaluated AzCH-CCP ACC-RBHA's data system for processing of each data type used for reporting the Contractor's CY 2022 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that AzCH-CCP ACC-RBHA followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 7-1 displays HSAG's PMV findings for each data type reviewed during CYE 2023 in alignment with the CMS EQR Protocol 2 audit requirements.

**Table 7-1—CYE 2023 PMV Findings**

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

## Results for Performance Measures

Table 7-2 presents the CY 2021 and CY 2022 AzCH-CCP ACC-RBHA results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and MY 2022. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and/or MY 2022. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

**Table 7-2—AzCH-CCP ACC-RBHA CY 2021 and CY 2022 Performance Measure Results**

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| ***Maternal and Perinatal Care*** | | | | |
| ***Prenatal and Postpartum Care*** | | | | |
| *Timeliness of Prenatal Care* [#] | 73.5%+ | 71.4%+ | → | ★ |
| *Postpartum Care* | 59.0%+ | 54.1%+ | → | ★ |
| ***Behavioral Health*** | | | | |
| ***Antidepressant Medication Management*** | | | | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | 60.9% | 60.5% | → | ★★ |
| *Effective Continuation Phase Treatment—Total (18+ Years)* | 46.2% | 44.1% | → | ★★★ |
| ***Follow-Up After ED Visit for Substance Use*** | | | | |
| *7-Day Follow-Up—Total* | — | 61.9% | — | ★★★★★ |
| *30-Day Follow-Up—Total* | — | 73.4% | — | ★★★★★ |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 49.9% | 61.3% | ↑ | ★★★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 73.6% | 79.3% | ↑ | ★★★★★ |
| ***Follow-Up After ED Visit for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 55.4% | 54.0% | → | ★★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 71.6% | 70.9% | → | ★★★★ |
| ***Use of Opioids at High Dosage*** | | | | |
| *18+ Years** | 11.3% | 12.3% | → | ★ |
| ***Initiation and Engagement of Substance Use Disorder (SUD) Treatment*** | | | | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | — | 54.2% | — | ★★★★ |
| *Engagement of SUD Treatment—Total—Total (13+ Years)** | — | 17.0% | — | ★★★ |
| ***Adherence to Antipsychotic Medications for Individuals with Schizophrenia*** | | | | |
| *18+ Years* | 59.6% | 58.5% | → | ★★ |

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| ***Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication*** | | | | |
| *18–64 Years* | 77.5% | 82.7% | ↑ | ★★★★ |
| ***Care of Acute and Chronic Conditions*** | | | | |
| ***Controlling High Blood Pressure*** | | | | |
| *18–85 Years* | 51.6%+ | 64.5%+ | ↑ | ★★★ |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | | | | |
| *HbA1c Control (<8.0 %)—Total (18–75 Years)* | — | 57.7%+ | — | ★★★★ |
| *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)** | 46.0%+ | 35.8%+ | ↑ | ★★★ |
| ***Pediatric Health*** | | | | |
| ***Oral Evaluation, Dental Services*** | | | | |
| *Total (0–20 Years)* [N] | — | 24.1% | — | — |
| ***Preventive Screening*** | | | | |
| ***Breast Cancer Screening*** | | | | |
| *Total (50–74 Years)* | 36.2% | 39.1% | ↑ | ★ |
| ***Cervical Cancer Screening*** | | | | |
| *21–64 Years* | 47.7%+ | 49.9%+ | → | ★ |
| ***Appropriate Utilization of Services*** | | | | |
| ***Ambulatory Care*** | | | | |
| *Emergency Department (ED) Visits—Total (0–85+ Years)* [F] | 1,171.7 | 1,161.0 | — | — |
| ***Plan All-Cause Readmissions*** | | | | |
| *Observed Readmissions—Total (18–64 Years)* | 14.2% | 19.6% | ↓ | — |
| *Expected Readmissions—Total (18–64 Years)* | — | 14.6% | — | — |
| *Outlier Rate—Total (18–64 Years)* | — | 115.6 | — | — |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)** | 1.2643 | 1.3425 | — | ★ |

* A lower rate indicates better performance for this measure.
+ Indicates the measure was reported using hybrid methodology.
# Caution should be considered when comparing CY 2021 to CY 2022 results as changes to the measure specifications occurred.
Cells shaded green indicate that the rate met or exceeded the MY 2021 and/or MY 2022 national Medicaid mean.
[1] Indicates a 2021–2022 comparison is not presented in the CYE 2023 Annual Technical Report because either there was a break in trending, the CY 2021 rate was not presented in the CYE 2022 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
↑ Indicates improvement of measure rates.
↓ Indicates decline of measure rates.
→ Indicates stable measure rates.

[2]Performance Levels for CY 2022 were based on comparisons of the HEDIS MY 2022 measure rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks.
Performance Levels for 2022 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile
[N] Measure has no NCQA Medicaid mean for comparison.
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.

## Strengths, Opportunities for Improvement, and Recommendations

Table 7-3 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC-RBHA related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 7-3—AzCH-CCP ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| In the Behavioral Health measure group:<br>• Ten of 13 (76.9 percent) AzCH-CCP ACC-RBHA measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. **[Quality, Timeliness, Access]**<br>• AzCH-CCP ACC-RBHA's performance measure rates for *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*, *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years), Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)*, as well as *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* were at or above the 75th percentile, indicating strength in providing follow-up behavioral healthcare to members. **[Quality, Timeliness, Access]**<br><br>In the Care of Acute and Chronic Conditions measure group:<br>• All three (100.0 percent) of AzCH-CCP ACC-RBHA's measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. **[Quality]**<br>• AzCH-CCP ACC-RBHA's performance measure rate for *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 %)—Total (18–75 Years)* was at or above the 75th percentile, indicating strength in providing follow-up care of acute and chronic conditions to members. **[Quality]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Opportunities for Improvement and Recommendations** |
| While AzCH-CCP ACC-RBHA was successful in reporting valid rates for all AHCCCS-required performance measures for its RBHA population, the audit identified some considerations and recommendations for future years' reporting. **[Quality]**<br><br>Recommendations:<br>• HSAG recommends that AzCH-CCP ACC-RBHA continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes AHCCCS' requirements for Contractor-enrolled members who switch product lines or Contractors and members for whom AzCH-CCP ACC-RBHA does not hold the primary insurance contract.<br>• AzCH-CCP ACC-RBHA had some difficulty reconciling the reported rates for measures with additional stratification, such as age groups for *Follow-Up After ED Visit for Substance Use*. This was due to timing of when rates were initially calculated by the Contractor's corporate team, and then reported out with revised rate runs later in the year. HSAG therefore recommends that AzCH-CCP ACC-RBHA ensure subpopulations are totaled to reflect the full population and conduct live system validation of data after its vendor's first run of MY 2023 rates, prior to reporting any performance measure data to AHCCCS.<br>• HSAG also recommends that AzCH-CCP ACC-RBHA continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race and ethnicity data to support performance measure reporting that requires stratification related to race and ethnicity. HSAG recommends that AzCH-CCP ACC-RBHA continue to ensure that the mapping of provider specialties to HEDIS provider types is compliant with AHCCCS' requirements for PMV reporting. |
| In the Maternal and Perinatal Care measure group, AzCH-CCP ACC-RBHA's performance measure rates for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* remain below the 25th percentile, indicating continued opportunity to increase access to timely prenatal and postpartum care. **[Quality, Timeliness, Access]**<br><br>Recommendation: While AzCH-CCP ACC-RBHA conducted a root cause analysis and implemented targeted interventions specific to the CY 2020 *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* rates, these rates remained low for both CY 2021 and CY 2022. HSAG therefore recommends that AzCH-CCP ACC-RBHA continue to implement appropriate interventions to improve performance relative to prenatal and postpartum care. HSAG also recommends that AzCH-CCP ACC-RBHA continue to monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measures. |
| In the Behavioral Health measure group, AzCH-CCP ACC-RBHA's performance measure rate for *Use of Opioids at High Dosage—18+ Years* remains below the 25th percentile. This result indicates a continued opportunity for AzCH-CCP ACC-RBHA to monitor prescribing and utilization data and to |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| implement interventions to improve care and services around opioid prescribing. The CDC guidelines on opioid prescribing for chronic, nonmalignant pain recommend the use of "additional precautions" when prescribing dosages ≥50 MED and recommend providers avoid or "carefully justify" increasing dosages ≥90 mg MED.[7-1] **[Quality]**<br><br>Recommendation: While AzCH-CCP ACC-RBHA conducted a root cause analysis and implemented interventions to determine why there was a higher proportion of members receiving prescriptions for opioids, performance remained below the 25th percentile in CY 2022. HSAG therefore recommends that AzCH-CCP ACC-RBHA continue to implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse. HSAG also recommends that AzCH-CCP ACC-RBHA monitor and expand on interventions currently in place to improve performance related to the *Use of Opioids at High Dosage—18+ Years* measure. |
| In the Preventive Screening measure group, AzCH-CCP ACC-RBHA's performance measure rates for *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* remain below the 25th percentile, indicating that not all women were receiving timely screening for breast and cervical cancers. Early detection reduces the risk of dying from these types of cancers and can lead to a greater range of treatment options and lower healthcare costs.[7-2] **[Quality]**<br><br>Recommendation: While AzCH-CCP ACC-RBHA conducted a root cause analysis and implemented interventions specific to the CY 2020 *Breast Cancer Screening* and *Cervical Cancer Screening* rates, these rates remained low for both CY 2021 and CY 2022. HSAG therefore recommends that AzCH-CCP ACC-RBHA continue to implement appropriate interventions to improve performance related to preventive screenings. HSAG also recommends that AzCH-CCP ACC-RBHA monitor and expand on interventions currently in place to improve performance related to the *Breast Cancer Screening* and *Cervical Cancer Screening* measures. |
| In the Appropriate Utilization of Services measure group, AzCH-CCP ACC-RBHA's performance measure rates for *Plan All-Cause Readmissions O/E Ratio—Total (18–64 Years)* remained below the 25th percentile. **[Quality]**<br><br>Recommendation: While AzCH-CCP ACC-RBHA initiated efforts to identify best practices for reducing unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay, its rates remained below the 25th percentile for CY 2022. AzCH-CCP ACC-RBHA also followed the recommendation of conducting a root cause analysis to identify factors contributing to members experiencing unplanned acute readmissions, which should include |

[7-1] National Committee for Quality Assurance. Use of Opioids at High Dosage (HDO). Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/. Accessed on: Jan 30, 2024.

[7-2] National Committee for Quality Assurance. Breast Cancer Screening (BCS). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Jan 30, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| evaluating that appropriate follow-up care is available to members on discharge from an acute inpatient admission or observation. HSAG recommends that AzCH-CCP ACC-RBHA continue to follow through on these performance improvement strategies in order to increase provider and member outreach and improve follow-up care after discharge from an acute inpatient admission or observation. |

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

Table 7-4 presents performance measure recommendations made to AzCH-CCP RBHA in the CYE 2022 Annual Technical Report[7-3] and AzCH-CCP ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which AzCH-CCP ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 7-4—AzCH-CCP ACC-RBHA Follow-Up to CYE 2022 Performance Measure Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| **Recommendation 1:** |
| HSAG recommended that AzCH-CCP RBHA continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. Additionally, HSAG recommended that AzCH-CCP RBHA continue to conduct a formal review of its source code followed by a complete test plan, including live system validation of data, prior to reporting any performance measure data. |
| **AzCH-CCP ACC-RBHA's Response:**<br>AzCH-CCP RBHA is continuing to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting.<br><br>AzCH-CCP RBHA is continuing to conduct and complete formal reviews of the source code, including a complete test plan, live system validation of data, and correction of any discrepancies identified. |
| **HSAG's Assessment:** HSAG has determined that AzCH-CCP ACC-RBHA has satisfactorily addressed these prior year's recommendations. |
| **Recommendation 2:** |

[7-3] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for Regional Behavioral Health Authorities. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportRBHA.pdf. Accessed on: Jan 30, 2024.

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| HSAG recommended that AzCH-CCP RBHA explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratifications related to race and ethnicity. AzCH-CCP RBHA should continue working with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information. |
| **AzCH-CCP ACC-RBHA's Response:**<br>AzCH-CCP RBHA's corporate partner has implemented software which predicts indirect cultural data for adult members with 99% accuracy. This assists AzCH-CCP RBHA in providing additional data sources for the capture of race and ethnicity data.<br><br>AzCH-CCP RBHA participates in the Arizona Health Improvement Plan (AzHIP) Data Advisory Committee where one of the focuses is gathering cultural data and identifying additional sources and opportunities as well as in the AHCCCS TI 2.0 Workgroup whose current focus is on health equity. |
| **HSAG's Assessment:** HSAG has determined that AzCH-CCP ACC-RBHA has satisfactorily addressed these prior year's recommendations; however, AzCH-CCP ACC-RBHA should continue working with AHCCCS on collaborative efforts to improve the capture of race and ethnicity data to support performance measure reporting that requires stratification related to race and ethnicity. |
| **Recommendation 3:** |
| While AzCH-CCP RBHA conducted a root cause analysis and implemented targeted interventions specific to the CY 2020 *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* rates, these rates remained low in CY 2021. HSAG therefore recommended that AzCH-CCP RBHA continue to implement appropriate interventions to improve performance relative to prenatal and postpartum care. HSAG also recommended that AzCH-CCP RBHA monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measures. |
| **AzCH-CCP ACC-RBHA's Response:**<br>AzCH-CCP RBHA's performance measure rate for *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, indicating an opportunity to increase access to timely postpartum care. AzCH-CCP RBHA conducted a root cause analysis that focused on increasing access to postpartum care by identifying those barriers, such as collaboration with providers and the health plan, successful communication with members, and effective gap lists.<br><br>In response to identified barriers, the following interventions were implemented:<br>• Start Smart for Your Baby (SSFB) effectively educates and encourages members via text messaging and emails. In CY 2022 a total of 3,555 members were enrolled.<br>• The PPC Provider Form supplies providers with educational material and engages providers for education, technical assistance, and performance improvement. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| • Implementation of a mobile application that provides a specialized care plan for members with tailored daily health checklists, provides alerts, care gaps, and progress tracking to CMS, and allows for two-way video/text communication with Care Management.<br>• Weekly Newborn Calls outreach to birthing parents to educate and assist with scheduling postpartum appointments. In CY 2022, 6,128 calls were attempted with 1,369 members reached at a 22.3% reach rate.<br>• Notice of Pregnancy Reports are sent to strategic partners and provider groups for member outreach. The goal of this report is to create a proactive outreach list so members can be engaged early with prenatal care and educated about the importance of postpartum care, available resources, and community supports.<br>• The PPC Workgroup is an internal monthly workgroup to include Care Management, Quality Management, and Health Equity to identify/address racial disparities and increase prenatal/postpartum outcome measures. |
| **HSAG's Assessment:** HSAG has determined that AzCH-CCP ACC-RBHA's response addressed these prior year's recommendations and has described specific activities being implemented to address the recommendations. Measure results, however, remain below the 25th percentile and HSAG recommends that AzCH-CCP ACC-RBHA continue implementation activities to work toward future improvement. |
| **Recommendation 4:** |
| HSAG recommended that AzCH-CCP RBHA conduct a root cause analysis or focus study to determine why some members were not managing their high blood pressure optimally. Upon identification of a root cause, HSAG recommended that AzCH-CCP RBHA implement appropriate interventions to improve performance related to this chronic condition. |
| **AzCH-CCP ACC-RBHA's Response:**<br>AzCH-CCP RBHA's performance measure rates for *Controlling High Blood Pressure* fell below the 25th percentile. AzCH-CCP RBHA conducted a root cause analysis that focused on assisting members in maintaining their chronic health conditions at optimal levels. The barriers identified were lack of member and provider engagement.<br><br>Interventions in place in response to the barriers are as follows:<br>• Supplemental data feeds have been effective in providing additional clinical data about a member beyond claims data. Supplemental data feeds may include the use of CPT II codes for reporting a clinical result, such as blood pressure.<br>• Coding for a quality reference guide is distributed to providers during provider meetings.<br>• Identified opportunity to increase education to providers by incorporating into Path to 5 to target larger audience.<br>• Implementation of member-facing educational material to educate members on the importance of engaging with their provider and having their blood pressure checked regularly. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| **HSAG's Assessment:** HSAG has determined that AzCH-CCP ACC-RBHA has satisfactorily addressed these prior year's recommendations. In CY 2022 AzCH-CCP ACC-RBHA has met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and has achieved performance measure rates in the 50th to 74th percentile range. |
| **Recommendation 5:** |
| While AzCH-CCP RBHA conducted a root cause analysis and implemented interventions specific to the CY 2020 *Breast Cancer Screening* and *Cervical Cancer Screening* rates, these rates remained low in CY 2021. HSAG therefore recommended that AzCH-CCP RBHA continue to implement appropriate interventions to improve performance related to preventive screenings. HSAG also recommended that AzCH-CCP RBHA monitor and expand on interventions currently in place to improve performance related to the *Breast Cancer Screening* and *Cervical Cancer Screening* measures. |
| **AzCH-CCP ACC-RBHA's Response:**<br>AzCH-CCP RBHA's performance measure rates for *Breast Cancer Screening* and *Cervical Cancer Screening* fell below the 25th percentile, indicating that women were not receiving timely screening for breast and cervical cancers. AzCH-CCP RBHA conducted a root cause analysis that focused on increasing the number of members receiving timely screenings and looking at those barriers affecting members, such as access to care/services, scheduling of appointments, and education. All performance measures and interventions are monitored, and their effectiveness is discussed during monthly meetings held by the Performance Improvement Subcommittee (PISC) and Quality Improvement Committee (QIC).<br><br>Interventions in place in response to the barriers identified are listed below:<br>• Mobile mammogram events increase access to members as they are open to the public.<br>• Collaboration with radiology facilities consisting of direct outreach. In Q3 CY 2022, mammogram collaboration with two large radiology facilities completed a total outreach of 1,640 members with a 30.4% successful outreach rate.<br>• Blitz call campaign served as an initiative to educate, encourage, and assist members to schedule necessary appointments; The call campaign had a successful reach rate of 11%.<br>• The Care Management and Quality Management Collaboration Workgroup meets monthly to coordinate efforts, refine interventions, and identify barriers and opportunities.<br>• Motivational Interview Training was developed in conjunction with the American Cancer Society and is catered to providers to encourage the utilization of motivational interviewing techniques to address screening hesitancy with members. |
| **HSAG's Assessment:** HSAG has determined that AzCH-CCP ACC-RBHA's response addressed these prior year's recommendations and has described specific activities being implemented to address the recommendations. Results, however, remain below the 25th percentile and HSAG recommends that AzCH-CCP ACC-RBHA continue implementation activities to work toward future improvement. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| **Recommendation 6:** |
| HSAG recommended that AzCH-CCP RBHA conduct a root cause analysis or focus study to determine why there was a higher proportion of members receiving prescriptions for opioids. Upon identification of a root cause, HSAG recommended that AzCH-CCP RBHA implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse. |
| **AzCH-CCP ACC-RBHA's Response:**<br>AzCH-CCP RBHA's performance measure rates for *Use of Opioids at High Dosage* fell below the 25th percentile, indicating an opportunity to increase provider and member outreach. AzCH-CCP RBHA conducted a root cause analysis that focused on increasing member and provider outreach by identifying those barriers, such as lack of education to members and lack of education to providers regarding best practices around opioid misuse and support.<br><br>Interventions in place in response to the barriers identified:<br>• Implementation of a medication adherence reward program which incentivizes members for taking daily medication. The 2022 cohort ended in September with a 26.3% program completion.<br>• Path to 5, a reference guide for providers used to educate on quality and performance measures. Includes best practices on closing quality care gaps.<br>• Provider letters are sent to the providers prescribing opioids at a high dosage along with other medications that may put members at a higher risk for HDO overdose. The letter offers education and additional assistance to develop a process to reduce patient risk.<br>• The provider quality liaisons (PQLs) who are building relationships with the top providers to increase performance and member satisfaction, improve knowledge, and provide technical assistance. |
| **HSAG's Assessment:** HSAG has determined that AzCH-CCP ACC-RBHA's response addressed these prior year's recommendations and has described specific activities being implemented to address the recommendations. Measure results, however, remain below the 25th percentile, and HSAG recommends that AzCH-CCP ACC-RBHA continue implementation activities to work toward future improvement. |
| **Recommendation 7:** |
| HSAG recommended that AzCH-CCP RBHA identify best practices for reducing unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay. HSAG also recommended that AzCH-CCP RBHA consider conducting a root cause analysis to identify factors contributing to members experiencing unplanned acute readmissions, which should include evaluating that appropriate follow-up care is available to members on discharge from an acute inpatient admission or observation. |
| **AzCH-CCP ACC-RBHA's Response:**<br>AzCH-CCP RBHA's performance measure rates for *Plan All-Cause Readmissions O/E Ratio—Total* fell below the 25th percentile, indicating an opportunity to increase provider and member outreach. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| AzCH-CCP RBHA conducted a root cause analysis that focused on increasing member and provider outreach by identifying those barriers, such as lack of education to members and lack of education to providers regarding best practices around appropriate follow-up care after discharge from an acute inpatient admission or observation.<br><br>Interventions in place in response to the barriers identified:<br>• Implementation of a mobile application designed to help members in developing a support system and to support members with SDOH.<br>• The Care Management and Quality Management Collaboration Workgroup meets monthly to coordinate efforts, refine interventions, and identify barriers and opportunities.<br>• Daily Behavioral Health Inpatient Reports available for AzCH-CCP Care Management and for Health Homes to begin discharge planning and coordinating care immediately. This process was enhanced by automating the movement of the reports daily to individual secure file transfer protocol (SFTP) sites.<br>• Path to 5, a reference guide for providers, is used to educate on quality and performance measures and includes best practices on closing quality care gaps.<br>• Population Health Management Workgroup, a cross-functional workgroup focused on performance improvement strategies to increase effectiveness of population health programming. |
| **HSAG's Assessment:** HSAG has determined that AzCH-CCP ACC-RBHA's response addressed these prior year's recommendations and has described specific activities being implemented to address the recommendations. Results, however, remain below the 25th percentile, and HSAG recommends that AzCH-CCP ACC-RBHA continue implementation activities to work toward future improvement. |

## *Validation of Performance Improvement Projects*

### Preventive Screening PIP

In CY 2023, AzCH-CCP ACC-RBHA continued the *Preventive Screening* PIP, which was initiated in CYE 2019. As the PIP had progressed through Remeasurement 1, PIP validation activities focused on improvement from the baseline results. AzCH-CCP ACC-RBHA submitted Remeasurement 1 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes or possible discontinuation of the intervention.

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

### *Validation Results*

Table 7-5 displays the overall confidence levels for the AzCH-CCP ACC-RBHA *Preventive Screening* PIP.

**Table 7-5—AzCH-CCP ACC-RBHA *Preventive Screening* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| AzCH-CCP ACC-RBHA | *High Confidence* | 100% | 100% | *Low Confidence* | 33% | 100% |

### *Measure Results*

Table 7-6 and Table 7-7 provide the *Preventive Screening* PIP baseline, intervention year, and Remeasurement 1 rates for each indicator for AzCH-CCP ACC-RBHA.

**Table 7-6—AzCH-CCP ACC-RBHA *Preventive Screening* PIP Rates for PIP Indicator 1**

| Contractor | PIP Indicator 1: *Breast Cancer Screening* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| AzCH-CCP ACC-RBHA | 38.5% | 39.1% |

**Table 7-7—AzCH-CCP ACC-RBHA *Preventive Screening* PIP Rates for PIP Indicator 2**

| Contractor | PIP Indicator 2: *Cervical Cancer Screening* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| AzCH-CCP ACC-RBHA | 43.9% | 36.7% |

### *Interventions*

Table 7-8 presents PIP interventions for AzCH-CCP ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 7-8—AzCH-CCP ACC-RBHA *Preventive Screening* PIP Interventions**

| Contractor | Intervention |
|---|---|
| AzCH-CCP ACC-RBHA | • Mobile mammogram events to increase access to breast cancer screenings. Please note these events are open to the public to encourage breast cancer screening education, reduce stigma, and encourage completion.<br>• Promotoras (community health workers/representatives) serve those members who are hard to locate in the community by linking them with resources to support health education, access to care, and prevention, as well as addressing any social determinants that may impact their ability to get the services they need.<br>• Education and promotion of the annual MHP member incentive for members who obtain their cervical cancer screening.<br>• Multi-prong member outreach campaigns consisting of mailers and emails to educate and encourage members to obtain needed screenings and tests.<br>• Quarterly Provider-Facing Motivational Interviewing Training focused on how to address barriers and engage members to complete recommended cancer screenings.<br>• Court Ordered Treatment (COT) Care Gap Initiative—Quarterly gap lists sent to the AzCH-CCP ACC-RBHA COT team for coordination with each COT member's assigned health home.<br>• Wellth Gap Closure Program—Members who are already enrolled in the Wellth Program for psychiatric medication adherence and based on the member's open care gaps, the member will be prompted through behavioral prompts and check-ins to explore more information relevant to the member's health and services that are beneficial to the member inclusive of breast cancer and cervical cancer screening.<br>• Behavioral Health Residential Facility (BHRF) Care Gap Initiative. Targeting Integrated SMI/RBHA adult members (18–64) admitted to a BHRF. Collaboration with BHRFs to coordinate preventive care for members within their care reducing transportation issues and increasing communication, education, and access to care.<br>• Population Health Management Workgroup to achieve three main goals: Advance the health of populations, improve member experience, and deliver systemwide transformation to better serve member population health needs. |

### *Strengths, Opportunities for Improvement, and Recommendations*

Table 7-9 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC-RBHA related to the *Preventive Screening* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 7-9—AzCH-CCP ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to the *Preventive Screening* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG noted that AzCH-CCP ACC-RBHA performed accurate statistical testing between the baseline and Remeasurement 1 results and demonstrated non-statistically significant improvement for indicator 1. **[Quality, Access]**<br><br>AzCH-CCP ACC-RBHA implemented and developed measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 2. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| For indicator 1, AzCH-CCP ACC-RBHA had an improvement of 0.59 percentage point in the indicator rate between the baseline year and Remeasurement Year 1. AzCH-CCP ACC-RBHA had a decline of 7.19 percentage points in the indicator rate between the baseline year and Remeasurement Year 1 for indicator 2. **[Quality, Access]**<br><br>Recommendations: As the PIP progresses, HSAG recommends that AzCH-CCP ACC-RBHA:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

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

Table 7-10 presents PIP recommendations made to AzCH-CCP ACC-RBHA in the CYE 2022 Annual Technical Report[7-4] and AzCH-CCP ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which AzCH-CCP ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

[7-4] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for Regional Behavioral Health Authorities Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportRBHA.pdf. Accessed on: Feb 8, 2024.

**Table 7-10—AzCH-CCP ACC-RBHA Follow-Up to CYE 2022 PIP Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| HSAG recommended that AzCH-CCP RBHA:<br>• Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary.<br>• Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available.<br>• Develop and document a plan for sustaining the improvement for any demonstrated improvement in indicator rates. |
| **AzCH-CCP ACC-RBHA's Response:**<br>AzCH-CCP RBHA identified the following barriers to assist in focusing interventions to better engage members in care:<br>• Member engagement was low across the board for preventive measures due to the COVID-19 pandemic. Additionally, due to the increase of provider burden because of the COVID-19 pandemic, the majority of member and provider outreach was paused for a portion of CY 2020.<br>• Lack of member awareness of why the screenings are important to complete.<br>• Lack of easily accessible transportation or alternative opportunities for care.<br><br>AzCH-CCP RBHA has assessed the impact and effectiveness of the following interventions during the first remeasurement year: |

| Interventions Assessment | |
|---|---|
| **Interventions** | **Impact/Effectiveness** |
| Mobile mammogram events to increase access to breast cancer screenings. Please note these events are open to the public to encourage breast cancer screening education, reduce stigma, and encourage completion. | This intervention's expected impact is to provide additional opportunities for access to care and encourage members to take the necessary steps to increase utilization. |
| Promotoras (community health workers/representatives) serve those members who are hard to locate in the community by linking them with resources to support health education, access to care, and prevention, as well as addressing any social determinants that may impact their ability to get the services they need. | This intervention's expected impact is to provide additional opportunities for access to care and encourage members to take the necessary steps to increase positive outcomes and reduce stigma within the community and family setting. |

| Prior Year's Recommendation from the EQR Technical Report for PIPs | |
|---|---|
| Education and promotion of the annual MHP member incentive for members who obtain their cervical cancer screening. | This intervention's expected impact is to provide incentives to increase comfortability with obtaining cervical cancer screenings and reduce stigma around obtaining such. |
| Multi-prong member outreach campaigns consisting of mailers and emails to educate and encourage members to obtain needed screenings and tests. | Impact to enrolled population would be an increase in the member's health literacy for BCS and CCS, as well as an increase in scheduled and kept appointments. |
| Quarterly Provider-Facing Motivational Interviewing Training focused on how to address barriers and engage members to complete recommended cancer screenings. | Impact to enrolled population would be increasing the number of providers who engage members into care by assisting with reducing stigma. |
| Population Health Management Workgroup to achieve three main goals: Advance the health of populations, improve member experience, and deliver systemwide transformation to better serve member population health needs. | Impact to enrolled population will be to increase effective engagement by identifying processes already in place with opportunities. |

AzCH-CCP RBHA's plan for sustaining improvement in indicator rates will be analyzed via the PDSA cycle to ensure ongoing improvement and appropriate corrections are made. Indicator rates along with their identified interventions are evaluated via specific intervention PDSA cycles and during PISC and QIC monthly meetings. Additionally, indicator rates and interventions are monitored through the Performance Measure Monitoring Report (PMMR) to ensure performance improvement during each quarter.

- By end of year 2022, AzCH-CCP was able to provide approximately 812 mammograms free of charge to the public.
- AzCH-CCP in CY 2022 outreached and met with four local radiology facilities to conduct member outreach and aid in the scheduling of mammography.
- Motivational Interviewing (MI) training was held in December for Q4 2022. PQLs continue to focus on sending information regarding the training to provider groups so they may provide it to their members. Additionally, the promotion of the training opportunity continues to be presented within integrated provider meetings. There were a total of 33 registrants with 16 attendees.
- By year end 2022, a total of 13,206 cervical cancer screening MHP rewards were distributed to members.
- The CM & QM Collaboration Workgroup continued to meet monthly through CY 2022 to coordinate efforts, refine interventions, and identify barriers and opportunities.

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| **HSAG's Assessment:** HSAG has determined that the Contractor has satisfactorily addressed these prior year's recommendations. |

## Prenatal and Postpartum Care PIP

In CY 2023, AzCH-CCP ACC-RBHA submitted baseline measurement results for the *Prenatal and Postpartum Care* PIP, which was initiated in CY 2022. AzCH-CCP ACC-RBHA submitted baseline performance indicator results and interventions implemented.

HSAG conducted an annual validation of the baseline year reflective of CY 2022 (January 1, 2022, through December 31, 2022) using AHCCCS-calculated and validated indicator rates. HSAG evaluated AzCH-CCP ACC-RBHA's performance indicator results based on an analysis of improvement strategies implemented as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection in Appendix A. Methodology.

### *Validation Results*

Table 7-11 displays the overall confidence levels for the AzCH-CCP ACC-RBHA *Prenatal and Postpartum Care* PIP.

**Table 7-11—AzCH-CCP ACC-RBHA *Prenatal and Postpartum Care* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| AzCH-CCP ACC-RBHA | *High Confidence* | 100% | 100% | *Not Assessed* | *Not Assessed* | *Not Assessed* |

### *Measure Results*

Table 7-12 and Table 7-13 provide the *Prenatal and Postpartum Care* PIP baseline rates for each indicator for AzCH-CCP ACC-RBHA.

**Table 7-12—AzCH-CCP ACC-RBHA *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 1**

| Contractor | PIP Indicator 1: *Timeliness of Prenatal Care* |
|---|---|
| | Baseline Year |
| | CY 2022 |
| AzCH-CCP ACC-RBHA | 71.4% |

**Table 7-13—AzCH-CCP ACC-RBHA *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 2**

| Contractor | PIP Indicator 2: *Postpartum Care* |
|---|---|
| | Baseline Year |
| | CY 2022 |
| AzCH-CCP ACC-RBHA | 54.1% |

### *Interventions*

Table 7-14 presents PIP interventions for AzCH-CCP ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 7-14—AzCH-CCP ACC-RBHA *Prenatal and Postpartum Care* PIP Interventions**

| Contractor | Interventions |
|---|---|
| AzCH-CCP ACC-RBHA | • Start Smart for Your Baby (SSFB) program, enrollment into care management (until 6 weeks after delivery).<br>• Envolve People Care (EPC), a self-management tool to provide prenatal resources and support, which members are able to access via the AzCH-CCP member portal.<br>• Wellframe Mobile Application, a mobile app that provides a specialized care plan for pregnant and postpartum members with a specialized daily health checklist; providers alerts, care gaps, and progress tracking to CMs; allows for two-way video/text communication with Care Management.<br>• QI and Maternal Child Health (MCH)/CM collaboration to build a proactive outreach program.<br>• Notice of Pregnancy Reports are sent to strategic partners and FQHCS to begin outreach and engage members in a timely manner for prenatal and postpartum care.<br>• The PPC Workgroup is an internal workgroup to include CM, QM, and other departments to increase prenatal/postpartum outcome measures.<br>• A Strategic Partner Collaboration to target members for prenatal care. Strategic partner assists by outreaching, scheduling, and completing in-home or telehealth visits with appropriate physicians. |

| Contractor | Interventions |
|---|---|
| | • Krames, an NCQA accredited self-management tool able to provide multiple resources, support, and education across a variety of topics inclusive of PPC, is accessible through the member portal.<br>• A Health Equity Dashboard provides a method to assess HEDIS® measures by race and ethnicity, ZIP Code hot spotting (determined by rate of disparity for HEDIS) for aggregate or specific measures, year-over-year comparisons with tables and run charts.<br>• Health Equity Committee coordination with the PPC Workgroup.<br>• A HEDIS Stratification Dashboard will provide an NCQA directed race and ethnicity stratification of applicable HEDIS performance measures. |

### *Strengths, Opportunities for Improvement, and Recommendations*

Table 7-15 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC-RBHA related to the *Prenatal and Postpartum Care* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 7-15—AzCH-CCP ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to the *Prenatal and Postpartum Care* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| AzCH-CCP ACC-RBHA implemented and developed measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 1. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| For indicator 1, 71.4 percent of women had a prenatal care visit in the first trimester and 54.1 percent had a postpartum visit between seven and 84 days after delivery during CYE 2022. **[Quality, Access]**<br><br>Recommendations: As the PIP progresses, HSAG recommends that AzCH-CCP ACC-RBHA:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

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

The *Prenatal and Postpartum Care* PIP was initiated in CY 2022; therefore, this section is not applicable.

## Compliance Reviews

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

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

AHCCCS stated that it views the readiness review process as an ongoing series of activities to monitor and ensure Contractor progress. AHCCCS initiates the readiness review process roughly six months prior to the contract effective date. These readiness activities are essential to establishing the capacity of the awarded Contractors to function in a number of critical areas, including operations and administration, service delivery, financial management, and systems management. The AzCH-CCP ACC-RBHA contract began October 1, 2022. The compliance review for the ACC-RBHA Program will be conducted in CYE 2024 and will therefore be included in the CYE 2024 annual technical report.

## Network Adequacy Validation

### Results

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

- South GSA: Cochise, Graham,[7-5] Greenlee, La Paz, Pima, Santa Cruz,[7-6] and Yuma counties

Each region-specific table summarizes semiannual validation results containing the percentage of members meeting each time/distance standard by quarter and county, with color-coding to identify whether or not the time/distance standard was "Met" or "Not Met."

The value "NA" is shown for time/distance standards that do not apply to the county or program.

The value "NR" is shown for time/distance standards in which no members met the network requirement denominator for the program and county; therefore, HSAG calculated no corresponding time/distance result.

[7-5] Graham County includes the 85542, 85192, and 85550 ZIP Codes representing the San Carlos Tribal area; these ZIP Codes are physically located in Gila or Pinal County.
[7-6] Santa Cruz County includes the 85645 ZIP Code; this ZIP Code is physically located in both Pima and Santa Cruz counties.

Yellow color-coding identifies instances in which HSAG's time/distance results met the minimum network requirement but differed from the ACOM 436 results.

Red color-coding identifies instances in which HSAG's time/distance results did not meet the compliance standard, regardless of the ACOM 436 results.

An asterisk (*) indicates that fewer than 10 members were included in the denominator of HSAG's results.

A carat (^) indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

**Table 7-16—AzCH-CCP ACC-RBHA Time/Distance Validation Results for South GSA—Percentage of Members Meeting Minimum Network Requirements**

| | Cochise | | Graham | | Greenlee | | La Paz | | Pima | | Santa Cruz | | Yuma | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Minimum Network Requirement | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0^ | 100.0^[3] | 100.0^ | 100.0^[3] | 100.0 | 100.0^[3] | 100.0^ | 100.0^[3] | 98.0^ | 99.4^[3] | 100.0^ | 100.0^[3] | 99.7^ | 100.0^[3] |
| BHRF | NA | NA | NA | NA | NA | NA | NA | NA | 94.9 | 96.4 | NA | NA | NA | NA |
| Cardiologist, Adult | 100.0^ | 100.0^[3] | 100.0^ | 100.0^[3] | 100.0 | 100.0[3] | 100.0^ | 100.0^[3] | 99.4^ | 99.5^[3] | 100.0 | 100.0^[3] | 100.0^ | 100.0^[3] |
| Cardiologist, Pediatric | 100.0*^ | 100.0^[3] | 100.0*^ | 100.0*^[3] | NR* | NR*[3] | NR*^ | NR*^[3] | 99.1^ | 100.0^[3] | 100.0* | 100.0*^[3] | 100.0^ | 100.0*^[3] |
| Crisis Stabilization Facility | 99.6 | 99.5[3] | 100.0 | 100.0[3] | 100.0 | 100.0[3] | 94.6 | 95.5[3] | 98.1 | 99.4[3] | 100.0 | 100.0[3] | 99.7 | 99.8[3] |
| Dentist, Pediatric | 100.0* | 90.9 | 50.0* | 100.0* | NR* | NR* | NR* | NR* | 98.1 | 98.0 | 100.0* | 66.7* | 100.0 | 100.0* |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 99.6 | 99.6 | 100.0 | 100.0 | 100.0 | 100.0 |
| OB/GYN | 100.0 | 100.0[3] | 100.0 | 100.0[3] | 100.0* | 100.0*[3] | 100.0 | 100.0[3] | 99.7 | 99.6[3] | 100.0 | 100.0[3] | 100.0 | 100.0[3] |
| Pharmacy | 99.4 | 99.2 | 99.5 | 100.0 | 100.0 | 100.0 | 95.9 | 97.0 | 98.2 | 98.7 | 100.0 | 100.0 | 99.7 | 99.7 |
| PCP, Adult | 99.6^ | 99.5^[3] | 99.0^ | 100.0^[3] | 100.0^ | 100.0^[3] | 100.0^ | 100.0^[3] | 99.8^ | 99.9^[3] | 100.0^ | 100.0^[3] | 99.7^ | 99.8^[3] |
| PCP, Pediatric | 100.0*^ | 100.0^[3] | 50.0*^ | 100.0*^[3] | NR*^ | NR*^[3] | NR*^ | NR*^[3] | 99.1^ | 99.0^[3] | 100.0*^ | 100.0*^[3] | 100.0^ | 100.0*^[3] |

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

* indicates that fewer than 10 members were included in the denominator of HSAG's results.
^indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.
[3] In CYE 2023 Q4, AzCH-CCP ACC-RBHA's data included substantially increased numbers of providers used to measure the following standards, as compared to prior submissions: Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult and Pediatric; Crisis Stabilization Facility; OB/GYN; and PCP, Adult and Pediatric. This potentially influenced the validated compliance for these provider types. The Contractor reported the increase was due to revisions in its extract file creating the PAT file that included all active provider addresses.

## Strengths, Opportunities for Improvement, and Recommendations

Table 7-17 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC-RBHA related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 7-17—AzCH-CCP ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to NAV**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths:<br>• AzCH-CCP ACC-RBHA met all time/distance network standards for all assigned counties in CYE 2023 except Graham and Santa Cruz counties. **[Access]**<br>• AzCH-CCP ACC-RBHA met all time/distance network standards for BHRF; Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult and Pediatric; Crisis Stabilization Facility; Hospital; OB/GYN; Pharmacy; and PCP, Adult. **[Access]**<br>Note: AzCH-CCP ACC-RBHA provides coverage in the following counties: Cochise, Graham, Greenlee La Paz, Pima, Santa Cruz, and Yuma. |
| **Opportunities for Improvement and Recommendations** |
| HSAG identified the following opportunities for improvement:<br>• Isolated data issues may have contributed to specific instances affecting AzCH-CCP ACC-RBHA's compliance with time/distance standards. **[Access]**<br>• AzCH-CCP ACC-RBHA failed to meet the time/distance for at least one quarter and/or county for Dentist, Pediatric and PCP, Pediatric. **[Access]**<br>Recommendation: HSAG recommends that AzCH-CCP ACC-RBHA maintain current compliance with network standards but continue to address network gaps, as applicable. |

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

Table 7-18 presents NAV recommendations made to AzCH-CCP RBHA in the CYE 2022 Annual Technical Report[7-7] and AzCH-CCP ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which AzCH-CCP ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language

[7-7] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for Regional Behavioral Health Authorities Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportRBHA.pdf. Accessed on: Jan 30, 2024.

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

**Table 7-18—AzCH-CCP ACC-RBHA Follow-Up to CY 2022 NAV Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for NAV |
|---|
| HSAG recommended that AzCH-CCP RBHA:<br>• Continue to monitor its processes for creating the PAT files and review the PAT file for accuracy prior to submitting to AHCCCS.<br>• Maintain current compliance with network standards. |
| **AzCH-CCP ACC-RBHA's Response:**<br>AzCH-CCP RBHA will continue to monitor its processes for creating the PAT files and review the PAT file for accuracy prior to submitting to AHCCCS. Additionally, AzCH-CCP RBHA continues to monitor and maintain its existing provider network coverage with ongoing evaluation and outreach to expand where able. |
| **HSAG's Assessment:**<br>HSAG has determined that AzCH-CCP ACC-RBHA has satisfactorily addressed these prior year's recommendations. |

# Care 1st ACC-RBHA

## Validation of Performance Measures

### Results for Information Systems Standards Review

The Care 1st ACC-RBHA contract went into effect on October 1, 2022. The audit will be conducted in CY 2024 and will therefore be included in the CY 2024 annual technical report.

### Results for Performance Measures

The Care 1st ACC-RBHA contract went into effect on October 1, 2022; therefore, there are no performance measure results to present for CY 2022. Care 1st ACC-RBHA CY 2023 performance measure results will be included in the CY 2024 annual technical report.

## Validation of Performance Improvement Projects

The Care 1st ACC-RBHA contract went into effect on October 1, 2022. PIP validation of the *Prenatal and Postpartum Care* PIP will be conducted in CYE 2024 and will therefore be included in the CYE 2024 annual technical report.

## Compliance Reviews

In November 2021, AHCCCS awarded Care 1st a new ACC-RBHA contract, expanding the current ACC contract. As a result, the Contractor went through an extensive readiness review, which was conducted from April through October 2022.

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

AHCCCS stated that it views the readiness review process as an ongoing series of activities to monitor and ensure Contractor progress. AHCCCS initiates the readiness review process roughly six months prior to the contract effective date. These readiness activities are essential to establishing the capacity of the awarded Contractors to function in a number of critical areas, including operations and administration, service delivery, financial management, and systems management. The Care 1st ACC-RBHA contract began October 1, 2022. The compliance review for the ACC-RBHA Program will be conducted in CYE 2024 and will therefore be included in the CYE 2024 annual technical report.

## Network Adequacy Validation

### Results

HSAG evaluated Care 1st ACC-RBHA's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents semiannual validation findings specific to the ACC-RBHA Program, with one results table for the following GSA:

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

Each region-specific table summarizes semiannual validation results containing the percentage of members meeting each time/distance standard by quarter and county, with color-coding to identify whether or not the time/distance standard was "Met" or "Not Met."

The value "NA" is shown for time/distance standards that do not apply to the county or program.

The value "NR" is shown for time/distance standards in which no members met the network requirement denominator for the program and county; therefore, HSAG calculated no corresponding time/distance result.

Yellow color-coding identifies instances in which HSAG's time/distance results met the minimum network requirement but differed from the ACOM 436 results.

Red color-coding identifies instances in which HSAG's time/distance results did not meet the compliance standard, regardless of the ACOM 436 results.

An asterisk (*) indicates that fewer than 10 members were included in the denominator of HSAG's results.

A carat (^) indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

**Table 7-19—Care 1st ACC-RBHA Time/Distance Validation Results for North GSA—Percentage of Members Meeting Minimum Network Requirements**

| | Apache | | Coconino | | Mohave | | Navajo | | Yavapai | |
|---|---|---|---|---|---|---|---|---|---|---|
| Minimum Network Requirement | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 96.9^ | 98.0^ | 99.3^ | 99.4^ | 99.9^ | 99.9^ | 99.2^ | 99.2^ | 100.0^ | 100.0^ |
| BHRF | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Cardiologist, Adult | 98.6^ | 99.5^ | 99.5^ | 99.5^ | 100.0^ | 100.0^ | 99.5^ | 99.5^ | 100.0^ | 100.0^ |
| Cardiologist, Pediatric | 100.0* | NR* | 100.0^ | 100.0^ | 100.0 | 100.0 | 100.0* | 100.0* | 100.0^ | 100.0^ |

| Minimum Network Requirement | Apache | | Coconino | | Mohave | | Navajo | | Yavapai | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Crisis Stabilization Facility | 95.1 | 95.0 | 97.8 | 98.2 | 99.2 | 99.2 | 99.1 | 99.2 | 99.3 | 99.3 |
| Dentist, Pediatric | 100.0* | NR* | 100.0 | 100.0 | 100.0 | 100.0 | 100.0* | 100.0* | 100.0 | 100.0 |
| Hospital | 98.7 | 98.5 | 100.0 | 100.0 | 99.9 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| OB/GYN | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 99.1 | 99.5 | 98.4 | 98.6 | 99.0 | 99.1 | 99.4 | 99.4 | 98.6 | 98.7 |
| PCP, Adult | 99.1^ | 99.5^ | 99.9^ | 99.6^ | 99.2^ | 99.1^ | 100.0^ | 99.8^ | 100.0^ | 99.7^ |
| PCP, Pediatric | 100.0*^ | NR*^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0*^ | 100.0*^ | 100.0^ | 100.0^ |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.
* indicates that fewer than 10 members were included in the denominator of HSAG's results.
^indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.

## Strengths, Opportunities for Improvement, and Recommendations

Table 7-20 presents strengths and opportunities for improvement for Care 1st ACC-RBHA related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 7-20—Care 1st ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to NAV**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths:<br>• Care 1st ACC-RBHA met all time/distance network standards for all assigned counties in CYE 2023 for both quarters. **[Access]**<br>Note: Care 1st ACC-RBHA provides coverage in the following counties: Apache, Coconino, Mohave, Navajo, and Yavapai. |
| **Opportunities for Improvement and Recommendations** |
| HSAG identified no opportunities for improvement for Care 1st ACC-RBHA.<br>• Recommendation: While HSAG identified no opportunities for improvement, HSAG recommends that Care 1st ACC-RBHA continue to maintain current compliance with network standards. |

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

Care 1st ACC-RBHA began operations October 1, 2022; therefore, this section is not applicable for Care 1st ACC-RBHA.

# HCA RBHA

## *Validation of Performance Measures*

### Results for Information Systems Standards Review

During CYE 2023, HSAG evaluated HCA-RBHA's data system for processing of each data type used for reporting the Contractor's CY 2022 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that HCA RBHA followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 7-21 displays HSAG's PMV findings for each data type reviewed during CYE 2023 in alignment with the CMS EQR Protocol 2 audit requirements.

**Table 7-21—CYE 2023 PMV Findings**

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

### Results for Performance Measures

Table 7-22 presents the CY 2021 and CY 2022 HCA RBHA performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and MY 2022. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and/or MY 2022. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

**Table 7-22—HCA RBHA CY 2021 and CY 2022 Performance Measure Results**

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| ***Maternal and Perinatal Care*** | | | | |
| ***Prenatal and Postpartum Care*** | | | | |
| *Timeliness of Prenatal Care*[#] | 82.9%[+] | 79.5%[+] | → | ★ |

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| *Postpartum Care*[##] | 61.0%[+] | 61.4%[+] | → | ★ |
| ***Behavioral Health*** | | | | |
| ***Antidepressant Medication Management*** | | | | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | 60.6% | 56.9% | → | ★★ |
| *Effective Continuation Phase Treatment—Total (18+ Years)* | 42.4% | 41.8% | → | ★★ |
| ***Follow-Up After ED Visit for Substance Use*** | | | | |
| *7-Day Follow-Up—Total* | — | 52.9% | — | ★★★★★ |
| *30-Day Follow-Up—Total* | — | 71.3% | — | ★★★★★ |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 58.4% | 70.3% | ↑ | ★★★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 75.0% | 84.9% | ↑ | ★★★★★ |
| ***Follow-Up After ED Visit for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 50.0% | 57.1% | → | ★★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 64.6% | 73.6% | → | ★★★★★ |
| ***Use of Opioids at High Dosage*** | | | | |
| *18+ Years** | — | NA[++] | — | — |
| ***Initiation and Engagement of Substance Use Disorder (SUD) Treatment*** | | | | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | — | 44.6% | — | ★★★ |
| *Engagement of SUD Treatment—Total—Total (13+ Years) ** | — | 12.4% | — | ★★ |
| ***Adherence to Antipsychotic Medications for Individuals with Schizophrenia*** | | | | |
| *18+ Years* | — | NA[++] | — | — |
| ***Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication*** | | | | |
| *18–64 Years* | — | NA[++] | — | — |
| ***Care of Acute and Chronic Conditions*** | | | | |
| ***Controlling High Blood Pressure*** | | | | |
| *18–85 Years* | — | NA[++] | — | — |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | | | | |
| *HbA1c Control (<8.0 Percent)—Total (18–75 Years)* | — | NA[++] | — | — |
| *HbA1c Poor Control (>9.0 Percent)—Total (18–75 Years) ** | — | NA[++] | — | — |
| ***Pediatric Health*** | | | | |
| ***Oral Evaluation, Dental Services*** | | | | |
| *Total (0–20 Years)*[N] | — | NA[++] | — | — |

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| ***Preventive Screening*** | | | | |
| ***Breast Cancer Screening*** | | | | |
| *Total (50–74 Years)* | — | NA[++] | — | — |
| ***Cervical Cancer Screening*** | | | | |
| *21–64 Years* | — | NA[++] | — | — |
| ***Appropriate Utilization of Services*** | | | | |
| ***Ambulatory Care*** | | | | |
| *Emergency Department (ED) Visits—Total (0–85+ Years)* [F] | 1,139.5 | 1,139.2 | — | — |
| ***Plan All-Cause Readmissions*** | | | | |
| *Observed Readmissions—Total (18–64 Years)* | 10.9% | 13.4% | → | — |
| *Expected Readmissions—Total (18–64 Years)* | — | 11.3% | — | — |
| *Outlier Rate—Total (18–64 Years)* | — | 41.4 | — | — |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)** | 0.9984 | 1.1839 | — | ★ |

* A lower rate indicates better performance for this measure.
+ Indicates the measure was reported using hybrid methodology.
[++] NA indicates the denominator was too small to report a valid rate, based on the applicable measure specification.
[#] Caution should be considered when comparing CY 2021 to CY 2022 results as changes to the measure specifications occurred.
[##] The HCA RBHA *Prenatal and Postpartum Care—Postpartum Care* measure indicator results may be impacted by the Contractor's September 30, 2022, RBHA contract termination and should be perceived with caution. This measure requires members to have continuous enrollment through 60 days after delivery to be included in the denominator, however Postpartum visits up to 84 days post-delivery meet measure requirements which may occur after the contract termination date for some members.
Cells shaded green indicate that the rate met or exceeded the MY 2021 and/or MY 2022 national Medicaid mean.
[1] Indicates a 2021–2022 comparison is not presented in the CYE 2023 Annual Technical Report because either there was a break in trending, the CY 2021 rate was not presented in the CYE 2022 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
↑ Indicates improvement of measure rates.
↓ Indicates decline of measure rates.
→ Indicates stable measure rates.
[2] Performance Levels for CY 2022 were based on comparisons of the HEDIS MY 2022 measure rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks.
Performance Levels for 2022 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile
[N] Measure has no NCQA Medicaid mean for comparison.
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.

## Strengths and Opportunities for Improvement

Table 7-23 presents strengths and opportunities for improvement for HCA RBHA for performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement. As of October 1, 2022, the Contractor no longer holds a contract for the RBHA Program; therefore, this section does not include recommendations.

**Table 7-23—HCA RBHA Strengths and Opportunities for Improvement Related to Performance Measures**

| Strengths and Opportunities for Improvement |
|---|
| **Strengths** |
| In the Behavioral Health measure group:<br>• Six of 13 (46.2 percent) HCA RBHA measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022: **[Quality, Timeliness, Access]**<br>– *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*<br>– *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)*<br>– *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years).*<br>• HCA RBHA's performance measure rates for the following measures were at or above the 90th percentile, indicating strength in providing behavioral health follow-up care to members: **[Quality, Timeliness, Access]**<br>– *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*<br>– *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)*<br>– *30-Day Follow-Up—Total (6+ Years),* and *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total (6+ Years)* |
| **Opportunities for Improvement** |
| In the Maternal and Perinatal Care measure group, HCA RBHA's performance measure rates for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Prenatal and Postpartum Care—Postpartum Care* were below the 25th percentile, indicating an opportunity to increase access to timely postpartum care. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.[7-8] **[Quality, Timeliness, Access]** |

[7-8] National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/. Accessed on: Jan 30, 2024.

| Strengths and Opportunities for Improvement |
|---|
| In the Appropriate Utilization of Services measure group:<br>• HCA RBHA's performance measure rates for *Plan All-Cause Readmissions O/E Ratio—Total (18–64 Years)* fell below the 25th percentile **[Quality]** |

## *Validation of Performance Improvement Projects*

### Preventive Screening PIP

In CYE 2023, HCA RBHA continued the *Preventive Screening* PIP, which was initiated in CYE 2019. As the PIP had progressed through Remeasurement 1, PIP validation activities focused on improvement from the baseline results. HCA RBHA submitted Remeasurement 1 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes or possible discontinuation of the intervention.

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

#### *Validation Results*

Table 7-24 displays the overall confidence levels for the HCA RBHA *Preventive Screening* PIP.

**Table 7-24—HCA RBHA *Preventive Screening* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| HCA RBHA | *High Confidence* | 100% | 100% | *Not Assessed* | *Not Assessed* | *Not Assessed* |

## Measure Results

Table 7-25 and Table 7-26 provide the *Preventive Screening* PIP baseline, intervention year, and Remeasurement 1 rates for each indicator for HCA RBHA.

**Table 7-25—HCA RBHA *Preventive Screening* PIP Rates for PIP Indicator 1**

| Contractor | PIP Indicator 1: *Breast Cancer Screening* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| HCA RBHA | 36.6% | *Not Applicable* |

**Table 7-26—HCA RBHA *Preventive Screening* PIP Rates for PIP Indicator 2**

| Contractor | PIP Indicator 2: *Cervical Cancer Screening* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| HCA RBHA | 41.0% | *Not Applicable* |

### *Interventions*

Table 7-27 presents PIP interventions for HCA RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 7-27—HCA RBHA *Preventive Screening* PIP Interventions**

| Contractor | Intervention |
|---|---|
| HCA RBHA | • HCA RBHA partners with mobile mammography providers to assist in the scheduling and members for mobile mammography events. HCA RBHA provides member gap lists and any other associated assistance required.<br>• Care management staff conduct outreach calls to member with gaps in care. During the calls, the staff educated members on the benefits of the preventive care visits, assisted with scheduling appointments, and arranged transportation.<br>• The HCA RBHA Quality Improvement Strategy (QIS) Team receives gap reports from the Quality Data Department and distributes those to providers for member outreach to schedule needed appointments. The HCA RBHA QIS team maintains active relationships with larger providers to ensure providers have access to up-to-date information on member gaps and measure details. |

| Contractor | Intervention |
|---|---|
| | • HCA RBHA also conducts regular outreach via other methods to ensure providers and members are aware of the need for these services and that these measures remain a focus for pediatric providers. HCA RBHA sent fax blasts, spoke about these measures at the provider forum, discussed value-based contracts with providers, and sent reminder letters to members.<br>• HCA RBHA is offering a gift card incentive for members who receive a qualifying service. Members need to call member services after completing their appointment, and gift cards will be mailed. Alternatively, HCA RBHA also brings gift cards to live events for distribution right after services are provided.<br>• Through VBP, HCA RBHA is leveraging Arizona's successful managed care model to address inadequacies of the current healthcare delivery system. This program includes Alternative Payment Models, Differential Adjusted Payments, Direct Payments, and Performance Based Payments. The incentive of higher payment for higher performance will ensure these providers focus on targeted measures. This measure has been included in the CY 2023 VBP Contracting. |

### *Strengths and Opportunities for Improvement*

Table 7-28 presents strengths and opportunities for improvement for HCA RBHA related to validation of the *Preventive Screening* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement. As of October 1, 2022, the Contractor no longer holds a contract for the RBHA/ACC-RBHA Program; therefore, this section does not include recommendations.

**Table 7-28—HCA RBHA Strengths and Opportunities for Improvement Related to the *Preventive Screening* PIP**

| Strengths and Opportunities for Improvement |
|---|
| **Strengths** |
| HCA RBHA developed and implemented interventions that may have led to improvement in indicator outcomes. **[Quality]** |
| **Opportunities for Improvement** |
| HSAG identified no opportunities for improvement related to HCA RBHA's *Preventive Screening* PIP. HCA's RBHA contract ended September 30, 2022; therefore, recommendations are not provided. |

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

HCA's RBHA contract ended September 30, 2022; therefore, follow-up to the prior year's recommendations was not provided by HCA RBHA.

## Compliance Reviews

### Results

AHCCCS conducted a compliance review of HCA RBHA in CYE 2021. On January 13, 2023, AHCCCS accepted and closed HCA RBHA's CAPs. Table 7-29 presents the compliance review results for HCA RBHA.

**Table 7-29—HCA RBHA Compliance Review Results**

| Focus Areas | CYE 2021 HCA RBHA Scores | CYE 2023 HCA RBHA CAP Update |
|---|---|---|
| CC | 100% | NA |
| CIS | 99% | NA |
| DGA | 96% | NA |
| DS | 85% | M |
| GA | 100% | NA |
| GS | 100% | NA |
| MCH | 96% | NA |
| MM | 96% | NA |
| MI | 98% | NA |
| QM | 100% | NA |
| QI | 94% | M |
| RI | 100% | NA |
| TPL | 100% | NA |
| ISOC | NR+ | NA |

+ NR = "not reviewed." This Focus Area was not reviewed separately during the compliance review cycle; however, elements of this Focus Area were included in other Focus Areas (e.g., ISOC standards included in MM).
NA = "not applicable." A CAP was not required as the CYE 2021 score was 95% or above.
M = "met." AHCCCS accepted and closed the Contractor's CAP.

### Strengths and Opportunities for Improvement

Table 7-30 presents strengths and opportunities for improvement for HCA RBHA, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 7-30—HCA RBHA Program Strengths and Opportunities for Improvement Related to Compliance**

| Strengths and Opportunities for Improvement |
|---|
| **Strengths** |
| HCA RBHA successfully closed CAPs in the following Focus Areas:<br>• Delivery Systems (DS) **[Timeliness, Access]**<br>• Quality Improvement (QI) **[Quality, Access]** |
| **Opportunities for Improvement** |
| HCA RBHA successfully closed all CAPs; therefore, HSAG did not identify any opportunities for improvement. |

## *Network Adequacy Validation*

HCA's RBHA contract ended September 30, 2022; therefore, NAV activities were not conducted.

# Mercy Care ACC-RBHA

## *Validation of Performance Measures*

### Results for Information Systems Standards Review

During CYE 2023, HSAG evaluated Mercy Care ACC-RBHA's data system for processing of each data type used for reporting the Contractor's CY 2022 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that Mercy Care ACC-RBHA followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 7-31 displays HSAG's PMV findings for each data type reviewed during CYE 2023 in alignment with the CMS EQR Protocol 2 audit requirements.

**Table 7-31—CYE 2023 PMV Findings**

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

### Results for Performance Measures

Table 7-32 presents the CY 2021 and CY 2022 Mercy Care ACC-RBHA performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and MY 2022. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and/or MY 2022. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

**Table 7-32—Mercy Care ACC-RBHA CY 2021 and CY 2022 Performance Measure Results**

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| ***Maternal and Perinatal Care*** | | | | |
| ***Prenatal and Postpartum Care*** | | | | |
| *Timeliness of Prenatal Care*[#] | 73.7%[+] | 78.6%[+] | → | ★ |

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| *Postpartum Care* | 55.4%+ | 73.6%+ | ↑ | ★ |
| ***Behavioral Health*** | | | | |
| ***Antidepressant Medication Management*** | | | | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | 53.9% | 48.7% | ↓ | ★ |
| *Effective Continuation Phase Treatment—Total (18+ Years)* | 41.8% | 34.0% | ↓ | ★ |
| ***Follow-Up After ED Visit for Substance Use*** | | | | |
| *7-Day Follow-Up—Total* | — | 55.1% | — | ★★★★★ |
| *30-Day Follow-Up—Total* | — | 74.1% | — | ★★★★★ |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 69.9% | 69.3% | → | ★★★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 84.5% | 83.6% | → | ★★★★★ |
| ***Follow-Up After ED Visit for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 54.3% | 58.5% | → | ★★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 71.0% | 72.1% | → | ★★★★ |
| ***Use of Opioids at High Dosage*** | | | | |
| *18+ Years** | 12.0% | 9.7% | → | ★ |
| ***Initiation and Engagement of Substance Use Disorder (SUD) Treatment*** | | | | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | — | 49.3% | — | ★★★★ |
| *Engagement of SUD Treatment—Total—Total (13+ Years) ** | — | 12.4% | — | ★★ |
| ***Adherence to Antipsychotic Medications for Individuals with Schizophrenia*** | | | | |
| *18+ Years* | 57.0% | 56.2% | → | ★★ |
| ***Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication*** | | | | |
| *18–64 Years* | 82.4% | 86.3% | ↑ | ★★★★★ |
| ***Care of Acute and Chronic Conditions*** | | | | |
| ***Controlling High Blood Pressure*** | | | | |
| *18–85 Years* | 57.9%+ | 65.0%+ | ↑ | ★★★ |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | | | | |
| *HbA1c Control (<8.0 %)—Total (18–75 Years)* | — | 65.2%+ | — | ★★★★★ |
| *HbA1c Poor Control (>9.0 %)—Total (18–75 Years) ** | 32.4%+ | 27.0%+ | → | ★★★★★ |
| ***Pediatric Health*** | | | | |
| ***Oral Evaluation, Dental Services*** | | | | |
| *Total (0–20 Years)* [N] | — | 19.8% | — | — |

| Measure | CY 2021 Performance | CY 2022 Performance | CY 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| ***Preventive Screening*** | | | | |
| ***Breast Cancer Screening*** | | | | |
| *Total (50–74 Years)* | 32.7% | 41.1% | ↑ | ★ |
| ***Cervical Cancer Screening*** | | | | |
| *21–64 Years* | 45.3%+ | 49.9%+ | → | ★ |
| ***Appropriate Utilization of Services*** | | | | |
| ***Ambulatory Care*** | | | | |
| *Emergency Department (ED) Visits—Total (0–85+ Years)* [F] | 1,241.9 | 1,189.6 | — | — |
| ***Plan All-Cause Readmissions*** | | | | |
| *Observed Readmissions—Total (18–64 Years)* | 15.3% | 15.6% | → | — |
| *Expected Readmissions—Total (18–64 Years)* | — | 11.8% | — | — |
| *Outlier Rate—Total (18–64 Years)* | — | 123.7 | — | — |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)** | 1.3246 | 1.3245 | — | ★ |

* A lower rate indicates better performance for this measure.
+ Indicates the measure was reported using hybrid methodology.
# Caution should be considered when comparing CY 2021 to CY 2022 results as changes to the measure specifications occurred.
Cells shaded green indicate that the rate met or exceeded the MY 2021 and/or MY 2022 national Medicaid mean.
[1] Indicates a 2021–2022 comparison is not presented in the CYE 2023 Annual Technical Report because either there was a break in trending, the CY 2021 rate was not presented in the CYE 2022 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
↑ Indicates improvement of measure rates.
↓ Indicates decline of measure rates.
→ Indicates stable measure rates.
[2] Performance Levels for CY 2022 were based on comparisons of the HEDIS MY 2022 measure rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks.
Performance Levels for 2022 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile
[N] Measure has no NCQA Medicaid mean for comparison.
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.

## Strengths, Opportunities for Improvement, and Recommendations

Table 7-33 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA related to performance measures, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 7-33—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| In the Behavioral Health measure group:<br>• Eight of 13 (61.5 percent) Mercy Care ACC-RBHA measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022: **[Quality, Timeliness, Access]**<br>– *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total)*<br>– *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+Years)* and *30-Day Follow-Up—Total (6+Years)*<br>– *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+Years)* and *30-Day Follow-Up—Total (6+Years)*<br>– *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)*<br>– *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication.*<br>• Mercy Care ACC-RBHA's performance measure rates for the following measures were at or above the 75th percentile, indicating strength in providing follow-up behavioral health care to members: **[Quality, Timeliness, Access]**<br>– *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total)*<br>– *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+Years)* and *30-Day Follow-Up—Total (6+Years)*<br>– *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+Years)* and *30-Day Follow-Up—Total (6+Years)*<br>– *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)*<br>– *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication—18–64 Years*<br>In the Care of Acute and Chronic Conditions measure group:<br>• All three (100.0 percent) of Mercy Care ACC-RBHA's measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. **[Quality]**<br>• Mercy Care ACC-RBHA's performance measure rates for *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 %)—Total (18–75 Years)* and *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)* were at or above the 90th percentile, indicating strength in providing follow-up care of acute and chronic conditions to members. **[Quality]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Opportunities for Improvement and Recommendations** |
| While Mercy Care ACC-RBHA was successful in reporting valid rates for all AHCCCS-required performance measures, the audit identified some considerations and recommendations for future years' reporting. **[Quality]**<br><br>Recommendation: HSAG recommends that Mercy Care ACC-RBHA continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes AHCCCS requirements for Contractor-enrolled members who switch product lines or Contractors and members for whom Mercy Care ACC-RBHA does not hold the primary insurance contract.<br>• HSAG recommends that Mercy Care ACC-RBHA continue to ensure that the mapping of provider specialties to HEDIS provider types is compliant with AHCCCS' requirements for PMV reporting.<br>• HSAG recommends that Mercy Care ACC-RBHA continue to conduct live system validation of data after its vendor's first run of MY 2023 rates, prior to reporting any performance measure data. |
| For CY 2023 performance measure reporting, race and ethnicity stratification is required based on NCQA HEDIS specifications. **[Quality]**<br><br>Recommendation: HSAG recommends that Mercy Care ACC-RBHA continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race and ethnicity data to support performance measure reporting that requires stratification related to race and ethnicity. |
| In the Maternal and Perinatal Care measure group, Mercy Care ACC-RBHA's performance measure rates for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* remain below the 25th percentile, indicating an opportunity to increase access to timely prenatal and postpartum care. **[Quality, Timeliness, Access]**<br><br>Recommendations:<br>• While Mercy Care ACC-RBHA conducted a root cause analysis and implemented targeted interventions specific to the CY 2020 *Prenatal and Postpartum Care—Postpartum Care* rates, both *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* rates were low in both CY 2021 and CY 2022. HSAG recommends that Mercy Care ACC-RBHA continue to implement appropriate interventions to improve performance relative to both prenatal and postpartum care.<br>• While improvement has been made for the *Postpartum Care* rates, HSAG recommends that Mercy Care ACC-RBHA continue to monitor and expand on interventions currently in place |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| to improve performance related to both the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measures. |
| In the Behavioral Health measure group:<br><br>Mercy Care ACC-RBHA's performance measure rate for *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* fell and remained below the 25th percentile, and the performance measure rate for *Effective Continuation Phase Treatment—Total (18+ Years)* also fell below the 25th percentile, suggesting that barriers exist for some members with a diagnosis of major depression to remain on antidepressant medication. Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness, and identifying and managing side effects. Effective medication treatment of major depression can improve a person's daily functioning and well-being and can reduce the risk of suicide.[7-9] Mercy Care ACC-RBHA's performance measure rate for *Use of Opioids at High Dosage (18+ Years)* remained below the 25th percentile. This result provides an opportunity for Mercy Care ACC-RBHA to monitor prescribing and utilization data and to implement interventions to improve care and services around opioid prescribing. The CDC guidelines on opioid prescribing for chronic, nonmalignant pain recommend the use of "additional precautions" when prescribing dosages ≥50 MED and recommend providers avoid or "carefully justify" increasing dosages ≥90 mg MED.[7-10] **[Quality]**<br><br>Recommendations:<br>• While Mercy Care ACC-RBHA conducted a root cause analysis and implemented interventions to determine why some members were not managing their antidepressant medication, the rates for *Antidepressant Medication Management—Effective Acute Phase Treatment* fell and remained below the 25th percentile, and the performance measure rate for *Effective Continuation Phase Treatment* also fell below the 25th percentile. HSAG recommends that Mercy Care ACC-RBHA continue to implement appropriate interventions to improve performance for both measures and consider the nature and scope of the issues (e.g., the issues are related to barriers such as a lack of patient and provider communication or patient education) when implementing interventions.<br>• While Mercy Care ACC-RBHA conducted a root cause analysis and implemented interventions to determine why there is a higher proportion of members receiving prescriptions for opioids, performance remained below the 25th percentile in CY 2022. HSAG therefore recommends that Mercy Care ACC-RBHA continue to implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse. HSAG also recommends that Mercy Care ACC-RBHA monitor and expand on |

[7-9] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Feb 1, 2024.
[7-10] National Committee for Quality Assurance. Use of Opioids at High Dosage (HDO). Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/. Accessed on: Jan 30, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| interventions currently in place to improve performance related to the *Use of Opioids at High Dosage (18+ Years)* measure. |
| In the Preventive Screening measure group, Mercy Care ACC-RBHA's performance measure rates for *Breast Cancer Screening* and *Cervical Cancer Screening* remained below the 25th percentile, indicating that not all women were receiving timely screening for breast and cervical cancers. Early detection reduces the risk of dying from these types of cancers and can lead to a greater range of treatment options and lower healthcare costs. **[Quality]**<br><br>Recommendation: While Mercy Care ACC-RBHA conducted a root cause analysis and implemented interventions specific to the CY 2020 *Breast Cancer Screening* and *Cervical Cancer Screening* rates, these measure rates remained low in CY 2021 and CY 2022. HSAG therefore recommends that Mercy Care ACC-RBHA continue to implement appropriate interventions to improve performance related to preventive screenings. HSAG also recommends that Mercy Care ACC-RBHA monitor and expand on interventions currently in place to improve performance related to the *Breast Cancer Screening* and *Cervical Cancer Screening* measures. |
| In the Appropriate Utilization of Services measure group, Mercy Care ACC-RBHA's performance measure rates for *Plan All-Cause Readmissions O/E Ratio—Total (18–64 Years)* remains below the 25th percentile **[Quality]**<br><br>Recommendation: While Mercy Care ACC-RBHA initiated efforts to identify best practices for reducing the unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay, these rates remained below the 25th percentile for CY 2022. Mercy Care ACC-RBHA also followed the recommendation of conducting a root cause analysis to identify factors contributing to members experiencing unplanned acute readmissions, which should include evaluating whether or not appropriate follow-up care is available to members upon discharge from an acute inpatient admission or observation. HSAG recommends that Mercy Care ACC-RBHA continue to follow through on these performance improvement strategies in order to increase provider and member outreach and improve follow-up care after discharge from an acute inpatient admission or observation. |

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

Table 7-34 presents performance measure recommendations made to Mercy Care RBHA in the CYE 2022 Annual Technical Report[7-11] and Mercy Care ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language

[7-11] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for Regional Behavioral Health Authorities. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportRBHA.pdf. Accessed on: Jan 30, 2024.

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

**Table 7-34—Mercy Care ACC-RBHA Follow-Up to CYE 2022 Performance Measure Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| **Recommendation 1:** |
| HSAG recommended that Mercy Care RBHA continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. Additionally, HSAG recommended that Mercy Care RBHA continue to conduct a formal review of its source code followed by a complete test plan, including live system validation of data, prior to reporting any performance measure data. |
| **Mercy Care ACC-RBHA's Response:**<br>Historically, Mercy Care RBHA has followed the NCQA HEDIS guidelines regarding continuous enrollment, which is required by AHCCCS beginning in MY 2023. As a result, Mercy Care RBHA is in compliance with the current requirements.<br><br>The National Medicaid Quality Data team ensures that necessary source code changes are made by the software vendor with the release of any changes to event data, and rates are reviewed monthly. Any anomalies/discrepancies/outliers that are found are reviewed, researched, and tested thoroughly before any data are reported to regulatory bodies. Additionally, monthly event checks using vendor resources as compared to any technical specifications to ensure that the vendor is accurately capturing the right reporting elements for all core and non-core activities, as well as higher monitoring of internal back-end system integrations to ensure that all data elements are within scope to be captured for reporting. |
| **HSAG's Assessment:** HSAG has determined that Mercy Care ACC-RBHA has satisfactorily addressed these prior year's recommendations. |
| **Recommendation 2:** |
| HSAG recommended that Mercy Care RBHA explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratification related to race and ethnicity. Mercy Care RBHA should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information. |
| **Mercy Care ACC-RBHA's Response:**<br>Mercy Care RBHA is working in collaboration with the Aetna Medicaid Quality & Report team to update the 834 mapping to include all applicable data. Additionally, exploration of leveraging the CMS enrollment files and case/care management data for capturing additional data is planned for 2024. As part of this additional work, Mercy Care RBHA and Aetna Medicaid are collaborating with the Health Equity Team to identify whether or not indirect data sources can be captured to supplement the direct data sources. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| Finally, AHCCCS implemented TI and DAP requirements to encourage providers to support data collection and is working with HIE to provide more information. Mercy Care RBHA has been working with the HIE on receiving the A08 alerts for race and ethnicity data directly. |
| **HSAG's Assessment:** HSAG has determined that Mercy Care ACC-RBHA has satisfactorily addressed these prior year's recommendations; however, Mercy Care ACC-RBHA should continue working with AHCCCS on collaborative efforts to improve the capture of race and ethnicity data to support performance measure reporting that requires stratification related to race and ethnicity stratification. |
| **Recommendation 3:** |
| While Mercy Care RBHA conducted a root cause analysis and implemented targeted interventions specific to the CY 2020 *Prenatal and Postpartum Care—Postpartum Care* rates, both CY 2021 *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* rates were low. HSAG therefore recommended that Mercy Care RBHA continue to implement appropriate interventions to improve performance relative to prenatal and postpartum care. HSAG also recommended that Mercy Care RBHA monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measures. |
| **Mercy Care ACC-RBHA's Response:**<br><br>Mercy Care RBHA continued the interventions that were reported in 2022, after completion of a root cause analysis. Those interventions include:<br>• Leveraging the American College of Obstetricians and Gynecologists (ACOG) data submitted to the perinatal Integrated Care Management (ICM) team for low-risk pregnancy identification, in addition to use by the perinatal Care Management team.<br>• Leveraging newborn notifications for identification of pregnant members.<br>• Implementation of a process to identify pregnant members through positive pregnancy tests in the HIE.<br>• Revision of the current process so that members who are referred to ICM but refuse care management or are unable to be reached are transitioned back to the low-risk outreach team.<br>• Workforce driver for additional staff to conduct postpartum outreach calls so that all members who appear on a call list receive an outreach call.<br>• Conducting digital outreach throughout the year to capture all postpartum members.<br>• Revising the outreach process so that the postpartum mailing is sent to the member regardless of whether or not the member's PCP or baby's PCP information is available (revise letter template and process).<br>• Expand education to OB/GYNs by MCH coordinators.<br>• Train two staff on the management of this measure to allow for knowledge and early intervention as well as supplying a back-up in the event of staff resignations. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| • Medical Record Vendor challenges—address through work locally at the health plan and nationally in partnership with NMQM.<br><br>Mercy Care RBHA's MY 2022 rate of 78.10% exceeds the NCQA HEDIS MY 2022 Medicaid Mean of 76.96% and meets the 50th percentile of 78.10%. |
| **HSAG's Assessment:** HSAG has determined that Mercy Care ACC-RBHA's response addressed these prior year's recommendations and has described specific activities being implemented to address the recommendations. Results, however, remain below the 25th percentile for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Prenatal and Postpartum Care—Postpartum Care.* HSAG recommends Mercy Care ACC-RBHA continue implementation activities to work towards improvement for CYE 2024. |
| **Recommendation 4:** |
| HSAG recommended that Mercy Care RBHA conduct a root cause analysis or focus study to determine why some members were not managing their antidepressant medication. Upon identification of a root cause, HSAG recommended that Mercy Care RBHA implement appropriate interventions to improve performance and consider the nature and scope of the issues (e.g., the issues are related to barriers such as a lack of patient and provider communication or patient education) when implementing interventions. |
| **Mercy Care ACC-RBHA's Response:**<br><br>Mercy Care RBHA conducted data review and best practice identification, presentation, and distribution to Accountable Care Organizations (ACOs) and Clinically Integrated Networks and added the *Antidepressant Medication Management* measure in the Mercy Care RBHA Value Based Program for 2023 contracts. However, Mercy Care RBHA's performance for the *Antidepressant Medication Management* measure continues to fall below the NCQA HEDIS Medicaid Mean, resulting in Mercy Care RBHA returning to the "plan" phase of the PDSA cycle, where additional interventions were developed for implementation:<br>• The Pharmacy Risk Prevention Report, which includes members at risk for noncompliance with adherence to medications, and includes gap in care data (measures: *AMM, HDO, SAA, SPD, SPC, SSD,* and *UOP*).<br>• Healthmine Application—Member Web portal to provide educational information regarding gaps in care along with digital and written member outreach (planned to be open for member access 11/01/2023).<br><br>Mercy Care RBHA will continue to monitor the plan's performance with this measure through the additional phases of the PDSA cycle and modify existing interventions or implement additional interventions as necessary. |
| **HSAG's Assessment:** HSAG has determined that Mercy Care ACC-RBHA's response addressed these prior year's recommendations and has described specific activities being implemented to address the recommendations. Results, however, remain below the 25th percentile for *Antidepressant Medication Management—Effective Acute Phase Treatment* and have fallen below the 25th percentile |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| for *Effective Continuation Phase Treatment*. HSAG recommends that Mercy Care ACC-RBHA continue implementation activities to work toward improvement for CYE 2024. |
| **Recommendation 5:** |
| While Mercy Care RBHA conducted a root cause analysis and implemented interventions specific to its CY 2020 *Breast Cancer Screening* and *Cervical Cancer Screening* rates, these rates remained low in CY 2021. HSAG therefore recommended that Mercy Care RBHA continue to implement appropriate interventions to improve performance related to preventive screenings. HSAG also recommended that Mercy Care RBHA monitor and expand on interventions currently in place to improve performance related to the *Breast Cancer Screening* and *Cervical Cancer Screening* measures. |
| **Mercy Care ACC-RBHA's Response:**<br>Mercy Care RBHA continued the interventions that were reported in 2022, after completion of a root cause analysis, and also developed and implemented additional interventions to further drive improvement. Those interventions include:<br>• Educational outreach to female members ages 40–74 to encourage well woman exams and mammograms (*BCS*).<br>• Providers are notified via mail of members who are due for a mammogram. They are given an order form to sign and send into us. We then contact the member and assist with scheduling a mammogram and submitting the order form.<br>• Outreach staff contact members who still have not had a mammogram to assist with scheduling an appointment.<br>• An incentive letter is mailed to members who still need a mammogram. Once they receive a mammogram and the facility signs the form, member can submit to us for a gift card if met before the deadline.<br>• Providers' outreach educating on the breast cancer screening guideline and provide them with a list of members in need of a mammogram.<br>• Text messaging, email, and IVR outreach to close gaps in care to members with Mercy Care RBHA.<br>• Content that is specific to mammogram disparities was included in provider newsletters and the Mercy Care RBHA Provider Conference.<br>• Offer additional provider education for those areas identified as under-utilizers and work with those providers to discuss how we can help utilize a mobile mammogram program to reach their members and promote our incentive program for breast cancer screenings.<br>• Partner with Arizona Diagnostics Radiology to outreach members specifically assigned to these providers.<br>• Addition of *BCS* measure to Value-Based programs.<br>• Collaboration with Native Health by providing targeted gap lists of members in need of a mammography screening.<br>• Collection of nonstandard supplemental data, particularly for members with other primary coverage, to close gaps in data. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| • Partner with Mercy Care RBHA Value-Based Services (VBS) providers to provide standard supplemental data feeds to improve data capture.<br>• Healthmine Application—Member Web portal to provide educational information regarding gaps in care along with digital and written member outreach.<br>• Provider "Gaps-in-Care" well-woman mailing includes a list of members who need breast or cervical cancer screening.<br>• Outreach staff contact members who need a Pap test and assist with scheduling an appointment.<br>• Provider outreach to provide education on the CCS screening guidelines and furnish a list of members still in need of a Pap test.<br>• Member education utilizing educational videos on the Mercy Care RBHA member website.<br>• Creation of a VBS program with the new RBHA BHH ACO, ANP, which includes incentivizing this measure.<br><br>Mercy Care RBHA will continue to monitor the plan's performance with these measures through the additional phases of the PDSA cycle and modify existing interventions or implement additional interventions as necessary. |
| **HSAG's Assessment:** HSAG has determined that Mercy Care ACC-RBHA's response addressed these recommendations and has described specific activities being implemented to address the recommendations. Measure results, however, remain below the 25th percentile, and HSAG recommends that Mercy Care ACC-RBHA continue implementation activities to work toward improvement for CYE 2024. |
| **Recommendation 6:** |
| HSAG recommended that Mercy Care RBHA conduct a root cause analysis or focus study to determine why there is a higher proportion of members receiving prescriptions for opioids. Upon identification of a root cause, HSAG recommended that Mercy Care RBHA implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse. |
| **Mercy Care ACC-RBHA's Response:**<br>Mercy Care RBHA conducted a root cause analysis. As a result of this analysis, Mercy Care RBHA developed the following interventions aimed at reducing the number and percentage of members who are prescribed high dose opioids:<br>• Pharmacy Risk Prevention Report, which includes members at risk for noncompliance with adherence to medications and includes gap in care data (measures: *AMM, HDO, SAA, SPD, SPC, SSD,* and *P*).<br>• Opioid/SUD Best Practices Presentation to Mercy Care RBHA VBS providers by MC associate chief medical officer.<br>• Educational Outreach Program (EOP) with provider fax including targeted member information for providers identified as having members on > 90 MME. This also includes an opioid prescriber report card.<br>• Telephonic one-on-one provider outreach to the top 10 high MME prescribers. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| • SMS (PBM program): This program targets high-risk drug classes, focusing on controlled substances, and inappropriate use and misuse related indicators such as poly-pharmacy, provider shopping, and high-total controlled substance claims volume. Quarterly, clinical pharmacists will evaluate controlled substance claims and any available supporting medical data to identify potential medication misuse and inappropriate claims for appropriate intervention. During subsequent quarters, pharmacists conduct follow-up activities utilizing physician responses and current claim activity. Situations identified as being potentially inappropriate may be referred to the client (plan) for further action.<br>• Creation and distribution of a report of members who are utilizing 50–89 MME for provider awareness and intervention prior to the member reaching 90 MME.<br>• Mercy Care RBHA's associate chief medical officer outreaches to prescribing providers of members who are in the *HDO* measure numerator.<br>• Mercy Care RBHA case managers will outreach members in the *HDO* measure for care coordination.<br><br>Mercy Care RBHA will continue to monitor the plan's performance with this measure through the additional phases of the PDSA cycle and modify existing interventions or implement additional interventions as necessary. |
| **HSAG's Assessment:** HSAG has determined that Mercy Care ACC-RBHA's response addressed these prior year's recommendations and has described specific activities being implemented to address the recommendations. Measure results, however, remain below the 25th percentile, and HSAG recommends the Mercy Care ACC-RBHA continue implementation activities to work toward improvement for CYE 2024. |
| **Recommendation 7:** |
| HSAG recommended that Mercy Care RBHA identify best practices for reducing the unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay. HSAG also recommended that Mercy Care RBHA consider conducting a root cause analysis to identify factors contributing to members experiencing unplanned acute readmissions, which should include evaluating that appropriate follow-up care is available to members upon discharge from an acute inpatient admission or observation. |
| **Mercy Care ACC-RBHA's Response:**<br>Mercy Care RBHA conducted a root cause analysis. As a result of this analysis, Mercy Care RBHA developed the following interventions aimed at reducing the unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay:<br>• Creation of a VBS program with the new RBHA BHH ACO, ANP, which includes incentivizing this measure.<br>• Creation of a new level of care of case management at RBHA health homes, Intensive Level of Care, to help provide more assistance for members who have higher utilization and greater clinical needs. Caseload size maximum will be between ACT and supportive.<br>• Behavioral health utilization management managers' and supervisors' meetings with newly contracted psychiatric hospitals within 90 days of the contract go live date, and then as needed or |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
| --- |
| requested, to review utilization management and disposition planning processes, answer questions, provide education, and identify barriers potentially impacting member outcomes. The goal is to establish strong relationships between hospital and Mercy Care RBHA leaders, support new providers on how to support best member outcomes through coordination of care, disposition planning, and reducing the potential for hospital readmissions.<br><br>Mercy Care RBHA will continue to monitor the plan's performance with this measure through the additional phases of the PDSA cycle and modify existing interventions or implement additional interventions as necessary. |
| **HSAG's Assessment:** HSAG has determined that Mercy Care ACC-RBHA's response addressed these prior year's recommendations and has described specific activities being implemented to address the recommendations. Measure results, however, remain below the 25th percentile, and HSAG recommends that Mercy Care ACC-RBHA continue implementation activities to work toward improvement for CYE 2024. |

## *Validation of Performance Improvement Projects*

### Preventive Screenings PIP

In CYE 2023, Mercy Care ACC-RBHA continued the *Preventive Screening* PIP, which was initiated in CYE 2019. As the PIP had progressed through Remeasurement 1, PIP validation activities focused on improvement from the baseline results. Mercy Care ACC-RBHA submitted Remeasurement 1 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes or possible discontinuation of the intervention.

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

#### *Validation Results*

Table 7-35 displays the overall confidence levels for the Mercy Care ACC-RBHA *Preventive Screening* PIP.

**Table 7-35—Marcy Care ACC-RBHA *Preventive Screening* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| Mercy Care ACC-RBHA | *High Confidence* | 100% | 100% | *Moderate Confidence* | 33% | 100% |

### *Measure Results*

Table 7-36 and Table 7-37 provide the *Preventive Screening* PIP baseline and intervention year rates for each indicator for Mercy Care ACC-RBHA.

**Table 7-36—Mercy Care ACC-RBHA *Preventive Screening* PIP Rates for PIP Indicator 1**

| Contractor | PIP Indicator 1: *Breast Cancer Screening* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| Mercy Care ACC-RBHA | 35.8% | 41.1% |

**Table 7-37—Mercy Care ACC-RBHA *Preventive Screening* PIP Rates for PIP Indicator 2**

| Contractor | PIP Indicator 2: *Cervical Cancer Screening* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| Mercy Care ACC-RBHA | 43.5% | 37.4% |

### *Interventions*

Table 7-38 presents PIP interventions for Mercy Care ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 7-38—Mercy Care ACC-RBHA *Preventive Screening* PIP Interventions**

| Contractor | Intervention |
|---|---|
| Mercy Care ACC-RBHA | **Mammogram Screening:**<br>• Educational outreach to female members ages 40–74 to encourage well-woman exams and mammograms (BCS).<br>• Female members ages 40–74 receive the BCS or BCS/CCS self-mailer.<br>• Members ages 50–74 years receive breast cancer trifold education piece.<br>• Members ages 50–74 years will receive partner organization notification, and the partner organization will be contacting those members who have not had a mammogram in the past year and assist with scheduling an appointment for a mammogram. The partner organization contacts members on the list which we have provided of members in need of a mammogram.<br>• Providers are notified via mail of members who are due for a mammogram. They are given an order form to sign and return to us. We then contact the member and assist with scheduling the mammogram and submitting the order form.<br>• Outreach staff contact members who still have not had a mammogram to assist with scheduling an appointment.<br>• An annual incentive letter is mailed in July to members who still need a mammogram. Once the member completes a mammogram and Mercy Care receives/verifies the claim from the provider, the incentive is sent to the member.<br>• MCH coordinators conduct provider site visits, including education on breast cancer screening guidelines and providing a list of members in need of a mammogram.<br>• Outreach follow-up: members receive a reminder card after a three-way-call wherein an appointment is scheduled.<br>• Twice annually, partner with Arizona Diagnostic Radiology to conduct outreach calls to members in need of a mammogram, to offer scheduling assistance.<br>• If active, participate in Arizona Cancer Coalition and the Arizona Cancer Coalition Cancer Workgroup.<br>• Third-party vendor member outreach campaign designed to reach members through IVR calls, text messages, and emails.<br>**Cervical Cancer Screening:**<br>• Educational outreach to female members ages 21–74 to encourage well woman exams.<br>– Female members ages 21–39 years receive the CCS self-mailer.<br>– Female members ages 40–74 years receive the BCS/CCS self-mailer.<br>• Multi-channel member outreach campaign provides information on covered services and the importance of screenings. |

| Contractor | Intervention |
|---|---|
| | • Provider Gaps-in-Care well-woman mailing includes a list of members who need a cervical cancer screening.<br>• Outreach staff contact members who need a Pap test and assist with scheduling an appointment.<br>• Provider site visits to provide education on the CCS screening guidelines and furnish a list of members still in need of a Pap test.<br>• Outreach follow-up: members receive a reminder card after a<br>• three-way-call wherein an appointment is scheduled.<br>• If active, participate in Arizona Cancer Coalition meetings and Arizona Cancer Coalition Cancer Workgroups.<br>• Third-party vendor member outreach campaign designed to reach members through IVR calls, text messages, and emails. |

### *Strengths, Opportunities for Improvement, and Recommendations*

Table 7-39 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA related to the *Preventive Screening* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 7-39—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to the *Preventive Screening* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG noted that Mercy Care ACC-RBHA performed accurate statistical testing between the baseline and Remeasurement 1 results and demonstrated statistically significant improvement for indicator 1. **[Quality, Access]**<br><br>Mercy Care ACC-RBHA implemented and developed measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 2. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| For indicator 1, Mercy Care ACC-RBHA had a statistically significant improvement of 5.26 percentage points in the indicator rate between the baseline year and Remeasurement Year 1. Mercy Care ACC-RBHA had a decline of 6.15 percentage points in the indicator rate between the baseline year and Remeasurement Year 1 for indicator 2. **[Quality, Access]**<br><br>Recommendations: As the PIP progresses, HSAG recommends that Mercy Care ACC-RBHA:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement. |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| • Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

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

Table 7-40 presents PIP recommendations made to Mercy Care RBHA in the CYE 2022 Annual Technical Report[7-12] and Mercy Care ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 7-40—Mercy Care ACC-RBHA Follow-Up to CYE 2022 PIP Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| HSAG recommended that Mercy Care RBHA:<br>• Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary.<br>• Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available.<br>• Develop and document a plan for sustaining the improvement for any demonstrated improvement in indicator rates. |
| **Mercy Care ACC-RBHA's Response:**<br>Mercy Care RBHA continues to review the PIP rates at least quarterly, with an annual final measurement year evaluation once the data are finalized. When Mercy Care RBHA identifies declines in performance, or that the rates are not on track to reach the defined goal, we initiate or continue to the next step in the PDSA cycle. Interventions are assessed for effectiveness, and best practices are identified, documented, and incorporated into the health plan's standard operating procedures. |
| **HSAG's Assessment:**<br>HSAG determined that Mercy Care ACC-RBHA satisfactorily addressed these prior year's recommendations. |

[7-12] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for Regional Behavioral Health Authorities Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportRBHA.pdf. Accessed on: Feb 8, 2024.

## Prenatal and Postpartum Care PIP

In CY 2023, Mercy Care ACC-RBHA submitted baseline measurement results for the *Prenatal and Postpartum Care* PIP, which was initiated in CY 2022. Mercy Care ACC-RBHA submitted baseline performance indicator results and interventions implemented.

HSAG conducted an annual validation of the baseline year reflective of CY 2022 (January 1, 2022, through December 31, 2022) using AHCCCS-calculated and validated indicator rates. HSAG evaluated Mercy Care ACC-RBHA's performance indicator results based on an analysis of improvement strategies implemented as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection in Appendix A. Methodology.

### *Validation Results*

Table 7-41 displays the overall confidence levels for the Mercy Care ACC-RBHA *Prenatal and Postpartum Care* PIP.

**Table 7-41—Mercy Care ACC-RBHA *Prenatal and Postpartum Care* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| Mercy Care ACC-RBHA | *High Confidence* | 100% | 100% | *Not Assessed* | *Not Assessed* | *Not Assessed* |

### *Measure Results*

Table 7-42 and Table 7-43 provide the *Prenatal and Postpartum Care* PIP baseline rates for each indicator for Mercy Care ACC-RBHA.

**Table 7-42—Mercy Care ACC-RBHA *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 1**

| Contractor | PIP Indicator 1: *Timeliness of Prenatal Care* |
|---|---|
| | Baseline Year |
| | CY 2022 |
| Mercy Care ACC-RBHA | 78.6% |

**Table 7-43—Mercy Care ACC-RBHA *Prenatal and Postpartum Care* PIP Rates for PIP Indicator 2**

| Contractor | PIP Indicator 2: *Postpartum Care* |
|---|---|
| | Baseline Year |
| | CY 2022 |
| Mercy Care ACC-RBHA | 73.6% |

### *Interventions*

Table 7-44 presents PIP interventions for Mercy Care ACC-RBHA. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 7-44—Mercy Care ACC-RBHA *Prenatal and Postpartum Care* PIP Interventions**

| Contractor | Interventions |
|---|---|
| Mercy Care ACC-RBHA | • Written member outreach activities which may include but are not limited to the "You and Your Baby" magazine.<br>• Written member outreach on postpartum depression.<br>• Educational outreach information is available on the Mercy Care website.<br>• Text messaging, email, and IVR outreach to close gaps in care.<br>• Outreach telephone calls to members who delivered a baby encouraging them to schedule a postpartum visit which includes offering transportation assistance.<br>• OB case management/care coordination to high-risk members who delivered and follow-up on postpartum needs. As member contact allows, OB Case Management performs postpartum depression screenings for eligible members.<br>• Coordinate referral and reporting of pregnant members with Mercy Care's ICM Perinatal Care Management program.<br>• Postpartum visit incentive. |

### *Strengths, Opportunities for Improvement, and Recommendations*

Table 7-45 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA related to the *Prenatal and Postpartum Care* PIP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 7-45—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to the *Prenatal and Postpartum Care* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| Mercy Care ACC-RBHA implemented and developed measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 1. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| For indicator 1, 78.6 percent of women had a prenatal care visit in the first trimester and 73.6 percent had a postpartum visit between seven and 84 days after delivery during CYE 2022. **[Quality, Access]**<br><br>Recommendations: As the PIP progresses, HSAG recommends that Mercy Care ACC-RBHA:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

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

The *Prenatal and Postpartum Care* PIP was initiated in CY 2022; therefore, this section is not applicable.

## *Compliance Reviews*

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

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

AHCCCS stated that it views the readiness review process as an ongoing series of activities to monitor and ensure Contractor progress. AHCCCS initiates the readiness review process roughly six months prior to the contract effective date. These readiness activities are essential to establishing the capacity of the awarded Contractors to function in a number of critical areas, including operations and administration, service delivery, financial management, and systems management. The Mercy Care

ACC-RBHA contract began October 1, 2022. The compliance review for the ACC-RBHA Program will be conducted in CYE 2024 and will therefore be included in the CYE 2024 annual technical report.

## Network Adequacy Validation

### Results

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

- Central GSA: Gila, Maricopa[7-13] and Pinal counties

Each region-specific table summarizes semiannual validation results containing the percentage of members meeting each time/distance standard by quarter and county, with color-coding to identify whether or not the time/distance standard was "Met" or "Not Met."

The value "NA" is shown for time/distance standards that do not apply to the county or program.

The value "NR" is shown for time/distance standards in which no members met the network requirement denominator for the program and county; therefore, HSAG calculated no corresponding time/distance result.

Yellow color-coding identifies instances in which HSAG's time/distance results met the minimum network requirement but differed from the ACOM 436 results.

Red color-coding identifies instances in which HSAG's time/distance results did not meet the compliance standard, regardless of the ACOM 436 results.

An asterisk (*) indicates that fewer than 10 members were included in the denominator of HSAG's results.

A carat (^) indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

[7-13] Maricopa County includes the 85342, 85358, and 85390 ZIP Codes; these ZIP Codes are physically located in both Maricopa and Yavapai counties.

**Table 7-46—Mercy Care ACC-RBHA Time/Distance Validation Results for Central GSA—Percentage of Members Meeting Minimum Network Requirements**

| Minimum Network Requirement | Gila | | Maricopa | | Pinal | |
|---|---|---|---|---|---|---|
| | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0^ | 100.0^ | 99.1^ | 99.2^ | 100.0^ | 100.0^ |
| BHRF | NA | NA | 99.5 | 99.3 | NA | NA |
| Cardiologist, Adult | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| Cardiologist, Pediatric | 100.0*^ | 100.0*^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| Crisis Stabilization Facility | 100.0 | 100.0 | 99.5 | 99.4 | 100.0 | 100.0 |
| Dentist, Pediatric | 50.0*[2] | 100.0* | 97.3[2] | 99.5 | 100.0[2] | 100.0 |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| OB/GYN | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 100.0 | 100.0 | 99.4 | 99.4 | 100.0 | 100.0 |
| PCP, Adult | 100.0^ | 100.0^ | 99.7^ | 99.8^ | 100.0^ | 100.0^ |
| PCP, Pediatric | 100.0*^ | 100.0*^ | 99.8^ | 99.8^ | 100.0^ | 100.0^ |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
represents time/distance standard results that do not meet the compliance standard based on HSAG's results.

* indicates that fewer than 10 members were included in the denominator of HSAG's results.
^indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.
[2] In CYE 2023 Q2, Mercy Care ACC-RBHA's data included decreased numbers of providers used to measure the Dentist, Pediatric standard. This influenced the validated compliance for this provider type. The error occurred because Mercy Care ACC-RBHA's file from its dental benefit's manager was not correctly reporting the entire network for its ACC-RBHA program. Mercy Care identified the cause and successfully tested the solution.

## Strengths, Opportunities for Improvement, and Recommendations

Table 7-47 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC-RBHA related to NAV, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 7-47—Mercy Care ACC-RBHA Strengths, Opportunities for Improvement, and Recommendations Related to NAV**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths:<br>• Mercy Care ACC-RBHA met all time/distance network standards for all assigned counties in CYE 2023 except Gila County. **[Access]**<br>• Mercy Care ACC-RBHA met all time/distance network standards for BHRF; Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult and Pediatric; Crisis Stabilization Facility; Hospital; OB/GYN; Pharmacy; and PCP, Adult and Pediatric. **[Access]**<br>Note: Mercy Care ACC-RBHA provides coverage in Gila. Maricopa, and Pinal counties. |
| **Opportunities for Improvement and Recommendations** |
| HSAG identified the following opportunities for improvement:<br>• Mercy Care ACC-RBHA failed to meet the standard for at least one quarter and/or county for Dentist, Pediatric. **[Access]**<br>•<br>• Recommendation: HSAG recommends that Mercy Care ACC-RBHA maintain current compliance with network standards but continue to address network gaps, as applicable. |

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

Table 7-48 presents NAV recommendations made to Mercy Care RBHA in the CYE 2022 Annual Technical Report[7-14] and Mercy Care ACC-RBHA's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care ACC-RBHA has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 7-48—Mercy Care ACC-RBHA Follow-Up to CYE 2022 NAV Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for NAV |
|---|
| • HSAG recommended that Mercy Care RBHA:<br>• Continue to monitor its processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS. |

[7-14] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for Regional Behavioral Health Authorities Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportRBHA.pdf. Accessed on: Jan 30, 2024.

| Prior Year's Recommendation from the EQR Technical Report for NAV |
|---|
| • Maintain current compliance with network standards but continue to address network gaps as applicable. |
| **Mercy Care ACC-RBHA's Response:**<br>Mercy Care RBHA continues existing processes to ensure that the plan maintains compliance with the AHCCCS network coverage requirements. |
| **HSAG's Assessment:**<br>HSAG has determined that Mercy Care ACC-RBHA has satisfactorily addressed these prior year's recommendations. |

# 8. DCS CHP Program Results

The **DCS CHP Program** provides medical, dental, and behavioral health services for children and youth in foster care throughout the state of Arizona.

This section provides, by EQR activity, DCS CHP activity-specific strengths, opportunities for improvement, and HSAG's recommendations for performance improvement. This section also includes information about the extent to which DCS CHP was able to address the prior year's recommendations for each activity. This section also includes CAHPS survey results for the DCS CHP Program. DCS CHP provides services through a subcontracted health plan, Mercy Care DCS CHP. This report uses DCS CHP when referring to the DCS CHP Contractor, and Mercy Care DCS CHP when referring to activities conducted by the DCS CHP subcontracted health plan (Mercy Care).

## DCS CHP Program

### *Validation of Performance Measures*

#### Results for Information Systems Standards Review

During CYE 2023, HSAG evaluated DCS CHP's data system for processing of each data type used for reporting the Contractor's CY 2022 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that DCS CHP followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 8-1 displays HSAG's PMV findings for each data type reviewed during CYE 2023 in alignment with the CMS EQR Protocol 2 audit requirements.

**Table 8-1—CYE 2023 PMV Findings**

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

## Results for Performance Measures

Table 8-2 presents the CY 2022 performance measure results for DCS CHP. Performance measure rate cells shaded green indicate that DCS CHP met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

**Table 8-2—CY 2022 Performance Measure Results for DCS CHP**

| Performance Measure | CY 2022 Performance |
|---|---|
| ***Pediatric Health*** | |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotics*** | |
| *Blood Glucose Testing—Total (1–17 Years)* | 71.4% |
| *Cholesterol Testing—Total (1–17 Years)* | 60.0% |
| *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* | 59.0% |
| ***Childhood Immunization Status**** | |
| *Combination 3* | 71.8%+ |
| *Combination 7* | 59.6%+ |
| *Combination 10* | 38.6%+ |
| ***Immunizations for Adolescents*** | |
| *Combination 1 (Meningococcal, Tdap)* | 97.0%+ |
| *Combination 2 (Meningococcal, Tdap, HPV)* | 57.0%+ |
| ***Oral Evaluation, Dental Services*** | |
| *Total (0–20 Years)*[N] | 66.0% |
| ***Child and Adolescent Well-Care Visits*** | |
| *Total (3–21 Years)* | 71.0% |

+ Indicates the measure was reported using hybrid methodology.
** Table A-1 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
[N] Measure has no NCQA Medicaid mean for comparison.

Cells shaded green indicate that the rate met or exceeded the national Medicaid mean for HEDIS MY 2022.

Table 8-3 presents the CY 2021 and CY 2022 performance measure results for DCS CHP. Performance measure rate cells shaded green indicate that DCS CHP met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and/or MY 2022. Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*).

**Table 8-3—CY 2021 and CY 2022 Performance Measure Results for DCS CHP**

| Measure | CY 2021 Performance | CY 2022 Performance | 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| ***Pediatric Health*** | | | | |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotics*** | | | | |
| *Blood Glucose Testing—Total (1–17 Years)* | — | 71.4% | — | ★★★★★ |
| *Cholesterol Testing—Total (1–17 Years)* | — | 60.0% | — | ★★★★★ |
| *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* | — | 59.0% | — | ★★★★★ |
| ***Childhood Immunization Status**** | | | | |
| *Combination 3* | 65.4%+ | 71.8%+ | → | ★★★★ |
| *Combination 7* | 48.7%+ | 59.6%+ | ↑ | ★★★ |
| *Combination 10* | 38.6%+ | 38.6%+ | → | ★★★★ |
| ***Immunizations for Adolescents*** | | | | |
| *Combination 1 (Meningococcal, Tdap)* | 98.5%+ | 97.0%+ | → | ★★★★★ |
| *Combination 2 (Meningococcal, Tdap, HPV)* | 70.9%+ | 57.0%+ | ↓ | ★★★★★ |
| ***Oral Evaluation, Dental Services*** | | | | |
| *Total (0–20 Years)* [N] | — | 66.0% | — | — |
| ***Child and Adolescent Well-Care Visits*** | | | | |
| *Total (3–21 Years)* | 66.9% | 71.0% | ↑ | ★★★★★ |

\+ Indicates the measure was reported using hybrid methodology.
** Table A-1 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
Cells shaded green indicate that the rate met or exceeded the MY 2021 and/or MY 2022 national Medicaid mean.
[1] Indicates a 2021–2022 comparison is not presented in the CYE 2023 Annual Technical Report because either there was a break in trending, the CY 2021 rate was not presented in the CYE 2022 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
[2] Performance Levels for CY 2022 were based on comparisons of the HEDIS MY 2022 measure rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks.
↑ Indicates improvement of measure rates.
↓ Indicates decline of measure rates.
→ Indicates stable measure rates.
Performance Levels for 2022 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile
[N] Measure has no NCQA Medicaid mean for comparison.
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.

Table 8-4 highlights DCS CHP's performance for the current year by measure group. The table illustrates the CY 2022 measure rates and performance relative to the NCQA national Medicaid Quality Compass HEDIS MY 2022 percentiles, where applicable. The performance level star ratings are defined as follows:

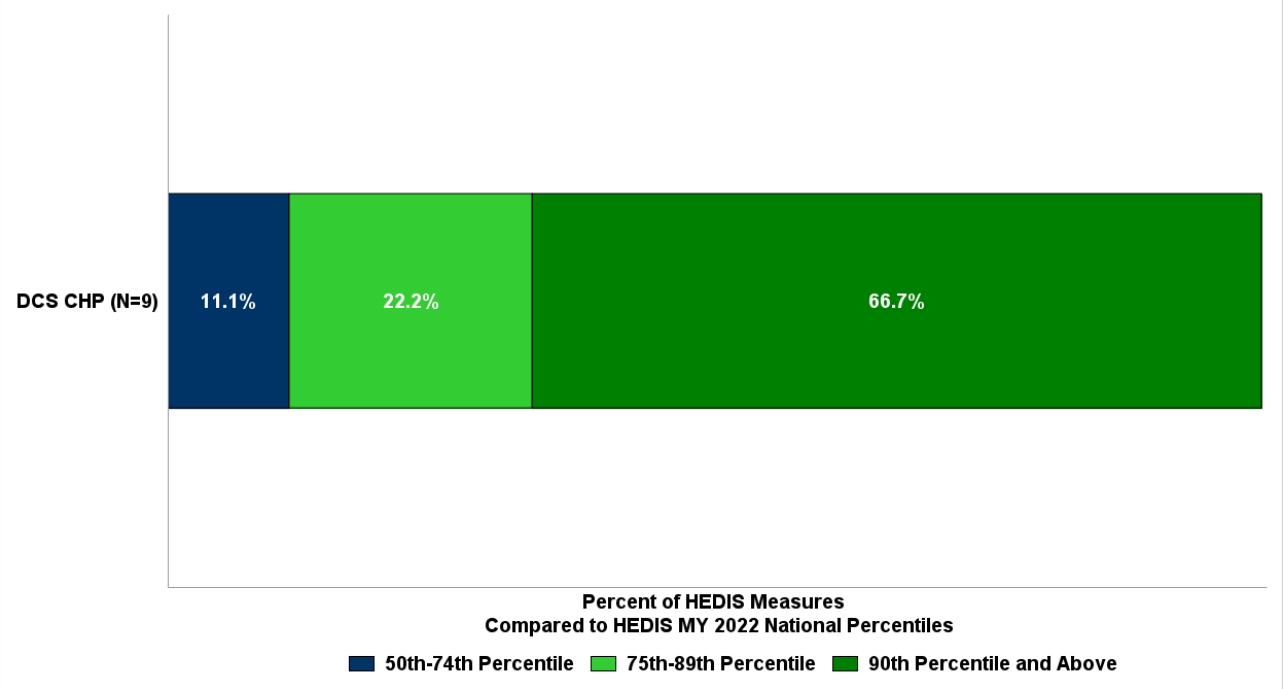
★★★★★ = 90th percentile and above
★★★★ = 75th percentile to 89th percentile
★★★ = 50th percentile to 74th percentile
★★ = 25th percentile to 49th percentile
★ = Below the 25th percentile

**Table 8-4—CY 2022 National Percentiles Comparison for DCS CHP**

| Performance Measure | CY 2022 Performance |
|---|---|
| ***Pediatric Health*** | |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotics*** | |
| *Blood Glucose Testing—Total (1–17 Years)* | ★★★★★ |
| *Cholesterol Testing—Total (1–17 Years)* | ★★★★★ |
| *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* | ★★★★★ |
| ***Childhood Immunization Status*** | |
| *Combination 3* | ★★★★ |
| *Combination 7* | ★★★ |
| *Combination 10* | ★★★★ |
| ***Immunizations for Adolescents*** | |
| *Combination 1 (Meningococcal, Tdap)* | ★★★★★ |
| *Combination 2 (Meningococcal, Tdap, HPV)* | ★★★★★ |
| ***Child and Adolescent Well-Care Visits*** | |
| *Total (3–21 Years)* | ★★★★★ |

Figure 8-1 displays DCS CHP's HEDIS MY 2022 performance compared to HEDIS MY 2022 National Percentiles. HSAG analyzed results from four performance measures and nine total measure rates for HEDIS MY 2022.

**Figure 8-1—Comparison of Measure Indicators to HEDIS Medicaid National Percentiles for DCS CHP**




## Strengths, Opportunities for Improvement, and Recommendations

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

**Table 8-5—DCS CHP Program Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| • In the Pediatric Health measure group:<br>• Nine of 10 (90.0 percent) DCS CHP rates for the following measures met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022: **[Quality, Access]**<br>– *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total (1–17 Years), Cholesterol Testing—Total (1–17 Years),* and *Blood Glucose and Cholesterol Testing—Total (1–17 Years)*<br>– *Childhood Immunization Status—Combination 3, Combination 7,* and *Combination 10*<br>– *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*<br>– *Child and Adolescent Well-Care Visits—Total (3–21 Years).* |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| • DCS CHP's rates for these performance measures were at or above the 90th percentile: **[Quality, Access]**<br>– *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total (1–17 Years), Cholesterol Testing—Total (1–17 Years),* and *Blood Glucose and Cholesterol Testing—Total (1–17 Years)*<br>– *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*<br>– *Child and Adolescent Well-Care Visits—Total (3–21 Years)*<br>• *Childhood Immunization Status—Combination 3* and *Combination 10* rates were at or above the 75th percentile. **[Quality, Access]**<br>•<br>• DCS CHP demonstrated strength in providing pediatric care for members. |
| **Opportunities for Improvement and Recommendations** |
| While DCS CHP generally had appropriate data systems, processes, and oversight, the audit identified the following considerations and recommendations for future years' reporting **[Quality]**:<br><br>Recommendations:<br>• HSAG recommends that DCS CHP continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting.<br>• HSAG recommends that DCS CHP continue to ensure that the mapping of provider specialties to HEDIS provider types is compliant with AHCCCS' requirements for PMV reporting.<br>• DCS CHP has continued to contract with Mercy Care as its subcontracted health plan to produce AHCCCS-required performance measures, and HSAG recommends that DCS CHP continue to maintain this partnership, which allows DCS CHP to appropriately report the AHCCCS PMV measures.<br>• For CY 2022 performance measure reporting, RES was required based on NCQA HEDIS specifications. While HSAG did not identify specific opportunities for DCS CHP to improve RES, DCS CHP could benefit from continuing to focus on refining RES reporting where required per measure specifications. Therefore, HSAG recommends that DCS CHP explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratifications related to RES. DCS CHP should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information. |

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

Table 8-6 presents performance measure recommendations made to DCS CHP in the CYE 2022 Annual Technical Report[8-1] and DCS CHP's follow-up to the recommendations, as well as an assessment of the degree to which DCS CHP has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 8-6—DCS CHP Program Follow-Up to CYE 2022 Performance Measure Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| **Recommendation 1:** |
| Mercy Care is an established, existing AHCCCS Contractor that already submits the same AHCCCS performance measures and an extended measure set, so its experience offers DCS CHP an increased likelihood of reporting reliable rates. Therefore, HSAG recommended that DCS CHP identify a method by which it can provide the required administrative data to Mercy Care so that Mercy Care can leverage its HEDIS Certified Measures[SM,8-2] vendor to produce future DCS CHP rates. HSAG further recommended that DCS CHP monitor and trend its subcontracted health plan's performance as part of its oversight activities and finalize the matrix of responsibilities and oversight plan that DCS CHP had indicated was in the process of being drafted for CY 2021. |
| **DCS CHP's Response:**<br>As eligibility data for this time period (CY 2022) was not available to Mercy Care, DCS CHP produced performance measures *Childhood Immunization Status (CIS)* and *Immunizations for Adolescents (IMA)*. All other DCS CHP performance measures for this time period (CY 2022) were produced by Mercy Care utilizing its HEDIS Certified Measures vendor. All of the CY 2022 annual performance measures were validated through the AHCCCS designated EQRO.<br><br>All future (CY 2023 and onward) performance measures will be produced by Mercy Care utilizing its HEDIS Certified Measures vendor. |
| **HSAG's Assessment:** HSAG has determined that DCS CHP has satisfactorily addressed these prior year's recommendations, which resulted in nine of the 10 performance measure rates meeting or exceeding the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. |
| **Recommendation 2:** |
| HSAG recommended that DCS CHP explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratifications related to RES. DCS CHP |

[8-1] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP). Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Jan 30, 2024.

[8-2] HEDIS Certified Measures [SM] is a service mark of the National Committee for Quality Assurance (NCQA).

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
| --- |
| should continue working with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information. |

**DCS CHP's Response:**

During calendar year 2023, DCS CHP coordinated efforts with DCS to identify race and ethnicity data for the DCS CHP population.
DCS CHP's enrollment is primarily children and youth, removed from their families, in the Department of Child Safety's (DCS') care. As such, biological parents may not be available to provide a comprehensive ethnic/race profile.

DCS' State Fiscal Year 2024 Strategic Plan provides the foundation for the Department's efforts to provide support to strengthen all types of families in the child's network and community; promote culture, practices and services which are anchored in a vision of Diversity, Equity & Inclusion (DEI) and accessibility; and build a culture that is characterized by compassion, empathy, collaborative problem-solving, inclusion, transparency, responsiveness, and engagement. As part of the annual objectives highlighted in the Department's Strategic Plan to address racial and ethnic disparities, DCS made a concerted effort to ensure data are complete in its child welfare information system, to the greatest extent possible.

DCS CHP's work with DCS resulted in the inclusion of the race and ethnicity data in the weekly removal reports produced by DCS' child welfare system. The DCS CHP eligibility and enrollment team then utilizes these removal reports to complete the Health-e-Arizona Plus application for each of the newly removed children/youth in DCS' care. The process for including race and ethnicity data during the application process is reliant on information gathered by DCS child welfare staff, as well as the availability of birth certificates and other data sources.

To enhance future reporting methodologies related to race and ethnicity data for Title XIX eligible DCS CHP members, the DCS CHP eligibility and enrollment team also revised its enrollment process to include mandatory entry of race and ethnicity data into the Health-e-Arizona Plus system, thereby enhancing the State systems with race and ethnicity data.

These data are then available for enrollment files generated by AHCCCS to health plans, including DCS CHP, for incorporation into the health plans' claims and enrollment systems and incorporation into data systems that inform performance measures. DCS CHP makes this information available to our partner Mercy Care for utilization in care management, and performance improvement efforts to evaluate and address racial and ethnic disparities.

As a result, DCS CHP continues to improve the availability of data in terms of completeness and accuracy. DCS CHP evaluated the age and ethnicity of the children/youth in out-of-home care as reported in the DCS Semi-Annual Child Welfare Report September 2023. Ethnicity within the DCS system of care appears to be significantly lower in the category of "Other" than that of what is reported to AHCCCS by health plan providers.

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| **HSAG's Assessment:** HSAG has determined that DCS CHP has satisfactorily addressed these prior year's recommendations; however, DCS CHP should continue working with AHCCCS on collaborative efforts to improve the capture of race and ethnicity data to support performance measure reporting that requires stratification related to RES. |
| **Recommendation 3:** |
| HSAG recommended that DCS CHP conduct a root cause analysis to determine why some children were not always getting their immunizations by their second birthday. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. DCS CHP should consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). Additionally, DCS CHP should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, HSAG recommends that DCS CHP implement appropriate interventions to improve the performance related to childhood immunizations. |
| **DCS CHP's Response:**<br>The measure *CIS* looks at members who turn 2 years of age in the measurement year. The eligibility criteria look at enrollment for the duration of the calendar year with some allowance for a gap. This gap is applicable during the eligibility period; i.e., between 12 and 24 months of age.<br><br>The DCS CHP population is primarily children and youth, removed from their families, in DCS' care. It is rare that the member is in care or in the health plan at birth because children in foster care are removed from their families. The majority of children are in care because of neglect, which may encompass medical neglect, where medical services have not been provided prior to entering DCS' care.<br><br>Because of the nature of the population and the timing of immunizations at birth and at 2 months, 4 months, 6 months, and 1 year of age and the restrictions on catch-up immunization when immunizations are delayed, the number of vaccines for children in foster care may not meet the required "number" of vaccines required by the *CIS* measure, even though the child may have been "up to date" at the time of review (with some vaccines that may have been provided outside of the date parameters for the *CIS* measure). In addition, Mercy Care conducted a root cause analysis of additional issues.<br><br>As a result of this analysis, Mercy Care developed the following interventions aimed at increasing the number and percentage of children who receive preventive vaccinations according to recommended schedules:<br>• Distribution of the latest AHCCCS Periodicity Schedule to MC care managers to remind caregivers of the required visit intervals.<br>• Partnership and collaboration with PCCN and EHN to promote EPSDT awareness. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| DCS CHP's final MY 2022 rates for all three combinations exceeded the MY 2022 NCQA HEDIS Medicaid means:<br>• *Childhood Immunization Status (Combination 3)* rate of 71.81% exceeds the NCQA HEDIS Medicaid mean of 63.16%<br>• *Childhood Immunization Status (Combination 7)* rate of 59.57% exceeds the NCQA HEDIS Medicaid mean of 54.86%<br>• *Childhood Immunization Status (Combination 10)* rate of 38.56% exceeds the NCQA HEDIS Medicaid mean of 31.86% |
| **HSAG's Assessment:** HSAG has determined that DCS CHP has satisfactorily addressed these prior year's recommendations, implementing interventions based on conducting a root cause analysis, and improving performance measure rates. |
| **Recommendation 4:** |
| HSAG recommended that DCS CHP identify best practices to support children in receiving well-care visits according to recommended schedules. HSAG also recommended that DCS CHP conduct a root cause analysis to determine why some children and adolescents were not always accessing well-care visits. Upon identification of a root cause, HSAG recommended that DCS CHP implement appropriate interventions to improve the performance related to well-care visits. (Of note, DCS CHP is currently conducting the *Back to Basics* PIP, which includes a root cause analysis and interventions to address this measure.) |
| **DCS CHP's Response:**<br>Well-care visits are measured by the *W30* and *WCV* measures. The measure *W30* looks at members who turn 15 months old in the measurement year. The eligibility criteria look at enrollment for the duration of the calendar year with some allowance for a gap. This gap is applicable during the eligibility period; i.e., between 3 and 15 months of age.<br><br>The DCS CHP population is primarily children and youth, removed from their families, in DCS' care. It is rare that the member is in care or in the health plan at birth because children in DCS care are removed from their families. The majority of children are in care because of neglect, which often encompasses medical neglect where care has not been provided in the time before they enter DCS' care.<br><br>The nature of the population and the timing of well visits at birth, 1 month, and 2 months occurs in the time frame that is not accounted for in the eligibility period.<br><br>In addition, a root cause analysis, inclusive of completion of a provider survey, was conducted to identify barriers to accessing well-child visits.<br><br>Identified barriers include:<br>• Members seen outside of the measurement period and not in accordance with the periodicity schedule; i.e., not having a full six visits prior to 15 months of age. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| • Providers only seeing members for sick visits or shots only visits and not well visits (adding modifier 25 and completing a well visit at the time of service).<br>• Claims lag may cause providers to feel that our data are "inaccurate" and they may be less likely to use the gaps in care lists to outreach members.<br>• Member postponement of many nonessential health services during the COVID-19 PHE.<br><br>As a result of these findings, the Mercy Care EPSDT coordinators provided enhanced provider education on:<br>• The AHCCCS periodicity schedule, which requires 8 well-visits by age 15 months and annual well visits after 24 months of age.<br>• Well-child visit codes.<br>• Sick and well-visit combination and coding (modifier 25).<br>• Mercy Care's "unlimited" well-child visit policy.<br><br>DCS CHP's final MY 2022 rates for *Child and Adolescent Well-Care Visits* and *Well-Child Visits in the First 30 Months—15–30 Months of Age* both exceeded the MY 2022 NCQA HEDIS Medicaid means:<br>• *Child and Adolescent Well-Care Visits* rate of 71.02% exceeds the NCQA HEDIS Medicaid mean of 48.61% and the 95th percentile of 66.23%<br>• *Well-Child Visits in the First 30 Months—15–30 Months of Age* rate of 70.91% exceeds the NCQA HEDIS Medicaid mean of 66.74%<br>• *Well-Child Visits in the First 30 Months—0–14 Months of Age* rate of 53.54% does not yet meet the NCQA HEDIS Medicaid mean of 56.76%; however, the rate with claims through 09/30/2023, 63.45%, does exceed the mean of 56.76% and demonstrates a 25.0 percent improvement over the 2022 rates for the same time period.<br><br>Additional interventions implemented to further improve and increase the rate of well-child visits include:<br>• Distribution of the latest AHCCCS Periodicity Schedule to MC care managers to remind caregivers of the required visit intervals.<br>• Partnership and collaboration with PCCN and EHN to promote EPSDT awareness.<br><br>Mercy Care and DCS CHP also worked with AHCCCS to implement a TJ modifier to the EPSDT claims for children in foster care as a provider incentive to increase EPSDT completion. |
| **HSAG's Assessment:** HSAG has determined that DCS CHP's response addressed these prior year's recommendation and has described specific activities that were implemented to address the recommendation. |

## Validation of Performance Improvement Projects

In CY 2023, DCS CHP continued the *Back to Basics* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 1, PIP validation activities focused on improvement from the baseline results. DCS CHP submitted Remeasurement 1 performance indicator results and interventions implemented along with the status of interventions, focus, and rationale for changes or discontinuation of the interventions.

HSAG conducted an annual validation of the first remeasurement year reflective of CY 2022 (January 1, 2022, through December 31, 2022) using AHCCCS-calculated and validated indicator rates. HSAG evaluated DCS CHP's performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in Appendix A. Methodology.

### Validation Results

Table 8-7 displays the overall confidence levels for the DCS CHP *Back to Basics* PIP.

**Table 8-7—DCS CHP *Back to Basics* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| DCS CHP | *High Confidence* | 100% | 100% | *No Confidence* | 33% | 100% |

### Measure Results

Table 8-8 provides the *Back to Basics* PIP baseline, intervention year, and Remeasurement 1 rates for the indicator for DCS CHP.

**Table 8-8—DCS CHP Program *Back to Basics* PIP Rates for Indicator 2**

| Contractor | PIP Indicator 2: *WCV* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| DCS CHP | 72.6% | 71.0% |

## Interventions

Table 8-9 presents PIP interventions for the DCS CHP Program. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 8-9—DCS CHP Program *Back to Basics* PIP Interventions**

| Contractor | Interventions |
|---|---|
| DCS CHP | • Integrated care management outreach members to focus on the provision of preventive EPSDT services and routine preventive dental visits.<br>• HPV educational mailing to members turning 11 years of age.<br>• Mailing to parents/guardians of 1-month-olds that includes a well-child magnet listing the ages that children need well visits and a booklet on immunizations and debunking immunization myths.<br>• EPSDT reminder cards, including information consistent with the AHCCCS periodicity schedule.<br>• EPSDT second reminder cards.<br>• Written reminders: member handbook, member newsletters, and newborn booklets to promote well-child visits; EPSDT reminder cards; and well-child reminder letters.<br>• Written provider outreach process which includes mailings to PCPs for members in need of an EPSDT visit; members 0–24 months of age in need of immunizations; adolescents in need of immunizations; a reminder on the requirement to conduct a developmental screening at the 9-, 18-, and 24-month visits; information pertaining to the member's historical dental care and whether or not the member is due for dental care.<br>• Virtual or face-to-face contacts between the Mercy Care coordinators and providers encouraging outreach efforts to members lacking childhood immunizations and/or well-child visits.<br>• Provider pay for performance to VBS groups for improving performance in the measure.<br>• Adolescent immunization reminder card is mailed to the parents/guardians of members during the month of the member's 12th birthday, reminding them of the importance of obtaining immunizations.<br>• Mailing to the Native American members in need of a well visit a cover letter and CDC brochure specific to the health of Native Americans.<br>• Follow-up calls to members who were referred for dental screening or services via an EPSDT visit.<br>• Dental mailing to members who were referred for dental screening or services via an EPSDT visit. |

| Contractor | Interventions |
|---|---|
| | • Self-mailer is sent to members 6–9 years of age and includes information on the importance of dental sealants.<br>• Educate PCPs on the application of fluoride varnish, including the required training and the process for submission of the certificate of completion.<br>• The dental vendor to send dental "gaps in care" letter to contracted dental providers who have members assigned to them through the dental home program who are in need of preventive dental care and/or dental sealant application.<br>• MCH/EPSDT, Network Management, and Care Management staff will develop a collaborative outreach and engagement strategy to improve surveillance of adolescent well visits.<br>• Care Management monitors gaps in care for all youth enrolled in Peds Care Management.<br>• Leverage tribal liaisons to engage members who might be difficult to engage or find, provide health information, offer a referral, assist with navigation, etc., to assist in addressing health disparities.<br>• Meet with Native Health and the Phoenix Indian Medical Center to determine if partnership opportunities exist.<br>• Partnership and collaboration with PCCN and EHN to promote EPSDT awareness.<br>• Implement the newly approved TJ modifier for all EPSDT codes to increase provider reimbursement for completion of EPSDT visits for DCS CHP members (200% for new patients, 150% for established patients).<br>• Distribution of the latest AHCCCS Periodicity Schedule to MC care managers to remind caregivers of the required visit intervals.<br>• Refer new members to PCCN providers for comprehensive EPSDT services and care. |

## Strengths, Opportunities for Improvement, and Recommendations

Table 8-10 presents strengths, opportunities for improvement, and recommendations for DCS CHP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 8-10—DCS CHP Program Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG noted that DCS CHP performed accurate statistical testing between the baseline and Remeasurement 1 results. **[Quality, Access]**<br><br>DCS CHP implemented and developed measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 2. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| For indicator 2, DCS CHP had a decline in the indicator rate between the baseline year and Remeasurement Year 1. **[Quality, Access]**<br><br>Recommendations: As the PIP progresses, HSAG recommends that DCS CHP:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

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

Table 8-11 presents PIP recommendations made to DCS CHP in the CYE 2022 Annual Technical Report[8-3] and DCS CHP's follow-up to the recommendations, as well as an assessment of the degree to which DCS CHP has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 8-11—DCS CHP Program Follow-Up to CYE 2022 PIP Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| HSAG recommends that DCS CHP:<br>• Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary. |

[8-3] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP). Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Jan 30, 2024.

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| • Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available.<br>• Develop and document a plan for sustaining the improvement for any demonstrated improvement in indicator rates. |
| **DCS CHP's Response:**<br>PIP indicator data are reviewed by DCS CHP quarterly and annually.<br><br>DCS CHP also reviews data complementary to *Back to Basics* PIP data (EPSDT and dental rates) monthly with our partner Mercy Care, which involves tracking of outcomes, trending, identification of the root causes of deficiencies, and addressing barriers as well as adjustments of interventions for improvement. Goals are continuously evaluated and adjusted to sustain and encourage continued improvement.<br><br>Methodology to evaluate whether or not goals are being met is determined through ongoing quality reviews and reported at quarterly quality management/performance improvement (QMPI) meetings. In addition, the Medical Management team and Pharmacy review utilization data quarterly. Areas of deficiency are identified and targeted for correction. All teams evaluate trends, disseminate information, and implement corrective actions as needed.<br><br>Interventions are monitored for performance using problem-solving models/methods such as PDSA to evaluate the effectiveness of the change. The PDSA cycle is iterative and may be cycled through multiple times until the problem is effectively addressed and the desired outcomes are achieved. Each cycle builds on the knowledge gained from the previous one, leading to continuous improvement over time.<br><br>Measurable and realistic goals are set according to NCQA HEDIS or CMS measurements. When DCS CHP is performing above those measurements in order to sustain the improvement trend, an administrative goal is set averaging the rates of the last three quarters and is continuously reevaluated. |
| **HSAG's Assessment:** HSAG has determined that the Contractor has satisfactorily addressed these prior year's recommendations. |

## *Compliance Reviews*

### Results

AHCCCS conducted a compliance review of DCS CHP from November 14, 2022, through November 17, 2022. On January 31, 2023, AHCCCS finalized the report findings, provided DCS CHP with a CAP submission matrix, and required a CAP for any standard with a total score of less than 95 percent. After the Contractor's first CAP submission, AHCCCS accepted some of the proposed CAPs but required additional information. On June 27, 2023, AHCCCS accepted DCS CHP's proposed CAPs and required the Contractor to submit updated policies, manuals, desktop procedures, and other vital documents to

provide evidence of CAP completion, due December 27, 2023. Table 8-12 presents the compliance review results for DCS CHP.

**Table 8-12—DCS CHP Program Compliance Review Results**

| Focus Areas | CYE 2022 DCS CHP Scores | CYE 2023 DCS CHP CAP Update |
|---|---|---|
| CC | 100% | NA |
| CIS | 99% | NA |
| DS | 7% | PM |
| GA | 60% | PM |
| GS | 100% | NA |
| MCH | 60% | PM |
| MM | 91% | PM |
| MI | 94% | PM |
| QM | 77% | PM |
| QI | 92% | PM |
| RI | 100% | NA |
| TPL | 100% | NA |
| ISOC | 100% | NA |

NA = "not applicable." A CAP was not required as the CYE 2022 score was 95% or above.
PM = "partially met." AHCCCS approved the Contractor's proposed CAP. The Contractor must submit evidence of compliance.
M = "met." AHCCCS accepted and closed the Contractor's CAP.

## Strengths, Opportunities for Improvement, and Recommendations

Table 8-13 presents strengths, opportunities for improvement, and recommendations for DCS CHP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 8-13—DCS CHP Program Strengths, Opportunities for Improvement, and Recommendations Related to Compliance**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| AHCCCS approved DCS CHP's proposed CAPs for all Focus Areas with scores less than 95 percent. DCS CHP will provide evidence of CAP completion in CYE 2024. |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Opportunities for Improvement and Recommendations** |
| DCS CHP has remaining CAPs in the following Focus Areas:<br>• Delivery Systems (DS) **[Timeliness, Access]**<br>• General Administration (GA) **[Timeliness, Access]**<br>• Adult, EPSDT and Maternal Child Health (MCH) **[Quality, Timeliness, Access]**<br>• Medical Management (MM) **[Timeliness, Access]**<br>• Member Information (MI) **[Quality]**<br>• Quality Management (QM) **[Quality]**<br>• Quality Improvement (QI) **[Quality, Access]**<br><br>Recommendation: HSAG recommends that DCS CHP continue to work on outstanding CAP items and submit to AHCCCS in the approved time frame. |

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

Table 8-14 presents compliance recommendations made to DCS CHP in the CYE 2022 Annual Technical Report[8-4] and DCS CHP's follow-up to the recommendations, as well as an assessment of the degree to which DCS CHP has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 8-14—DCS CHP Program Follow-Up to CYE 2022 Compliance Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for Compliance |
|---|
| HSAG recommended that DCS CHP consider conducting a self-assessment of the DS, GA, MCH, MM, MI, QM and QI Focus Area requirements. |
| **DCS CHP's Response:**<br>DCS CHP did not provide a response to the prior year's recommendation related to compliance review activities. |
| **HSAG's Assessment:**<br>Based on the CAP approval for all Focus Areas reviewed in CYE 2023, HSAG determined that DCS CHP satisfactorily addressed the prior year's recommendation related to compliance review. |

[8-4] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP). Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Jan 30, 2024.

## Network Adequacy Validation

HSAG's semiannual validation of DCS CHP's results showed minor discrepancies between the Contractor's self-reported ACOM 436 results and HSAG's time/distance calculations in each quarter that data could be compared. While minor differences (i.e., less than 1 percentage point) between HSAG's time/distance calculation results and the Contractor's time/distance calculation results were common, these findings may be attributable to the timing of the input data, software versions used by the Contractor, or due to a small number of members eligible for inclusion in time/distance calculations for the standard and county.

Table 8-15 summarizes HSAG's assessment of DCS CHP's compliance with AHCCCS' minimum time/distance network standards. A check mark indicates that DCS CHP met the minimum network standard for each Arizona county during the semiannual assessment, and an "X" indicates that DCS CHP failed to meet one or more minimum network standards in any assigned county or quarter.

**Table 8-15—Summary of CYE 2023 Compliance with Minimum Time/Distance Network Requirements for DCS CHP**

| Minimum Network Requirement | DCS CHP |
|---|---|
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | ✓ |
| BHRF (Only Maricopa and Pima Counties) | X |
| Cardiologist, Pediatric | ✓ |
| Dentist, Pediatric | X |
| Hospital | ✓ |
| Obstetrician/Gynecologist | ✓ |
| Pharmacy | X |
| PCP, Pediatric | X |

DCS CHP consistently met the Behavioral Health Outpatient and Integrated Clinic, Pediatric; Cardiologist, Pediatric; Hospital; and OB/GYN standards while not consistently meeting the standards for BHRF; Dentist, Pediatric; PCP, Pediatric; and Pharmacy. DCS CHP met all minimum time/distance network standards during both quarters in Cochise, Maricopa, Mohave, Navajo, Pinal, Santa Cruz, Yavapai, and Yuma counties.

As part of the NAV, AHCCCS maintained its feedback process for DCS CHP to review and improve the accuracy of its data submissions. Specifically, AHCCCS supplied DCS CHP with a copy of HSAG's quarterly network adequacy analysis, a copy of the PAT file that HSAG used to conduct the analysis, and a copy of HSAG's saturation analysis results. When issues were identified, DCS CHP was expected to research the instances and make corrections for future PAT data and/or ACOM 436 submissions.

DCS CHP should continue to monitor and maintain its existing provider network as of CYE 2023 Q4, with specific attention to ensuring the availability of the following provider types:

- BHRF in Pima County
- Dentist, Pediatric in Apache, Gila, Graham, Greenlee and La Paz counties
- Pharmacy in Graham County

## Results

HSAG evaluated DCS CHP's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents semiannual validation findings specific to the DCS CHP Program, with one results table for each of the following GSAs:

- Central GSA: Gila, Maricopa,[8-5] and Pinal counties
- North GSA: Apache, Coconino, Mohave, Navajo, and Yavapai counties
- South GSA: Cochise, Graham,[8-6] Greenlee, La Paz, Pima, Santa Cruz,[8-7] and Yuma counties

Each region-specific table summarizes semiannual validation results containing the percentage of members meeting each time/distance standard by quarter and county, with color-coding to identify whether or not the time/distance standard was "Met" or "Not Met."

The value "NA" is shown for time/distance standards that do not apply to the county or program.

The value "NR" is shown for time/distance standards in which no members met the network requirement denominator for the program and county; therefore, HSAG calculated no corresponding time/distance result.

Yellow color-coding identifies instances in which HSAG's time/distance results met the minimum network requirement but differed from the ACOM 436 results.

Red color-coding identifies instances in which HSAG's time/distance results did not meet the compliance standard, regardless of the ACOM 436 results.

An asterisk (*) indicates that fewer than 10 members were included in the denominator of HSAG's results.

A carat (^) indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

[8-5] Maricopa County includes the 85342, 85358, and 85390 ZIP Codes; these ZIP Codes are physically located in both Maricopa and Yavapai counties.
[8-6] Graham County includes the 85542, 85192, and 85550 ZIP Codes representing the San Carlos Tribal area; these ZIP Codes are physically located in Gila or Pinal County.
[8-7] Santa Cruz County includes the 85645 ZIP Code; this ZIP Code is physically located in both Pima and Santa Cruz counties.

**Table 8-16—DCS CHP Time/Distance Validation Results for Central GSA—Percentage of Members Meeting Minimum Network Requirements**

| | Gila | | Maricopa | | Pinal | |
|---|---|---|---|---|---|---|
| Minimum Network Requirement | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 100.0^ | 100.0^ | 97.1^ | 97.5^ | 100.0^ | 100.0^ |
| BHRF | NA | NA | 99.5 | 98.3 | NA | NA |
| Cardiologist, Pediatric | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| Dentist, Pediatric | 100.0 | 34.5 | 99.5 | 99.4 | 99.7 | 99.4 |
| Hospital | 100.0 | 100.0 | 99.9 | 100.0 | 100.0 | 100.0 |
| OB/GYN | 100.0* | 100.0* | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 100.0 | 100.0 | 99.2 | 99.2 | 100.0 | 100.0 |
| PCP, Pediatric | 100.0^ | 100.0^ | 99.8^ | 99.8^ | 100.0^ | 100.0^ |

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

represents time/distance standard results that do not meet the compliance standard based on HSAG's results.

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

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

NA indicates results are not applicable to the county.

**Table 8-17—DCS CHP Time/Distance Validation Results for North GSA—Percentage of Members Meeting Minimum Network Requirements**

| | Apache | | Coconino | | Mohave | | Navajo | | Yavapai | |
|---|---|---|---|---|---|---|---|---|---|---|
| Minimum Network Requirement | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 93.1^ | 93.0^ | 82.2^ | 83.9^ | 94.8^ | 96.1^ | 95.8^ | 96.4^ | 100.0^ | 100.0^ |
| BHRF | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Cardiologist, Pediatric | 93.1^ | 97.7^ | 100.0^ | 100.0^ | 100.0^ | 98.9^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| Dentist, Pediatric | 86.2 | 83.7 | 97.3 | 97.4 | 93.5 | 92.2 | 97.2 | 96.4 | 98.8 | 98.6 |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 | 98.1 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| OB/GYN | 100.0* | 100.0* | 100.0 | 100.0 | 100.0 | 100.0 | 100.0* | 100.0* | 100.0 | 100.0 |
| Pharmacy | 100.0 | 100.0 | 80.0 | 91.2 | 94.2 | 96.1 | 95.8 | 97.3 | 97.1 | 98.2 |
| PCP, Pediatric | 93.1^ | 95.3^ | 78.7^ | 91.2^ | 96.8^ | 95.0^ | 94.4^ | 98.2^ | 100.0^ | 100.0^ |

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

represents time/distance standard results that do not meet the compliance standard based on HSAG's results.

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

^ indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.

**Table 8-18—DCS CHP Time/Distance Validation Results for South GSA—Percentage of Members Meeting Minimum Network Requirements**

| | Cochise | | Graham | | Greenlee | | La Paz | | Pima | | Santa Cruz | | Yuma | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Minimum Network Requirement** | **Q2** | **Q4** | **Q2** | **Q4** | **Q2** | **Q4** | **Q2** | **Q4** | **Q2** | **Q4** | **Q2** | **Q4** | **Q2** | **Q4** |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0*^ | 100.0^ | 100.0^ | 100.0^ | 94.9^ | 95.2^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| BHRF | NA | NA | NA | NA | NA | NA | NA | NA | 87.8 | 87.9 | NA | NA | NA | NA |
| Cardiologist, Pediatric | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0*^ | 100.0^ | 100.0^ | 100.0^ | 99.8^ | 99.8^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| Dentist, Pediatric | 98.2 | 94.8 | 94.7 | 84.3 | 100.0* | 86.7 | 64.3 | 84.6 | 98.0 | 97.4 | 100.0 | 100.0 | 100.0 | 100.0 |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 | 100.0* | 100.0 | 100.0 | 100.0 | 99.6 | 99.4 | 100.0 | 100.0 | 100.0 | 100.0 |
| OB/GYN | 100.0 | 100.0 | 100.0* | 100.0* | NR* | 100.0* | 100.0* | 100.0* | 100.0 | 99.3 | NR* | NR* | 100.0 | 100.0 |
| Pharmacy | 98.2 | 94.8 | 94.7 | 88.2 | 100.0* | 100.0 | 92.9 | 100.0 | 98.6 | 97.8 | 100.0 | 100.0 | 100.0 | 100.0 |
| PCP, Pediatric | 98.2^ | 94.8^ | 94.7^ | 88.2^ | 100.0*^ | 100.0^ | 100.0^ | 100.0^ | 99.2^ | 99.3^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
represents time/distance standard results that do not meet the compliance standard based on HSAG's results.
NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.
* indicates that fewer than 10 members were included in the denominator of HSAG's results.
^ indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.

## Strengths, Opportunities for Improvement, and Recommendations

Table 8-19 presents strengths, opportunities for improvement, and recommendations for DCS CHP, as well as the related domains (Quality, Access, and/or Timeliness) for each strength and opportunity for improvement.

**Table 8-19—DCS CHP Program Strengths, Opportunities for Improvement, and Recommendations Related to NAV**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths:<br>• DCS CHP met all minimum time/distance network standards during both quarters in Cochise, Maricopa, Mohave, Navajo, Pinal, Santa Cruz, Yavapai, and Yuma counties. **[Access]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| • DCS CHP met the Behavioral Health Outpatient and Integrated Clinic, Pediatric; Cardiologist, Pediatric; Hospital; and OB/GYN standards. **[Access]**<br><br>Note: DCS CHP provides coverage statewide in the following counties: Apache, Cochise, Coconino, Gila, Graham, Greenlee, La Paz Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma. |
| **Opportunities for Improvement and Recommendations** |
| HSAG identified the following opportunities for improvement:<br>• DCS CHP did not meet standards for at least one quarter and/or county for the BHRF; Dentist, Pediatric; and Pharmacy standards. **[Access]**<br><br>Recommendation: HSAG recommends that DCS CHP maintain current compliance with network standards but continue to address network gaps, as applicable. |

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

Table 8-20 presents NAV recommendations made to DCS CHP in the CYE 2022 Annual Technical Report[8-8] and DCS CHP's follow-up to the recommendations, as well as an assessment of the degree to which DCS CHP has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 8-20—DCS CHP Program Follow-Up to CY 2022 NAV Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for NAV |
|---|
| HSAG recommended that Mercy Care DCS CHP maintain current compliance with network standards but continue to address network gaps, as applicable. |
| **DCS CHP's Response:**<br>DCS CHP did not provide a response to the prior year's recommendation. |
| **HSAG's Assessment:**<br>HSAG has determined that DCS CHP was unresponsive and did not describe specific activities planned to address the prior year's recommendation. |

[8-8] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP) Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportACCandDCSCHP.pdf. Accessed on: Jan 30, 2024.

## Consumer Assessment of Healthcare Providers and Systems Results

### DCS CHP Results

HSAG administered member experience surveys on AHCCCS' behalf to members enrolled in the AHCCCS' DCS CHP. DCS CHP is Arizona's CHIP for eligible children (under age 18 years) who do not qualify for other AHCCCS health insurance. AHCCCS contracted with HSAG to administer and report the results of the CAHPS Health Plan Survey for DCS CHP. The goal of the CAHPS Health Plan Survey is to provide performance feedback that is actionable and will aid in improving overall member experience.

HSAG calculated results for four global ratings, four composite measures, one individual item measure, three CCC composite measures (CCC population only), and two CCC individual item measures (CCC population only).

Table 8-21 shows the scores and overall member experience ratings on each CAHPS measure for both the general child and CCC populations.

**Table 8-21—NCQA Comparisons**

| Measure | 2023 General Child | 2023 CCC Medicaid |
|---|---|---|
| **Global Ratings** | | |
| *Rating of Health Plan* | ★<br>61.8% | ★<br>52.8% |
| *Rating of All Health Care* | ★<br>65.4% | ★<br>55.4% |
| *Rating of Personal Doctor* | ★★★<br>79.0% | ★★<br>76.4% |
| *Rating of Specialist Seen Most Often* | ★★★★<br>77.4% | ★★★<br>75.7% |
| **Composite Measures** | | |
| *Getting Needed Care* | ★★<br>82.7% | ★<br>79.8% |
| *Getting Care Quickly* | ★★★<br>89.3% | ★★<br>87.3% |
| *How Well Doctors Communicate* | ★★★★★<br>98.0% | ★★★★★<br>96.9% |
| *Customer Service* | ★<br>82.0%+ | NA<br>83.3%+ |

| Measure | 2023 General Child | 2023 CCC Medicaid |
|---|---|---|
| **Individual Item Measure** | | |
| *Coordination of Care* | ★ 79.3% | ★ 70.9% |
| **CCC Composite Measures and Items** | | |
| *Access to Specialized Services* | NA | ★ 69.3%+ |
| *FCC: Personal Doctor Who Knows Child* | NA | ★ 87.5% |
| *Coordination of Care for Children with Chronic Conditions* | NA | ★ 73.5%+ |
| *Access to Prescription Medicines* | NA | ★ 85.1% |
| *FCC: Getting Needed Information* | NA | ★★★ 92.9% |

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
Star Assignments Based on Percentiles:
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
NA indicates that this measure is not applicable for the population or the benchmark is not available.

## Strengths, Opportunities for Improvement, and Recommendations

Table 8-22 presents program-level strengths, opportunities for improvement, and recommendations for DCS CHP related to the 2023 DCS CHP program-level CAHPS results.

**Table 8-22—DCS CHP Strengths, Opportunities for Improvement, and Recommendations Related to CAHPS**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths for DCS CHP:<br>• DCS CHP's member experience rating for *How Well Doctors Communicate* met or exceeded the 90th percentile for the general child and CCC populations. **[Quality]**<br>• DCS CHP's member experience rating for *Rating of Specialist Seen Most Often* met or exceeded the 75th percentile for the general child population. **[Quality]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Opportunities for Improvement and Recommendations** |
| HSAG identified the following opportunities for improvement for DCS CHP:<br>• DCS CHP's member experience rating for *Rating of Health Plan*, *Rating of All Health Care*, and *Coordination of Care* were below the 25th percentiles for the general child and CCC populations. **[Quality]**<br>• DCS CHP's member experience rating for *Customer Service* was below the 25th percentile for the general child population. **[Quality]**<br>• DCS CHP's member experience rating for *Getting Needed Care*, *Access to Specialized Services*, *FCC: Personal Doctor Who Knows Child, Coordination of Care for Children with Chronic Conditions*, and *Access to Prescription Medicines* were below the 25th percentiles for the CCC population. **[Quality, Access]**<br>• DCS CHP's member experience rating for *Getting Needed Care* was between the 25th and 49th percentiles for the general child population. **[Quality, Access]**<br>• DCS CHP's member experience rating for *Rating of Personal Doctor* and *Getting Care Quickly* were between the 25th and 49th percentiles for the CCC population. **[Quality, Timeliness]**<br>•<br>Recommendation: HSAG recommends that DCS CHP explore what may be driving lower experience scores and develop initiatives designed to improve quality and access to care, including a focus on improving parents'/caretakers' overall experiences with the health plan, healthcare, personal doctor, access to care in a timely manner, access to prescription medicines, coordination of care, and customer service for child members. |

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

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

CYE 2023 was the first year HSAG conducted the CAHPS survey for the DCS CHP population. Therefore, this section is not applicable.

# 9. ALTCS-EPD Program-Level Comparative Results

The **ALTCS-EPD Program** provides LTSS and integrated physical and behavioral health services to eligible members who are elderly and/or have a physical disability.

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

## Performance Measure Validation

During CYE 2023, HSAG evaluated each ALTCS-EPD Program Contractor's data system for processing of each data type used for reporting the Contractor's CY 2022 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements.[9-1] A summary of these findings by ALTCS-EPD Program Contractor is provided in Table 9-1. Table 9-1 also displays whether or not each ALTCS-EPD Program Contractor met the assessed Information Systems (IS) standards, which demonstrates whether or not the Contractor has effective IS practices and control procedures for data reporting. Additional information about each ALTCS-EPD Program Contractor's general findings for each data type reviewed can be found in Section 10. ALTCS-EPD Program Contractor-Specific Results. Additional information regarding the CMS EQR Protocol 2 audit requirements, including additional information about the levels of scoring, can be found in the Validation of Performance Measures section of Appendix A. Methodology.

**Table 9-1—Performance Measures Validation Contractor Comparison: CMS EQR Protocol 2 Validation Results for ALTCS-EPD Program Contractors**

| Data Type | BUFC LTC | Mercy Care LTC | UHCCP LTC |
|---|---|---|---|
| **Medical Services Data** | *Met* | *Met* | *Met* |
| **Enrollment Data** | *Met* | *Met* | *Met* |
| **Provider Data** | *Met* | *Met* | *Met* |
| **Medical Record Review Processes** | *Met* | *Met* | *Met* |
| **Supplemental Data** | *Met* | *Met* | *Met* |
| **Data Preproduction Processing** | *Met* | *Met* | *Met* |
| **Data Integration and Reporting** | *Met* | *Met* | *Met* |

[9-1] The Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 19, 2024.

## ALTCS-EPD Program-Level Results

Table 9-2 presents the CY 2022 aggregate performance measure results for the ALTCS-EPD Program Contractors. Performance measure rate cells shaded green indicate that the Contractor met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the national Medicaid mean are shaded green. Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

**Table 9-2—CY 2022 Performance Measure Results for ALTCS-EPD Program Contractors**

| Measure | BUFC LTC | Mercy Care LTC | UHCCP LTC | ALTCS-EPD Program Aggregate |
|---|---|---|---|---|
| ***Behavioral Health*** | | | | |
| ***Antidepressant Medication Management*** | | | | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | 74.4% | 68.9% | 83.0% | 75.6% |
| *Effective Continuation Phase Treatment—Total (18+ Years)* | 65.6% | 59.5% | 74.3% | 66.6% |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | NA ++ | 55.6% | 39.6% | 48.0% |
| *30-Day Follow-Up—Total (6+ Years)* | NA ++ | 72.2% | 66.0% | 69.7% |
| ***Use of Opioids at High Dosage*** | | | | |
| *18+ Years** | 12.2% | 12.1% | 10.8% | 11.6% |
| ***Initiation and Engagement of Substance Use Disorder (SUD) Treatment*** | | | | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | 50.2% | 56.7% | 55.8% | 54.8% |
| *Engagement of SUD Treatment—Total—Total (13+ Years)** | 4.8% | 10.2% | 5.3% | 7.1% |
| ***Care of Acute and Chronic Conditions*** | | | | |
| ***Controlling High Blood Pressure*** | | | | |
| *18–85 Years* | 74.5%+ | 74.7%+ | 72.5%+ | 74.0%+ |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | | | | |
| *HbA1c Control (<8.0 %)—Total (18–75 Years)* | 63.0%+ | 69.6%+ | 64.0%+ | 66.4%+ |
| *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)** | 37.0%+ | 23.4%+ | 27.0%+ | 27.5%+ |
| ***Pediatric Health*** | | | | |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotic Medications*** | | | | |
| *Blood Glucose Testing—Total (1–17 Years)* | NA ++ | NA ++ | NA ++ | NA ++ |
| *Cholesterol Testing—Total (1–17 Years)* | NA ++ | NA ++ | NA ++ | NA ++ |

| Measure | BUFC LTC | Mercy Care LTC | UHCCP LTC | ALTCS-EPD Program Aggregate |
|---|---|---|---|---|
| *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* | NA ++ | NA ++ | NA ++ | NA ++ |
| ***Oral Evaluation, Dental Services*** | | | | |
| *Total (0–20 Years)* N | 31.0% | 44.2% | 42.7% | 41.0% |
| ***Well-Child Visits in the First 30 Months of Life*** | | | | |
| *Six or More Well-Child Visits* | NA ++ | NA ++ | NA ++ | NA ++ |
| *15 Months–30 Months—Two or More Well-Child Visits* | NA ++ | NA ++ | NA ++ | NA ++ |
| ***Preventive Screening*** | | | | |
| ***Breast Cancer Screening*** | | | | |
| *Total (50–74 Years)* | 41.0% | 35.2% | 41.6% | 38.5% |
| ***Cervical Cancer Screening*** | | | | |
| *Total (21–64 Years)* | 44.8%+ | 33.1%+ | 32.6%+ | 35.5%+ |
| ***Appropriate Utilization of Services*** | | | | |
| ***Ambulatory Care*** | | | | |
| *Emergency Department (ED) Visits—Total (0–85+ Years)* F | 688.3 | 687.6 | 787.6 | 721.1 |
| ***Plan All-Cause Readmissions*** | | | | |
| *Observed Readmissions—Total (18–64 Years)* | 9.0% | 12.5% | 9.7% | 11.0% |
| *Expected Readmissions—Total (18–64 Years)* | 9.0% | 15.9% | 15.6% | 14.2% |
| *Outlier Rate—Total (18–64 Years)* | 90.4 | 107.9 | 96.9 | 100.2 |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)** | NA ++ | 0.7893 | 0.6241 | 0.7752 |

* A lower rate indicates better performance for this measure.
\+ Indicates the measure was reported using hybrid methodology.
++ NA indicates the denominator was too small to report a valid rate, based on the applicable measure specification.
N Measure has no NCQA Medicaid mean for comparison.
F NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months.
Cells shaded green indicate that the rate met or exceeded the MY 2022 national Medicaid mean.

Table 9-3 presents the CY 2021 and CY 2022 ALTCS-EPD Program Aggregate for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and MY 2022. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and/or MY 2022. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*).

**Table 9-3—CY 2021 and CY 2022 Performance Measure Aggregate Results for ALTCS-EPD Program Contractors**

| Measure | CY 2021 Performance | CY 2022 Performance | 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| ***Behavioral Health*** | | | | |
| ***Antidepressant Medication Management*** | | | | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | 72.0% | 75.6% | → | ★★★★★ |
| *Effective Continuation Phase Treatment—Total (18+ Years)* | 62.6% | 66.6% | → | ★★★★★ |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 44.4% | 48.0% | → | ★★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 51.6% | 69.7% | ↑ | ★★★★ |
| ***Use of Opioids at High Dosage**** | | | | |
| *18+ Years* | 11.9% | 11.6% | → | ★ |
| ***Initiation and Engagement of Substance Use Disorder (SUD) Treatment*** | | | | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | — | 54.8% | — | ★★★★ |
| *Engagement of SUD Treatment—Total—Total (13+ Years)** | — | 7.1% | — | ★ |
| ***Care of Acute and Chronic Conditions*** | | | | |
| ***Controlling High Blood Pressure*** | | | | |
| *18–85 Years* | 68.2% | 74.0% | ↑ | ★★★★★ |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | | | | |
| *HbA1c Control (<8.0 %)—Total (18–75 Years)* | — | 66.4% | — | ★★★★★ |
| *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)** | 33.0% | 27.5% | ↑ | ★★★★★ |
| ***Pediatric Health*** | | | | |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotics*** | | | | |
| *Blood Glucose Testing—Total (1–17 Years)* | — | NA | — | — |
| *Cholesterol Testing—Total (1–17 Years)* | — | NA | — | — |
| *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* | — | NA | — | — |
| ***Oral Evaluation, Dental Services*** | | | | |
| *Total (0–20 Years)*[N] | — | 41.0% | — | — |
| ***Well-Child Visits in the First 30 Months of Life*** | | | | |
| *Six or More Well-Child Visits* | — | NA | — | — |
| *15 Months–30 Months—Two or More Well-Child Visits* | — | NA | — | — |

| Measure | CY 2021 Performance | CY 2022 Performance | 2021–2022 Comparison[1] | 2022 Performance Level[2] |
|---|---|---|---|---|
| ***Preventive Screening*** | | | | |
| ***Breast Cancer Screening*** | | | | |
| *Total (50–74 Years)* | 35.4% | 38.5% | ↑ | ★ |
| ***Cervical Cancer Screening*** | | | | |
| *Total (21–64 Years)* | — | 35.5% | — | ★ |
| ***Appropriate Utilization of Services*** | | | | |
| ***Ambulatory Care*** | | | | |
| *Emergency Department (ED) Visits—Total (0–85+ Years)* [F] | 679.2 | 721.1 | — | — |
| ***Plan All-Cause Readmissions*** | | | | |
| *Observed Readmissions—Total (18–64 Years)* | 9.9% | 11.0% | → | — |
| *Expected Readmissions—Total (18–64 Years)* | — | 14.3% | — | — |
| *Outlier Rate—Total (18–64 Years)* | — | 100.2 | — | — |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)** | 0.7015 | 0.7752 | — | ★★★★★ |

* A lower rate indicates better performance for this measure.
+ Indicates the measure was reported using hybrid methodology in CY 2022 and mixed methodology (i.e., combination of administrative and hybrid) in CY 2021.
Cells shaded green indicate that the rate met or exceeded the MY 2021 and/or MY 2022 national Medicaid mean.
[1] Indicates a 2021–2022 comparison is not presented in the CYE 2023 Annual Technical Report because either the CY 2021 rate was not presented in the CYE 2022 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
NA indicates that the ALTCS-EPD Program Contractor was not required to report the measure (i.e., small denominator).
[2] Aggregated rates were calculated and compared from MY 2021 to MY 2022, and comparisons were based on a Chi-square test of statistical significance with a p value of <0.01 due to large denominators.
↑ Indicates improvement of measure rates.
↓ Indicates decline of measure rates.
→ Indicates stable measure rates.
[N] Measure has no NCQA Medicaid mean for comparison.
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.

Table 9-4 highlights the ALTCS-EPD Program Contractors' performance for the current year by measure group. The table illustrates the Contractors' CY 2022 measure rates and their performance relative to the NCQA national Medicaid Quality Compass HEDIS MY 2022 percentiles, where applicable. The performance level star ratings are defined as follows:

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

**Table 9-4—CY 2022 National Percentiles Comparison for ALTCS-EPD Program Contractors**

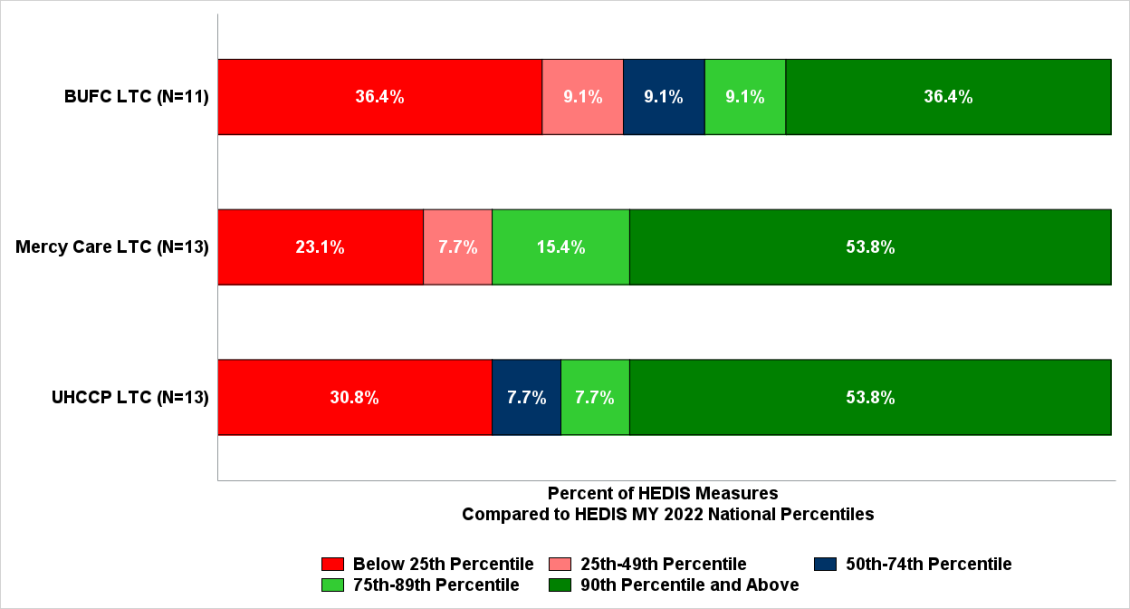
| Measure | BUFC LTC | Mercy Care LTC | UHCCP LTC | ALTCS-EPD Program Aggregate |
|---|---|---|---|---|
| ***Behavioral Health*** | | | | |
| ***Antidepressant Medication Management*** | | | | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | ★★★★★ | ★★★★ | ★★★★★ | ★★★★★ |
| *Effective Continuation Phase Treatment—Total (18+ Years)* | ★★★★★ | ★★★★★ | ★★★★★ | ★★★★★ |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | NA | ★★★★★ | ★★★ | ★★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | NA | ★★★★ | ★★★★ | ★★★★ |
| ***Use of Opioids at High Dosage*** | | | | |
| *18+ Years* | ★ | ★ | ★ | ★ |
| ***Initiation and Engagement of Substance Use Disorder (SUD) Treatment*** | | | | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | ★★★★ | ★★★★★ | ★★★★★ | ★★★★ |
| *Engagement of SUD Treatment—Total—Total (13+ Years)* | ★ | ★★ | ★ | ★ |
| ***Care of Acute and Chronic Conditions*** | | | | |
| ***Controlling High Blood Pressure*** | | | | |
| *18–85 Years* | ★★★★★ | ★★★★★ | ★★★★★ | ★★★★★ |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | | | | |
| *HbA1c Control (<8.0 %)—Total (18–75 Years)* | ★★★★★ | ★★★★★ | ★★★★★ | ★★★★★ |
| *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)* | ★★★ | ★★★★★ | ★★★★★ | ★★★★★ |
| ***Pediatric Health*** | | | | |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotic Medications*** | | | | |
| *Blood Glucose Testing—Total (1–17 Years)* | NA | NA | NA | NA |
| *Cholesterol Testing—Total (1–17 Years)* | NA | NA | NA | NA |
| *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* | NA | NA | NA | NA |
| ***Well-Child Visits in the First 30 Months of Life*** | | | | |
| *Six or More Well-Child Visits* | NA | NA | NA | NA |
| *15 Months–30 Months—Two or More Well-Child Visits* | NA | NA | NA | NA |
| ***Preventive Screening*** | | | | |
| ***Breast Cancer Screening*** | | | | |
| *Total (50–74 Years)* | ★ | ★ | ★ | ★ |

| Measure | BUFC LTC | Mercy Care LTC | UHCCP LTC | ALTCS-EPD Program Aggregate |
|---|---|---|---|---|
| ***Cervical Cancer Screening*** | | | | |
| *Total (21–64 Years)* | ★ | ★ | ★ | ★ |
| ***Appropriate Utilization of Services*** | | | | |
| ***Plan All-Cause Readmissions*** | | | | |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)* | ★★ | ★★★★★ | ★★★★★ | ★★★★★ |

NA indicates that the ALTCS-EPD Program Contractor was not required to report the measure (i.e., small denominator).

Figure 9-1 displays the ALTCS-EPD Program Contractors' HEDIS CY 2022 performance compared to NCQA CY 2022 National Percentiles. HSAG analyzed results from 11 performance measures for HEDIS CY 2022 for a total of 18 measure rates.

**Figure 9-1—Comparison of Measure Indicators to HEDIS Medicaid National Percentiles for ALTCS-EPD Contractors**




## *ALTCS-EPD Program-Level Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measure Validation*

Table 9-5 presents program-level strengths, opportunities for improvement, and recommendations (as applicable) for the ALTCS-EPD Program related to performance measures.

**Table 9-5—ALTCS-EPD Program Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| In the Behavioral Health measure group:<br>• The *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total (18+ Years)* measure rates for all ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. These results may indicate that members with a diagnosis of major depression who were enrolled with the three ALTCS-EPD Program Contractors may be receiving continuous medication treatment. Effective medication treatment of major depression can improve a person's daily functioning and well-being and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated as well.[9-2] **[Quality]**<br>• The *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* measure rates for all ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. These results may indicate that members enrolled with the three ALTCS-EPD Program Contractors may be initiating SUD treatment, which, in conjunction with counseling or other behavioral therapies, has been shown to reduce SUD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.[9-3] **[Quality, Timeliness, Access]**<br>• The *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* measure rates for two of the three ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. These results suggest that the members enrolled with two of the three ALTCS-EPD Program Contractors received timely follow-up after hospitalization for mental illness, in comparison to the national Medicaid HMO mean. **[Quality, Timeliness, Access]** |
| In the Care of Acute and Chronic Conditions measure group:<br>• The *HbA1c Control (<8.0 %)—Total (18–75 Years)* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)—Total (18–75 Years)* measure rates for all ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022, indicating that members with diabetes enrolled with the three ALTCS-EPD Program Contractors may be able to manage |

[9-2] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Jan 30, 2024.
[9-3] National Committee for Quality Assurance. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET). Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/. Accessed on: Jan 30, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| their condition according to evidence-based guidelines through the appropriate use of medications, diet and nutrition, or physical activity. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[9-4] **[Quality]**<br>• The *Controlling High Blood Pressure—18–85 Years* measure rate for all ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022, indicating that members enrolled with the three ALTCS-EPD Program Contractors who had a hypertension diagnosis may have had controlled blood pressure most of the time. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[9-5] **[Quality]** |
| In the Appropriate Utilization of Services measure group, the *Plan All-Cause Readmissions—O/E Ratio—Total—(18–64 Years)* measure rate for two of the three ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022, indicating that members were generally not experiencing unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay. [**Quality**] |
| **Opportunities for Improvement and Recommendations** |
| In the Behavioral Health measure group, the rates for all three ALTCS-EPD Program Contractors and the ALTCS-EPD Program Aggregate rate for *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and remain below the 25th percentile for two of the three ALTCS-EPD Program Contractors and the ALTCS-EPD Program Aggregate, indicating that members who initiated in SUD treatment may not have had two or more additional SUD treatment services or MAT in the 34 days following their initiation visit. Treatment, including MAT, in conjunction with counseling or other behavioral therapies, has been shown to reduce SUD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.[9-6] **[Quality, Timeliness, Access]**<br><br>Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors continue all efforts being made to conduct a root cause analysis or focus study to determine why some members were not accessing SUD services or MAT following their initiation visit. The ALTCS-EPD Program Contractors should continue to consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, a lack of service providers, or the need for |

[9-4] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2024.
[9-5] National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Jan 30, 2024.
[9-6] National Committee for Quality Assurance. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET). Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/. Accessed on: Jan 30, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| community outreach and education). Upon identification of a root cause, the ALTCS-EPD Program Contractors should implement appropriate interventions to improve performance related to engaging in timely treatment following the initiation visit.<br><br>Rates for all three ALTCS-EPD Program Contractors and the ALTCS-EPD Program Aggregate rate for *Use of Opioids at High Dosage—18+ Years)* did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and remain below the 25th percentile. These results indicate that there is an opportunity for the ALTCS-EPD Program Contractors to better monitor prescribing and utilization data and implement interventions to improve care and services around opioid prescribing. The CDC guidelines on opioid prescribing for chronic, nonmalignant pain recommend the use of "additional precautions" when prescribing dosages ≥50 MED and recommend providers avoid or "carefully justify" increasing dosages ≥90 mg MED.[9-7] **[Quality]**<br><br>Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors continue to evaluate their opioid prescription monitoring efforts to identify opportunities to enhance oversight of prescription opioids at a high dosage. Through this process, each ALTCS-EPD Program Contractor should determine if it is necessary to deploy additional mechanisms to identify members who may be at high risk for opioid overuse and misuse, as literature suggests there is a correlation between high dosages of prescription opioids and the risk of both fatal and nonfatal overdoses.[9-8] Each ALTCS-EPD Program Contractor should continue to report any completed prescription opioid monitoring effort enhancements to AHCCCS. |
| In the Preventive Screening measure group, the rates for all three ALTCS-EPD Program Contractors and the ALTCS-EPD Program Aggregate rate for *Breast Cancer Screening—Total (50–74 Years)* did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and fell below the 25th percentile, indicating that some women may not be receiving timely screening for breast cancer. Early detection reduces the risk of dying from this type of cancer and can lead to a greater range of treatment options and lower healthcare costs.[9-9] **[Quality]**<br><br>Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors continue all efforts being made to conduct a root cause analysis or focus study to determine why some female members were not receiving timely screenings for breast cancer. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, the ALTCS-EPD Program Contractors should implement appropriate interventions to improve the performance related to these preventive screenings. (Of note, the ALTCS-EPD Program |

[9-7] National Committee for Quality Assurance. Use of Opioids at High Dosage (HDO). Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/. Accessed on: Jan 30, 2024.
[9-8] Ibid.
[9-9] National Committee for Quality Assurance. Breast Cancer Screening. Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Jan 30, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| Contractors are currently conducting the *Breast Cancer Screening* PIP, which includes a root cause analysis and interventions to address this measure.)<br><br>Rates for all three ALTCS-EPD Program Contractors and the ALTCS-EPD Program Aggregate rate for *Cervical Cancer Screening—Total (21–64 Years)* did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022 and fell below the 25th percentile, indicating that some women may not be receiving timely screening for cervical cancer. Effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate.[9-10] **[Quality]**<br><br>Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors implement appropriate interventions to improve performance related to preventive screenings. HSAG also recommends that the ALTCS-EPD Program Contractors monitor and expand on interventions currently in place to improve performance related to the *Cervical Cancer Screening—Total (21–64 Years)* measure. |
| For CY 2022 performance measure reporting, RES is required based on NCQA HEDIS specifications. While HSAG noted that two of the three ALTCS-EPD Contractors could benefit from improvement in performance measure reporting using RES, all ALTCS-EPD Contractors could benefit from continuing to focus on refining RES reporting where required per measure specification. **[Quality]**<br><br>Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors continue to explore data sources for the capture of race and ethnicity data to support performance measure reporting that requires stratifications related to RES. The ALTCS-EPD Program Contractors should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information. |

## Performance Improvement Projects

Breast cancer is the most common female cancer in the United States for every major ethnic group, the second most common cause of cancer death in women,[9-11] and accounts for 15 percent of all new cancer diagnoses in the U.S.[9-12] Ensuring that all women receive regular breast cancer screening is critically important in disease prevention, early detection, and treatment. Breast cancer screening for women is aimed at identifying breast abnormalities as early as possible, and ideally before warning signs or

[9-10] National Committee for Quality Assurance. Cervical Cancer Screening. Available at: https://www.ncqa.org/hedis/measures/cervical-cancer-screening/. Accessed on: Jan 29, 2024.
[9-11] Jemal A, Siegel R, Ward E, et al. Cancer Statistics, 2009. *CA: A Cancer Journal for Clinicians*. 2009 Jul-Aug;59(4):225-49. Epub 2009 May 27.
[9-12] Howlader N, Noone AM, Krapcho M, Miller D, Brest A, Yu M, Ruhl J, Tatalovich Z, Mariotto A, Lewis DR, Chen HS, Feuer EJ, Cronin KA (eds). SEER Cancer Statistics Review, 1975-2016, National Cancer Institute. Bethesda, MD; 2016.

symptoms are present, when the chances of survival are the highest. Even if breast cancer incidences cannot be substantially reduced for some women who are at high risk for developing the disease, the risk of death from breast cancer can be reduced by regular screenings.

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Breast Cancer Screening* PIP for the ALTCS-EPD Program. The objective of the *Breast Cancer Screening* PIP is to increase the number and percentage of breast cancer screenings.

## ALTCS-EPD Program-Level Validation Results

Table 9-6 presents the ALTCS-EPD program-level overall validation results for each Contractor for the *Breast Cancer Screening* PIP.

**Table 9-6—ALTCS-EPD Program Contactors' *Breast Cancer Screening* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| BUFC LTC | *Low Confidence* | 87% | 89% | *Moderate Confidence* | 67% | 100% |
| Mercy Care LTC | *High Confidence* | 100% | 100% | *No Confidence* | 33% | 100% |
| UHCCP LTC | *High Confidence* | 100% | 100% | *High Confidence* | 100% | 100% |

## ALTCS-EPD Program-Level Measure Results

Table 9-7 presents the indicator rate for each Contractor during the baseline, intervention, and Remeasurement 1 periods.

**Table 9-7—ALTCS-EPD Program Contractors' *Breast Cancer Screening* PIP Comparative Rates**

| Contractor | PIP Indicator: *Breast Cancer Screening* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| BUFC LTC | Not Reported^ | 41.0% |
| Mercy Care LTC | 37.8% | 35.2% |
| UHCCP LTC | 34.1% | 41.6% |

^In CYE 2019, the BUFC LTC indicator rate had a small denominator, which did not allow for reporting of the measure. As such, the CY 2020 rate of 38.5% served as the baseline for BUFC LTC.

## ALTCS-EPD Program-Level Interventions

For the *Breast Cancer Screening* PIP, all Contractors provided lists of interventions that were in place for this validation cycle. These lists detailed the identified population, the intervention(s) in place, and whether or not the intervention(s) will be continued. The most common interventions across the ALTCS-EPD Program Contractors included targeting members and providers for outreach and education related to breast cancer screenings. Outreach methods included IVR, person-to-person, and automated phone calls; text message campaigns; events; mobile units; emails; and letters and other physical mailers. Provider and member incentives were also used as well as provider gap reports. The impact of these interventions on outcomes was assessed though Remeasurement 1 indicator rates (CY 2022). For further descriptions of each Contractor's interventions, see Section 10. ALTCS-EPD Program Contractor-Specific Results.

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

Table 9-8 presents program-level strengths, opportunities for improvement, and recommendations (as applicable) for the ALTCS-EPD Program related to PIPs.

**Table 9-8—ALTCS-EPD Program Strengths, Opportunities for Improvement, and Recommendations Related to the *Breast Cancer Screening* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG noted that two of the three Contractors performed accurate statistical testing between the baseline and Remeasurement 1 results. **[Quality, Access]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| ALTCS-EPD Program Contractors implemented and developed measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 2. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| Although HSAG did not identify any Program-Level opportunities for improvement, to support successful progression of the PIP in the next CY, HSAG recommends that the ALTCS-EPD Program Contractors:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

## Compliance Reviews

AHCCCS includes the following Focus Areas in its compliance review activity. For information about compliance activities for the ALTCS-EPD Program, see Section 10. ALTCS-EPD Program Contractor-Specific Results. Table 9-9 presents the Focus Areas, including each associated acronym, used by AHCCCS during its compliance review.

**Table 9-9—Focus Areas and Associated Acronyms**

| Focus Area | Acronyms |
|---|---|
| Corporate Compliance | CC |
| Claims and Information Standards | CIS |
| Case Management | CM |
| Delivery Systems | DS |
| General Administration | GA |
| Grievance Systems Focus Area | GS |
| Adult, EPSDT, and Maternal Child Health | MCH |
| Medical Management | MM |
| Member Information | MI |
| Quality Management | QM |
| Quality Improvement | QI |
| Reinsurance | RI |
| Third-Party Liability | TPL |
| Integrated Systems of Care | ISOC |

## ALTCS-EPD Program-Level Results

AHCCCS conducts a full compliance review for each Contractor every three years. This current three-year review cycle spans from CYE 2023 to CYE 2025. In CYE 2023, AHCCCS conducted compliance reviews for BUFC LTC, Mercy Care LTC, and UHCCP LTC. Results for the ALTCS-EPD Program Contractors are available in Section 10. ALTCS-EPD Program Contractor-Specific Results. Table 9-10 presents program-level and comparative results for the ALTCS-EPD Program for compliance reviews based on the review of all Focus Areas conducted in CYE 2023.

**Table 9-10—ALTCS-EPD Program-Level Compliance Review Results**

| Focus Areas | BUFC LTC | Mercy Care LTC | UHCCP LTC | Program-Level Average |
|---|---|---|---|---|
| Year Reviewed | CYE 2023 | CYE 2023 | CYE 2023 | CYE 2023 |
| CC | 100% | 100% | 100% | 100% |
| CIS | 99% | 97% | 99% | 98% |
| CM | 93% | 77% | 87% | 86% |
| DS | 88% | 97% | 98% | 94% |
| GA | 100% | 100% | 100% | 100% |
| GS | 98% | 99% | 100% | 99% |
| MCH | 98% | 89% | 90% | 92% |
| MM | 84% | 97% | 96% | 92% |
| MI | 96% | 97% | 97% | 97% |
| QM | 88% | 84% | 95% | 89% |
| QI | 95% | 99% | 100% | 98% |
| RI | 100% | 100% | 100% | 100% |
| TPL | 100% | 100% | 100% | 100% |
| ISOC | 96% | 98% | 85% | 93% |

## ALTCS-EPD Program-Level Strengths, Opportunities for Improvement, and Recommendations Related to Compliance Review

Table 9-11 presents program-level strengths, opportunities for improvement, and recommendations (as applicable) for the ALTCS-EPD Program related to compliance.

**Table 9-11—ALTCS-EPD Program Strengths, Opportunities for Improvement, and Recommendations Related to Compliance**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| The ALTCS-EPD Program-level average score was at or above 95 percent in the following Focus Areas:<br>• Corporate Compliance (CC) **[Quality, Access]**<br>• Claims and Information Standards (CIS) **[Access]**<br>• General Administration (GA) **[Timeliness, Access]**<br>• Grievance Systems (GS) **[Timeliness, Access]**<br>• Member Information (MI) **[Quality]**<br>• Quality Improvement (QI) **[Quality, Access]**<br>• Reinsurance (RI) **[Quality]**<br>• Third-Party Liability (TPL) **[Quality, Timeliness, Access]** |
| **Opportunities for Improvement and Recommendations** |
| The ALTCS-EPD Program-level average score was below 95 percent in the following Focus Areas:<br>• Case Management (CM) **[Quality, Access]**<br>• Delivery Systems (DS) **[Timeliness, Access]**<br>• Adult, EPSDT and Maternal Child Health (MCH) **[Quality, Timeliness, Access]**<br>• Medical Management (MM) **[Timeliness, Access]**<br>• Quality Management (QM) **[Quality]**<br>• Integrated Systems of Care (ISOC) **[Quality, Access]**<br><br>Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors propose and implement CAPs related to the CM, DS, MCH, MM, QM, and ISOC Focus Area requirements. |

# Network Adequacy Validation

## *ALTCS-EPD Program-Level Results*

HSAG's semiannual validation of the ALTCS-EPD Program Contractors' results showed minor discrepancies between the Contractors' self-reported ACOM 436 results and HSAG's time/distance calculations for all Contractors in each quarter for which data could be compared. While minor differences (i.e., less than 1 percentage point) between HSAG's time/distance calculation results and each Contractor's time/distance calculation results were common, these findings are most likely

attributable to the timing of the input data, software versions used by each Contractor, or due to a small number of members eligible for inclusion in time/distance calculations for the standard and county.

Table 9-12 summarizes HSAG's assessment of each ALTCS-EPD Program Contractor's compliance with AHCCCS' minimum time/distance network standards. A check mark indicates that the ALTCS-EPD Program Contractor met the minimum network standard for each Arizona county during each of the semiannual assessments, and an "X" indicates that the ALTCS-EPD Program Contractor failed to meet one or more minimum network standards in any county or quarter. Section 10. ALTCS-EPD Program Contractor-Specific Results contains NAV results specific to each Contractor and biannual validation period.

**Table 9-12—Summary of CYE 2023 Compliance with Minimum Time/Distance Network Requirements for ALTCS-EPD Program Contractors**

| Minimum Network Requirement | BUFC LTC | Mercy Care LTC | UHCCP LTC |
|---|---|---|---|
| Behavioral Health Outpatient and Integrated Clinic, Adult | ✓ | ✓ | ✓ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | ✓ | ✓ | ✓ |
| BHRF (Only Maricopa and Pima Counties) | ✓ | ✓ | ✓ |
| Cardiologist, Adult | ✓ | ✓ | ✓ |
| Cardiologist, Pediatric | ✓ | ✓ | ✓ |
| Dentist, Pediatric | ✓ | ✓ | ✓ |
| Hospital | ✓ | ✓ | ✓ |
| Nursing Facility | ✓ | ✓ | X |
| OB/GYN | ✓ | ✓ | ✓ |
| Pharmacy | X | ✓ | ✓ |
| PCP, Adult | ✓ | ✓ | ✓ |
| PCP, Pediatric | ✓ | ✓ | ✓ |

ALTCS-EPD Program Contractors consistently met the Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; BHRF; Cardiologist, Adult and Pediatric; Dentist, Pediatric; Hospital; OB/GYN; and PCP, Adult and Pediatric standards while not consistently meeting standards for Nursing Facility and Pharmacy.

As part of the NAV, AHCCCS maintained its feedback process for ALTCS-EPD Program Contractors to review and improve the accuracy of their data submissions. Specifically, AHCCCS supplied each ALTCS-EPD Program Contractor with a copy of HSAG's quarterly network adequacy analysis, a copy of the PAT file that HSAG used to conduct the analysis, and a copy of HSAG's saturation analysis

results. When issues were identified, ALTCS-EPD Program Contractors were expected to research the instances and make corrections for future PAT data and/or ACOM 436 submissions.

The applicable ALTCS-EPD Program Contractors met all minimum time/distance network standards during both quarters in Apache, Cochise, Gila, Graham, Greenlee, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties.

Overall, the applicable ALTCS-EPD Program Contractors met all minimum time/distance network standards during both quarters in Apache, Cochise, Gila, Graham, Greenlee, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. Based on the semiannual NAV results, only one ALTCS-EPD Program Contractor met all requirements for all standards and quarters in its respective counties.

Each ALTCS-EPD Program Contractor should continue to monitor and maintain its existing provider network as of CYE 2023 Q4, with specific attention to ensuring the availability of the following provider types among the applicable ALTCS-EPD Program Contractors:

- Nursing Facility in Coconino County
- Pharmacy in La Paz County

## *ALTCS-EPD Program Conclusions, Opportunities for Improvement, and Recommendations Related to Network Adequacy Validation*

Table 9-13 presents program-level strengths, opportunities for improvement, and recommendations (as applicable) for the ALTCS-EPD Program related to NAV.

**Table 9-13—ALTCS-EPD Program Strengths, Opportunities for Improvement, and Recommendations Related to NAV**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths:<br>• The applicable ALTCS-EPD Program Contractors met all minimum time/distance network standards during both quarters in CYE 2023 in Apache, Cochise, Gila, Graham, Greenlee, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. **[Access]**<br>• The ALTCS-EPD Program Contractors consistently met the BHRF; Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; Cardiologist, Adult and Pediatric; Dentist, Pediatric; Hospital; OB/GYN; and PCP, Adult and Pediatric standards. **[Access]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Opportunities for Improvement and Recommendations** |

HSAG identified the following opportunities for improvement:

- Based on the semiannual NAV results, not all ALTCS-EPD Program Contractors consistently met the Nursing Facility standard in Coconino County and the Pharmacy standard in La Paz County. **[Access]**

  Recommendations:

  - HSAG recommends that AHCCCS support the ALTCS-EPD Program Contractors in continuing to monitor their processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.
  - HSAG recommends that AHCCCS support each ALTCS-EPD Program Contractor in continuing to monitor and maintain its existing provider network coverage as of CYE 2023 Q4, with specific attention to ensuring the availability of the following provider types among the applicable ALTCS-EPD Program Contractors:
    - Nursing Facility in Coconino County
    - Pharmacy in La Paz County

# 10. ALTCS-EPD Program Contractor-Specific Results

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

## BUFC LTC

### *Validation of Performance Measures*

#### Results for Information Systems Standards Review

During CYE 2023, HSAG evaluated BUFC LTC's data system for processing of each data type used for reporting the Contractor's CY 2022 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that BUFC LTC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 10-1 displays HSAG's PMV findings for each data type reviewed during CYE 2023 in alignment with the CMS EQR Protocol 2 audit requirements.

**Table 10-1—CYE 2023 PMV Findings**

| Data Type | HSAG Findings |
|---|---|
| **Medical Services Data** | *No identified concerns* |
| **Enrollment Data** | *No identified concerns* |
| **Provider Data** | *No identified concerns* |
| **Medical Record Review Process** | *No identified concerns* |
| **Supplemental Data** | *No identified concerns* |
| **Data Integration** | *HSAG identified concerns with BUFC LTC's data integration processes related to the calculation of one measure in scope of the PMV audit, which was not selected by AHCCCS for inclusion in this annual technical report. BUFC LTC's measures vendor did not correctly calculate the eligible population for the Screening for Depression and Follow-Up Plan measure, which therefore received a Do Not Report designation for CY 2022.* |

## Results for Performance Measures

Table 10-2 presents the CY 2021 and CY 2022 BUFC LTC performance measure results that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and MY 2022. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and/or MY 2022. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*).

**Table 10-2—CY 2021 and CY 2022 BUFC LTC Performance Measure Results**

| Measure | CY 2021 Performance | CY 2022 Performance | 2021–2022 Comparison | 2022 Performance Level[1] |
|---|---|---|---|---|
| ***Behavioral Health*** | | | | |
| ***Antidepressant Medication Management*** | | | | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | 45.2% | 74.4% | ↑ | ★★★★★ |
| *Effective Continuation Phase Treatment—Total (18+ Years)* | 26.2% | 65.6% | ↑ | ★★★★★ |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | — | NA++ | — | — |
| *30-Day Follow-Up—Total (6+ Years)* | — | NA++ | — | — |
| ***Use of Opioids at High Dosage*** | | | | |
| *18+ Years** | 9.3% | 12.2% | → | ★ |
| ***Initiation and Engagement of Substance Use Disorder (SUD) Treatment*** | | | | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | — | 50.2% | — | ★★★★ |
| *Engagement of SUD Treatment—Total—Total (13+ Years)* | — | 4.8% | — | ★ |
| ***Care of Acute and Chronic Conditions*** | | | | |
| ***Controlling High Blood Pressure*** | | | | |
| *18–85 Years* | 46.9% | 74.5% + | ↑ | ★★★★★ |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | | | | |
| *HbA1c Control (<8.0 %)—Total (18–75 Years)* | — | 63.0% + | — | ★★★★★ |
| *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)** | 62.1% | 37.0% + | ↑ | ★★★ |
| ***Pediatric Health*** | | | | |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotics*** | | | | |
| *Blood Glucose Testing—Total (1–17 Years)* | — | NA++ | — | — |
| *Cholesterol Testing—Total (1–17 Years)* | — | NA++ | — | — |
| *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* | — | NA++ | — | — |

| Measure | CY 2021 Performance | CY 2022 Performance | 2021–2022 Comparison | 2022 Performance Level[1] |
|---|---|---|---|---|
| ***Oral Evaluation, Dental Services*** | | | | |
| *Total (0–20 Years)* [N] | — | 31.0% | — | — |
| ***Well-Child Visits in the First 30 Months of Life*** | | | | |
| *Six or More Well-Child Visits* | — | NA[++] | — | — |
| *15 Months–30 Months—Two or More Well-Child Visits* | — | NA[++] | — | — |
| ***Preventive Screening*** | | | | |
| ***Breast Cancer Screening*** | | | | |
| *Total (50–74 Years)* | 38.6% | 41.0% | → | ★ |
| ***Cervical Cancer Screening*** | | | | |
| *21–64 Years* | — | 44.8% + | — | ★ |
| ***Appropriate Utilization of Services*** | | | | |
| ***Ambulatory Care*** | | | | |
| *Emergency Department (ED) Visits—Total (0–85+ Years)* [F] | 595.7 | 688.3 | — | — |
| ***Plan All-Cause Readmissions*** | | | | |
| *Observed Readmissions—Total (18–64 Years)* | 9.1% | 9.0% | → | — |
| *Expected Readmissions—Total (18–64 Years)* | — | 9.0% | — | — |
| *Outlier Rate—Total (18–64 Years)* | — | 90.4 | — | — |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)** | 0.8150 | NA[++] | — | — |

* A lower rate indicates better performance for this measure.

\+ Indicates the measure was reported using hybrid methodology.

[++] NA indicates the denominator was too small to report a valid rate, based on the applicable measure specification.

Cells shaded green indicate that the rate met or exceeded the MY 2021 and/or MY 2022 national Medicaid mean.

— Indicates a 2021–2022 comparison is not presented in the CYE 2023 Annual Technical Report because either there was a break in trending, the CY 2021 rate was not presented in the CYE 2022 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

↑ Indicates improvement of measure rates.

→ Indicates stable measure rates.

[1] Performance Levels for CY 2022 were based on comparisons of the HEDIS MY 2022 measure rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks.

Performance Levels for 2022 represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

[N] Measure has no NCQA Medicaid mean for comparison.

[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.

## Strengths, Opportunities for Improvement, and Recommendations

Table 10-3 presents strengths, opportunities for improvement, and recommendations (as applicable) for BUFC LTC related to performance measures, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

**Table 10-3—BUFC LTC Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| In the Behavioral Health measure group, BUFC LTC's performance measure rates for *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total (18+ Years),* and *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* were at or above the 75th percentile, indicating strength in providing behavioral health follow-up care to members **[Quality, Timeliness, Access]** |
| In the Care of Acute and Chronic Conditions measure group:<br>• BUFC LTC's performance measure rate for *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 %)—Total (18–75 Years)* was at or above the 90th percentile, indicating that most members with diabetes had controlled HbA1c levels most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[10-1] **[Quality]**<br>• BUFC LTC's performance measure rate for *Controlling High Blood Pressure (18–85 Years)* was at or above the 90th percentile, indicating that most members with a diagnosis of hypertension had controlled blood pressure. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[10-2] **[Quality]** |
| **Opportunities for Improvement and Recommendations** |
| While BUFC LTC was successful in reporting valid rates for nearly all rates for its ALTCS-EPD population, the audit review identified some considerations and recommendations for future years' reporting. |

[10-1] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Feb 1, 2024.
[10-2] National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Feb 1, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| Recommendations:<br>• While there were no concerns with the processing of practitioner data, the audit found that BUFC LTC could benefit from a practitioner credentialing software solution from the perspective of data processing and resource efficiency.<br>• While BUFC LTC integrated some available electronic health record (EHR) data to report the required measure stratifications by race and ethnicity for MY 2022 data reporting, BUFC should work with AHCCCS to clarify race and ethnicity data available on the 834 file and develop a methodology for integrating these data for future reporting to augment EHR data to improve data completeness.<br>• BUFC LTC should work with its performance measure vendor to identify the cause of the incorrect eligible population for the *Screening for Depression and Follow-Up Plan (CDF)* measure to prevent the same issue from impacting future reporting. |
| In the Preventive Screening measure group, BUFC LTC's performance measure rate for *Breast Cancer Screening* and *Cervical Cancer Screening* fell below the 25th percentile, indicating that not all women were receiving timely screening for breast or cervical cancer. Early detection reduces the risk of dying from this type of cancer and can lead to a greater range of treatment options and lower healthcare costs. **[Quality]**<br><br>Recommendation: HSAG recommends that BUFC LTC drill down to race, ethnicity, and age stratifications as well as SDOH to help determine gaps in care and continue to implement appropriate interventions to improve the performance related to these preventive screenings. HSAG also recommends that BUFC LTC monitor and expand on interventions currently in place to improve performance related to the *Breast Cancer Screening* measure. In addition to drilling down into breast cancer screenings, it would also be beneficial to drill down for members who are due for cervical cancer screening to also implement interventions to improve the performance related to preventive cervical cancer screenings. Some of these interventions could include a mobile clinic to conduct the screening, transportation programs, and adjusting hours for visits to accommodate those with job/childcare concerns. |
| In the Behavioral Health measure group, BUFC LTC's performance measure rate for *Use of Opioids at High Dosage (18+ Years)* fell below the 25th percentile. This result provides an opportunity for BUFC LTC to monitor prescribing and utilization data and to implement interventions to improve care and services around opioid prescribing. The CDC guideline on opioid prescribing for chronic, nonmalignant pain recommends the use of "additional precautions" when prescribing dosages ≥50 MED and recommends providers avoid or "carefully justify" increasing dosages ≥90 mg MED. [10-3] **[Quality]** |

[10-3] National Committee for Quality Assurance. Use of Opioids at High Dosage (HDO). Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/. Accessed on: Feb 1, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| Recommendation: HSAG recommends that BUFC LTC conduct a drill down analysis based on race, ethnicity, and age stratifications to determine why there is a higher proportion of members receiving prescriptions for opioids. Upon identification of a root cause, HSAG recommends that BUFC LTC implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse and potentially implement other treatment options that do not include opioids if possible.<br><br>BUFC LTC's performance measure rate for *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* fell below the 25th percentile. **[Quality, Timeliness, Access]**<br><br>Recommendation: HSAG recommends that BUFC LTC conduct a drill down analysis based on race, ethnicity, and age stratifications to determine why members were not receiving timely SUD services or MAT following their initiation visit. BUFC LTC should consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, BUFC LTC should implement interventions that address the identified root cause of the low rate, targeting the interventions so that BUFC LTC improves performance related to initiating and engaging in timely treatment following a new episode of SUD dependence. |

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

Table 10-4 presents performance measure recommendations made to BUFC LTC in the CYE 2022 Annual Technical Report[10-4] and BUFC LTC's follow-up to the recommendations, as well as an assessment of the degree to which BUFC LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 10-4—BUFC LTC Follow-Up to CYE 2022 Performance Measure Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| **Recommendation 1:** |
| As BUFC LTC did not report any measures following the hybrid methodology, HSAG recommended that BUFC LTC review and clarify expectations related to hybrid/MRR requirements for future years' |

[10-4] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for Arizona Long Term Care System. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportEPDandDDD.pdf. Accessed on: Feb 1, 2024.

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| reporting to ensure it is able to align with the AHCCCS-required methodology for the specified hybrid measures. This should include the planning and development of abstraction tools, data capture, and integration for non-HEDIS measures, if required. |
| **BUFC LTC's Response:**<br>BUFC LTC established a plan to implement utilization of the hybrid methodology for CY 2022. |
| **HSAG's Assessment:** HSAG has determined that BUFC LTC has satisfactorily addressed this prior year's recommendation. |
| **Recommendation 2:** |
| While there were no concerns with the processing of practitioner data, audit results indicate that BUFC LTC could benefit from a practitioner credentialing software solution from the perspective of data processing and resource efficiency. HSAG recommended that BUFC LTC continue with its planned efforts related to increased supplemental data capture via a planned project and integration of AHCCCS blind-spot data. |
| **BUFC LTC's Response:**<br>BUFC LTC hired a new senior director and manager for HIE/Contexture & Data Interoperability in April 2023 to focus on retrieving additional EMR data from increased sources. BUFC LTC is currently piloting a new data abstraction vendor called "Health Gorilla" to obtain more data from additional contracted providers that are not connected to our platform and/or the HIE (go-live Q1 2024). BUFC LTC has also implemented an NSSD (non-standard supplemental data) program to allow providers to send in evidence via the Contractor's vendor, using a provider-facing tool. Evidence is reviewed against NCQA measure specifications and then entered into the vendor's tool, only if it meets criteria to close the quality measure data gap. |
| **HSAG's Assessment:** HSAG has determined that BUFC LTC has satisfactorily addressed this prior year's recommendation. |
| **Recommendation 3:** |
| HSAG recommended that BUFC LTC continue to explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require race and ethnicity stratifications. BUFC LTC should continue to work with AHCCCS related to collaborative efforts to improve completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information. |
| **BUFC LTC's Response:**<br>BUFC LTC pulls in race and ethnicity data from enrollment and then augments "blanks" or "unknown" with data coming in from the HIE. |
| **HSAG's Assessment:** HSAG has determined that BUFC LTC has satisfactorily addressed these prior year's recommendations; however, BUFC LTC should continue to work with AHCCCS to ensure completed and accurate race and ethnicity data are captured from the primary source of the 834 file. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| **Recommendation 4:** |
| While BUFC LTC implemented interventions specific to the CY 2020 *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total* rate, this rate remained low in CY 2021. HSAG therefore continued to recommend that BUFC LTC conduct a root cause analysis to determine why members were not receiving timely SUD services or MAT following their initiation visit. BUFC LTC should consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, BUFC LTC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, BUFC LTC should implement interventions that address the identified root cause of the low rate, targeting the interventions so that BUFC LTC improves performance related to initiating and engaging in timely treatment following a new episode of SUD dependence. |
| **BUFC LTC's Response:** |
| BUFC LTC completed a root cause analysis for the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD—Total—Total* rate. Additionally, the Quality Management Team has identified this as a measure that would benefit from a PIP, and a workgroup will be initiated with CY 2023 being the baseline year. This will assist in further assessing any additional root causes and establish interventions that can be implemented to improve our compliance with this measure. It is important to note for the BUFC LTC population this measure typically has a smaller denominator, with the year-end 2022 denominator being 198 eligible members. |
| **HSAG's Assessment:** HSAG has determined that BUFC LTC has satisfactorily addressed these prior year's recommendations; however, due to a break in trending for this measure as a result of measure specification changes, BUFC LTC will need to reassess intervention impact on this measure over time. |
| **Recommendation 5:** |
| HSAG recommended that BUFC LTC conduct a root cause analysis or focus study to determine why some members are not managing their antidepressant medication. Upon identification of a root cause, HSAG recommended that BUFC LTC implement appropriate interventions to improve performance, and consider the nature and scope of the issues (e.g., the issues are related to barriers such as a lack of patient and provider communication or patient education) when implementing interventions. |
| **BUFC LTC's Response:** |
| BUFC LTC will continue to monitor the trends within this measure monthly. It has been recognized that the year-end rates for MY 2022 were 28% better than those in 2021 and were surpassing the goal of 60.0%. Rates continue to improve month over month. |
| **HSAG's Assessment:** HSAG has determined that BUFC LTC has addressed these prior year's recommendations since rates did show a significant improvement from the prior year; however BUFC LTC did not provide any information supporting that a root cause analysis was conducted to provide insight into which interventions were most impactful. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| **Recommendation 6:** |
| While BUFC LTC implemented interventions specific to the CY 2020 *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* rate, HSAG continued to recommend that BUFC LTC conduct a root cause analysis or focus study to determine why some members with diabetes did not have controlled HbA1c levels. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, BUFC LTC should implement interventions that address the identified root cause of the low rate, targeting the interventions so that BUFC LTC improves performance related to diabetes management. |
| **BUFC LTC's Response:**<br>BUFC LTC completed a root cause analysis for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measure. Additionally, the following interventions have been established for implementation:<br>• Utilization of gap reports to compare to medical record information to identify members who may have supplemental documentation that could be submitted for gap closure.<br>• Utilize provider forums and newsletters to provide education on coding requirements.<br>• Utilize social media for member awareness and education on diabetes management. |
| **HSAG's Assessment:** BUFC LTC identified interventions implemented as a result of conducting a root cause analysis; therefore, HSAG determined that BUFC LTC has satisfactorily addressed these prior year's recommendations. |
| **Recommendation 7:** |
| HSAG recommended that BUFC LTC conduct a root cause analysis or focus study to determine why some members were not managing their high blood pressure optimally. Upon identification of a root cause, HSAG recommended that BUFC LTC implement appropriate interventions to improve performance related to this chronic condition. |
| **BUFC LTC's Response:**<br>BUFC LTC completed a root cause analysis for the *Controlling High Blood Pressure* measure. Additional interventions that have been established to improve the overall compliance rates include the following:<br>• Quality member-facing teams conduct year-round outreach and scheduling for annual wellness visits.<br>• The performance measure vendor's gap reports are being run and compared to medical record reports to identify potential members who may have supporting documentation available to close gaps.<br>• Education in member newsletters on diet and the importance of blood pressure monitoring.<br>• The Case Management team will address SDOH factors including access and knowledge of proper nutrition.<br>• Coordination with the registered nurses after the blood pressure cuffs are requested to outreach the members for a telehealth visit to ensure members are using the blood pressure cuffs appropriately. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| • BUFC LTC provides telephonic outreach to members with open care gaps to educate, assist with scheduling, and offer a digital blood pressure cuff via mail for monitoring.<br>• Measure included in all provider value-based contracts. |
| **HSAG's Assessment:** BUFC LTC identified interventions implemented as a result of conducting a root cause analysis; therefore, HSAG determined that BUFC LTC has satisfactorily addressed these prior year's recommendations. |
| **Recommendation 8:** |
| While BUFC LTC implemented interventions specific to the CY 2020 *Breast Cancer Screening* rate, this rate remained low in CY 2021. HSAG therefore continued to recommend that BUFC LTC conduct a root cause analysis or focus study to determine why some of its female members were not receiving timely screenings for breast cancer. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, BUFC LTC should implement interventions that address the identified root cause of the low rate, targeting the interventions so that BUFC LTC improves performance related to these preventive screenings. |
| **BUFC LTC's Response:**<br>BUFC LTC completed a root cause analysis for the *Breast Cancer Screening* measure. Additional interventions that have been established to improve the overall compliance rates include the following:<br>• BUFC LTC case managers will ask members eligible for a breast cancer screening if they have had a mammogram completed during the assessment with the member.<br>• BUFC LTC case managers will provide members with education on the importance of mammograms.<br>• Member-facing teams conduct year-round outreach for members due for a breast cancer screening and direct schedule with Banner Imaging facilities.<br>• Quarterly gaps in care lists will be generated and sent to the case managers for outreach to members needing a breast cancer screening.<br>• Deliver annual breast cancer screening mailers and postcards and utilize social media for expanding awareness of the importance of screening and early detection. |
| **HSAG's Assessment:** BUFC LTC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; however, the *Breast Cancer Screening* rate remained low in CY 2022. While opportunity remains to improve this rate, HSAG has determined that BUFC LTC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 9:** |
| HSAG recommended that BUFC LTC identify best practices to support children in receiving well-care visits according to recommended schedules. HSAG also recommended that BUFC LTC consider conducting a root cause analysis to identify barriers that members are experiencing in accessing care and services in order to implement appropriate interventions to improve the performance related to the Pediatric Health domain. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| **BUFC LTC's Response:**<br>BUFC LTC completed a root cause analysis for the *Child and Adolescent Well-Care Visits* measure. It is important to note that for the BUFC LTC population, this measure typically has a small denominator, with a year-end 2022 denominator of 103 members. Additionally, the following interventions have been established to improve the overall compliance rates:<br>• Quality member-facing teams conduct year-round outreach and scheduling for well-child visits and provide education on immunizations due.<br>• Quarterly gaps in care lists will be generated and sent to the BUFC LTC case managers for outreach to members still needing a well-child visit.<br>• Send mailers/postcards for annual checkup reminders.<br>• Utilize social media platforms for additional awareness on the importance of routine and well-care visits.<br>• Increase provider education and updates during provider forums. |
| **HSAG's Assessment:** BUFC LTC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that BUFC LTC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 10:** |
| HSAG recommended that BUFC LTC conduct a root cause analysis or focus study to determine why there is a higher proportion of members receiving prescriptions for opioids. Upon identification of a root cause, HSAG recommended that BUFC LTC implement appropriate interventions to identify members who may be considered at high risk for opioid overuse and misuse. |
| **BUFC LTC's Response:**<br>BUFC LTC will conduct additional research on best practices and review with leadership to assess those practices that will potentially have the biggest impact on the population. The Quality Management team will continue to monitor trends within the compliance rates monthly. BUFC LTC has identified that this measure has demonstrated consistent growth year over year. |
| **HSAG's Assessment:** HSAG has determined that BUFC LTC has not satisfactorily addressed these prior year's recommendations, as BUFC LTC did not provide evidence of conducting a root cause analysis or associated interventions. |

## *Validation of Performance Improvement Projects*

In CYE 2023, BUFC LTC continued the *Breast Cancer Screening* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 1, PIP validation activities focused on improvement from the baseline results. BUFC LTC submitted Remeasurement 1 performance indicator results and interventions implemented during this validation cycle along with the status of interventions, focus, and rationale for changes or discontinuation of the intervention.

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

## Validation Results

Table 10-5 displays the overall confidence levels for the BUFC LTC *Breast Cancer Screening* PIP.

**Table 10-5—BUFC LTC *Breast Cancer Screening* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| BUFC LTC | *Low Confidence* | 87% | 89% | *Moderate Confidence* | 67% | 100% |

## Measure Results

Table 10-6 provides the *Breast Cancer Screening* PIP baseline, intervention, and Remeasurement Year 1 rates for BUFC LTC.

**Table 10-6—BUFC LTC *Breast Cancer Screening* PIP Rates**

| Contractor | PIP Indicator: *Breast Cancer Screening* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2020* | CY 2022 |
| BUFC LTC | 38.5% | 41.0% |

*In CYE 2019, the BUFC LTC indicator rate had a small denominator, which did not allow for reporting of the measure. As such, CY 2020 served as the baseline for BUFC LTC.

## Interventions

Table 10-7 presents PIP interventions for BUFC LTC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 10-7—BUFC LTC *Breast Cancer Screening* PIP Interventions**

| Contractor | Interventions |
|---|---|
| BUFC LTC | • ALTCS case managers will ask applicable female members if they have had a mammogram completed during the assessment with the member and provide the member with education on the importance of mammograms.<br>• ALTCS case managers identify applicable members who need a mammogram or will soon become overdue and attempt outreach calls to offer assistance with scheduling a mammogram appointment.<br>• BUFC imaging will collaborate with the ALTCS Care Management department to assist with scheduling members who need a mammogram in Maricopa County.<br>• Quarterly gaps in care lists will be generated and sent to the ALTCS case managers for outreach to members still needing a screening.<br>• Initiated discussions for contracting with a mobile mammogram unit.<br>• Annual breast screening mailers.<br>• Include educational materials in English and Spanish on the Banner Health website.<br>• Collecting and reviewing non-standard supplemental documentation to close care gaps.<br>• The member outreach team will contact BUFC members identified as due and/or past due for a mammogram within the measurement period and assist to schedule an appointment. |

## Strengths, Opportunities for Improvement, and Recommendations

Table 10-8 presents strengths, opportunities for improvement, and recommendations (as applicable) for BUFC LTC related to the *Breast Cancer Screening* PIP, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

**Table 10-8—BUFC LTC Strengths, Opportunities for Improvement, and Recommendations Related to the *Breast Cancer Screening* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG noted that the indicator rate showed a non-statistically significant increase over the baseline year (CY 2020) indicator rate at Remeasurement 1. **[Quality, Access]**<br><br>BUFC LTC developed and implemented measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 2. **[Quality, Access]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Opportunities for Improvement and Recommendations** |
| HSAG noted that BUFC LTC did not complete statistical testing at Remeasurement 1. **[Quality]**<br><br>Recommendation: As the PIP progresses, HSAG recommends that BUFC LTC:<br>• Complete statistical testing between the baseline (CY 2020) and all remeasure periods using HSAG's statistical testing reference documents sent to the Contractor on November 27, 2023.<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

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

Table 10-9 presents PIP recommendations made to BUFC LTC in the CYE 2022 Annual Technical Report[10-5] and BUFC LTC's follow-up to the recommendations, as well as an assessment of the degree to which BUFC LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 10-9—BUFC LTC Follow-Up to CYE 2022 PIP Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| HSAG recommended that BUFC LTC:<br>• Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary.<br>• Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available.<br>• Develop and document a plan for sustaining the improvement for any demonstrated improvement in indicator rates. |
| **BUFC LTC's Response:**<br>The *Breast Cancer Screening* PIP has a workgroup that has been established with key leaders from the appropriate BUFC LTC team. This workgroup meets as frequently as monthly or bimonthly to |

[10-5] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for Arizona Long Term Care System. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportEPDandDDD.pdf. Accessed on: Feb 1, 2024.

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| continue monitoring trends in compliance rates, reviewing best practices, and analyzing subpopulations to assess for disparities requiring targeted interventions. During these workgroup meetings, interventions are reviewed, successes are discussed, along with identified barriers to success. The workgroup uses the PDSA Cycle to monitor interventions implemented and track their success to ensure progress is sustained. BUFC LTC completed a root cause analysis and PDSA cycle.<br><br>Interventions being implemented include:<br>• BUFC LTC case managers ask members eligible for a breast cancer screening if they have had a mammogram completed during the assessment with the member.<br>• BUFC LTC case managers provide members with education on the importance of mammograms.<br>• Member-facing teams conduct year-round outreach for members due for a breast cancer screening and direct schedule with Banner Imaging facilities.<br>• Quarterly gaps in care lists will be generated and sent to the case managers for outreach to members needing a breast cancer screening.<br>• Members are sent educational mailers on the importance of mammograms and preventive screenings.<br>• Social media is utilized to expand awareness of the importance of screening and early detection. |
| **HSAG's Assessment:** HSAG has determined that the Contractor has satisfactorily addressed these prior year's recommendations. |

## *Compliance Reviews*

### Results

AHCCCS conducted a compliance review of BUFC LTC from March 6, 2023, through March 9, 2023. On May 19, 2023, AHCCCS finalized the report findings, provided BUFC LTC with a CAP submission matrix, and required a CAP for any standard with a total score of less than 95 percent. On August 18, 2023, AHCCCS accepted BUFC LTC's proposed CAPs and required the Contractor to submit updated policies, manuals, desktop procedures, and other vital documents to provide evidence of CAP completion by February 18, 2024. Table 10-10 presents the compliance review results for BUFC LTC.

**Table 10-10—BUFC LTC Compliance Review Results**

| Focus Areas | CYE 2023 BUFC LTC Scores | CYE 2023 Program-Level Average |
|---|---|---|
| CC | 100% | 100% |
| CIS | 99% | 98% |

| Focus Areas | CYE 2023 BUFC LTC Scores | CYE 2023 Program-Level Average |
|---|---|---|
| CM | 93% | 86% |
| DS | 88% | 94% |
| GA | 100% | 100% |
| GS | 98% | 99% |
| MCH | 98% | 92% |
| MM | 84% | 92% |
| MI | 96% | 97% |
| QM | 88% | 89% |
| QI | 95% | 98% |
| RI | 100% | 100% |
| TPL | 100% | 100% |
| ISOC | 96% | 93% |

## Strengths, Opportunities for Improvement, and Recommendations

Table 10-11 presents strengths, opportunities for improvement, and recommendations (as applicable) for BUFC LTC related to compliance activities, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

**Table 10-11—BUFC LTC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| BUFC LTC scored at or above 95 percent in the following Focus Areas:<br>• Corporate Compliance (CC) **[Quality, Access]**<br>• Claims and Information Standards (CIS) **[Access]**<br>• General Administration (GA) **[Timeliness, Access]**<br>• Grievance Systems (GS) **[Timeliness, Access]**<br>• Adult, EPSDT and Maternal Child Health (MCH) **[Quality, Timeliness, Access]**<br>• Member Information (MI) **[Quality]**<br>• Quality Improvement (QI) **[Quality, Access]**<br>• Reinsurance (RI) **[Quality]**<br>• Third-Party Liability (TPL) **[Quality, Timeliness, Access]**<br>• Integrated Systems of Care (ISOC) **[Quality, Access]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Opportunities for Improvement and Recommendations** |
| BUFC LTC scored below 95 percent in the following Focus Areas:<br>• Case Management (CM) **[Quality, Access]**<br>• Delivery Systems (DS) **[Timeliness, Access]**<br>• Medical Management (MM) **[Timeliness, Access]**<br>• Quality Management (QM) **[Quality]**<br><br>Recommendation: HSAG recommends that BUFC LTC propose and implement CAPs for the CM, DS, MM, and QM Focus Areas as approved by AHCCCS. |

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

Table 10-12 presents compliance recommendations made to BUFC LTC in the CYE 2022 Annual Technical Report[10-6] and BUFC LTC's follow-up to the recommendations, as well as an assessment of the degree to which BUFC LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 10-12—BUFC LTC's Follow-Up to CYE 2022 Compliance Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for Compliance |
|---|
| HSAG recommended that in advance of the forthcoming compliance review, BUFC LTC conduct a self-assessment of the CM, DS, MCH, MM, and QM requirements. |
| **BUFC LTC's Response:**<br>BUFC LTC will continue to correct any findings identified in its CAP to monitor compliance with the requirements in each of the AHCCCS Focus Areas listed above. In 2023, BUFC LTC was awarded a three (3) year NCQA Medicaid HMO Accreditation, Long Term Services and Supports Distinction and Deeming Status as a health plan and has an additional NCQA health equity accreditation on the way. This is a testament to our overall quality improvement (QI) framework and illustrates our ability to deliver efficient, effective, person-centered care to meet our members' needs and help keep them in the community. |

[10-6] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for Arizona Long Term Care System. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportEPDandDDD.pdf. Accessed on: Feb 1, 2024.

| Prior Year's Recommendation from the EQR Technical Report for Compliance |
|---|
| **HSAG's Assessment:**<br>Based on the results of the CYE 2023 compliance review activity and the response provided, HSAG determined that BUFC LTC has partially addressed this prior year's recommendation, as BUFC LTC continued to score below 95 percent in the CM, DS, MM, and QM Focus Areas. |

## *Network Adequacy Validation*

### Results

HSAG evaluated BUFC LTC's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents biannual validation findings specific to the ALTCS-EPD Program, with one results table for each of the following GSAs:

- Central GSA: Gila, Maricopa,[10-7] and Pinal counties
- South GSA: Cochise, Graham,[10-8] Greenlee, La Paz, Pima, Santa Cruz,[10-9] and Yuma counties

Each region-specific table summarizes semiannual validation results containing the percentage of members meeting each time/distance standard by quarter and county, with color-coding to identify whether the time/distance standard was "*Met*" or "*Not Met*."

The value "NA" is shown for time/distance standards that do not apply to the county or program.

The value "NR" is shown for time/distance standards in which no members met the network requirement denominator for the program and county; therefore, HSAG calculated no corresponding time/distance result.

Yellow color-coding identifies instances in which HSAG's time/distance results met the minimum network requirement but differed from the ACOM 436 results.

Red color-coding identifies instances in which HSAG's time/distance results did not meet the compliance standard, regardless of the ACOM 436 results.

An asterisk (*) indicates that fewer than 10 members were included in the denominator of HSAG's results.

A carat (^) indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

[10-7] Maricopa County includes the 85342, 85358, and 85390 ZIP Codes; these ZIP Codes are physically located in both Maricopa and Yavapai counties.
[10-8] Graham County includes the 85542, 85192, and 85550 ZIP Codes representing the San Carlos Tribal area; these ZIP Codes are physically located in Gila or Pinal County.
[10-9] Santa Cruz County includes the 85645 ZIP Code; this ZIP Code is physically located in both Pima and Santa Cruz counties.

**Table 10-13—BUFC LTC Time/Distance Validation Results for Central GSA—Percentage of Members Meeting Minimum Network Requirements**

| | Gila | | Maricopa | | Pinal | |
|---|---|---|---|---|---|---|
| Minimum Network Requirement | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0 | 100.0^ | 99.5^ | 99.6^ | 100.0^ | 100.0^ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 100.0* | NR*^ | 97.5^ | 97.6^ | 100.0*^ | 100.0*^ |
| BHRF | NA | NA | 99.1 | 99.2 | NA | NA |
| Cardiologist, Adult | 100.0 | 100.0^ | 99.6^ | 99.7^ | 99.7^ | 100.0^ |
| Cardiologist, Pediatric | 100.0* | 100.0*^ | 100.0^ | 100.0^ | 100.0* | 100.0*^ |
| Dentist, Pediatric | 100.0* | 100.0* | 100.0 | 100.0 | 100.0* | 100.0* |
| Hospital | 100.0 | 100.0 | 99.8 | 100.0 | 100.0 | 100.0 |
| Nursing Facility | 100.0 | 100.0 | 99.4 | 99.7 | 100.0 | 100.0 |
| OB/GYN | 100.0* | 100.0* | 100.0 | 100.0 | 100.0* | 100.0 |
| Pharmacy | 100.0 | 100.0 | 99.5 | 99.6 | 100.0 | 100.0 |
| PCP, Adult | 100.0^ | 100.0^ | 99.9^ | 99.9^ | 99.7^ | 100.0^ |
| PCP, Pediatric | 100.0*^ | 100.0*^ | 100.0^ | 100.0^ | 100.0*^ | 100.0*^ |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.
* indicates that fewer than 10 members were included in the denominator of HSAG's results.
^ indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.

**Table 10-14—BUFC LTC Time/Distance Validation Results for South GSA—Percentage of Members Meeting Minimum Network Requirements**

| | Cochise | | Graham | | Greenlee | | La Paz | | Pima | | Santa Cruz | | Yuma | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Minimum Network Requirement | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0^ | 100.0^ | 100.0 | 100.0^ | 100.0* | 100.0*^ | 100.0^ | 100.0^ | 98.7^ | 98.5^ | 100.0^ | 100.0^ | 99.9^ | 100.0^ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 100.0*^ | 100.0*^ | 100.0* | 100.0*^ | NR* | NR*^ | NR* | NR*^ | 90.0^ | 92.5^ | 100.0*^ | 100.0*^ | 100.0*^ | 100.0*^ |
| BHRF | NA | NA | NA | NA | NA | NA | NA | NA | 91.9 | 92.5 | NA | NA | NA | NA |

| Minimum Network Requirement | Cochise | | Graham | | Greenlee | | La Paz | | Pima | | Santa Cruz | | Yuma | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Cardiologist, Adult | 100.0^ | 100.0^ | 100.0 | 100.0^ | 100.0* | 100.0*^ | 100.0 | 100.0^ | 98.7^ | 99.4^ | 100.0 | 100.0^ | 100.0^ | 100.0^ |
| Cardiologist, Pediatric | 100.0*^ | 100.0*^ | 100.0* | 100.0*^ | NR* | NR* | NR* | NR* | 100.0 | 100.0^ | 100.0* | 100.0*^ | 100.0^ | 100.0^ |
| Dentist, Pediatric | 100.0* | 100.0* | 100.0* | 100.0* | NR* | NR* | NR* | NR* | 100.0 | 98.1 | 100.0* | 100.0* | 100.0 | 100.0 |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 | 100.0* | 100.0* | 100.0 | 100.0 | 99.8 | 99.9 | 100.0 | 100.0 | 100.0 | 100.0 |
| Nursing Facility | 100.0 | 100.0 | 100.0 | 100.0 | 100.0* | 100.0* | 100.0 | 100.0 | 99.6 | 99.6 | 100.0 | 100.0 | 100.0 | 100.0 |
| OB/GYN | 100.0 | 100.0 | 100.0* | 100.0* | 100.0* | 100.0* | 100.0* | 100.0* | 100.0 | 100.0 | 100.0* | 100.0* | 100.0 | 100.0 |
| Pharmacy | 99.8 | 99.8 | 100.0 | 100.0 | 100.0* | 100.0* | 95.3 | 89.1 | 98.9 | 99.2 | 100.0 | 100.0 | 99.9 | 100.0 |
| PCP, Adult | 99.8^ | 99.8^ | 100.0^ | 100.0^ | 100.0* | 100.0*^ | 100.0^ | 100.0^ | 99.9^ | 99.8^ | 100.0^ | 100.0^ | 99.9^ | 100.0^ |
| PCP, Pediatric | 100.0*^ | 100.0*^ | 100.0*^ | 100.0*^ | NR* | NR* | NR*^ | NR* | 100.0^ | 100.0^ | 100.0* | 100.0*^ | 100.0^ | 100.0^ |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
represents time/distance standard results that do not meet the compliance standard based on HSAG's results.
NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.
* indicates that fewer than 10 members were included in the denominator of HSAG's results.
^indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county

## Strengths, Opportunities for Improvement, and Recommendations

Table 10-15 presents strengths, opportunities for improvement, and recommendations (as applicable) for BUFC LTC related to NAV, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

**Table 10-15—BUFC LTC Strengths, Opportunities for Improvement, and Recommendations Related to NAV**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths:<br>• BUFC LTC met all time/distance network standards for both quarters in CYE 2023 in Cochise, Gila, Graham, Greenlee Maricopa, Pima, Pinal, Santa Cruz and Yuma counties. **[Access]**<br>• BUFC LTC met time/distance network standards for BHRF; Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; Cardiologist, Adult and Pediatric; Dentist, Pediatric; Hospital; Nursing Facility; OB/GYN; and PCP, Adult and Pediatric. **[Access]**<br><br>Note: BUFC LTC provides coverage in the following counties: Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Santa Cruz, and Yuma. |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Opportunities for Improvement and Recommendations** |
| HSAG identified the following opportunities for improvement:<br>• BUFC LTC failed to meet the time/distance standard for at least one quarter and/or county for Pharmacy. **[Access]**<br><br>Recommendation: HSAG recommends that BUFC LTC maintain current compliance with network standards but continue to address network gaps, as applicable. |

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

Table 10-16 presents NAV recommendations made to BUFC LTC in the CYE 2022 Annual Technical Report[10-10] and BUFC LTC's follow-up to the recommendations, as well as an assessment of the degree to which BUFC LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 10-16—BUFC LTC Follow-Up to CYE 2022 NAV Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for NAV |
|---|
| HSAG recommended that BUFC LTC:<br>• Maintain current compliance with network standards but continue to address network gaps, as applicable.<br>• Continue to monitor its processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS. |
| **BUFC LTC's Response:**<br>If there are additional providers in the area to fill the gap, the providers are approached to join our network. If there are no providers in the area, the network is left with a gap and an exception is submitted.<br><br>BUFC LTC runs the PAT file twice a year. Two weeks before the due date, BUFC LTC runs the file and compares it against the previous submission. BUFC LTC analyzes the comparison to see if any outliers stand out and, if so, conducts a deep dive to further investigate. If the variance is in line with natural network changes such as provider moves, adds, etc., those are submitted prior to the deadline. |

[10-10] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for Arizona Long Term Care System. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportEPDandDDD.pdf. Accessed on: Feb 1, 2024.

| Prior Year's Recommendation from the EQR Technical Report for NAV |
| --- |
| **HSAG's Assessment:**<br>HSAG has determined that BUFC LTC has satisfactorily addressed these prior year's recommendations. |

# Mercy Care LTC

## *Validation of Performance Measures*

### Results for Information Systems Standards Review

During CYE 2023, HSAG evaluated Mercy Care LTC's data system for processing of each data type used for reporting the Contractor's CY 2022 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that Mercy Care LTC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 10-17 displays HSAG's PMV findings for each data type reviewed during CYE 2023 in alignment with the CMS EQR Protocol 2 audit requirements.

**Table 10-17—CYE 2023 PMV Findings**

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

### Results for Performance Measures

Table 10-18 presents the CY 2021 and CY 2022 Mercy Care LTC performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and MY 2022. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and/or MY 2022. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

**Table 10-18—CY 2021 and CY 2022 Mercy Care LTC Performance Measure Results**

| Measure | CY 2021 Performance | CY 2022 Performance | 2021–2022 Comparison | 2022 Performance Level[I] |
|---|---|---|---|---|
| ***Behavioral Health*** | | | | |
| ***Antidepressant Medication Management*** | | | | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | 72.1% | 68.9% | → | ★★★★ |
| *Effective Continuation Phase Treatment—Total (18+ Years)* | 64.5% | 59.5% | → | ★★★★★ |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 48.0% | 55.6% | → | ★★★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 52.0% | 72.2% | ↑ | ★★★★ |
| ***Use of Opioids at High Dosage*** | | | | |
| *18+ Years** | 12.8% | 12.1% | → | ★ |
| ***Initiation and Engagement of Substance Use Disorder (SUD) Treatment*** | | | | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | — | 56.7% | — | ★★★★★ |
| *Engagement of SUD Treatment—Total—Total (13+ Years)* | — | 10.2% | — | ★★ |
| ***Care of Acute and Chronic Conditions*** | | | | |
| ***Controlling High Blood Pressure*** | | | | |
| *18–85 Years* | 71.3% + | 74.7% + | → | ★★★★★ |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | | | | |
| *HbA1c Control (<8.0 %)—Total (18–75 Years)* | — | 69.6% + | — | ★★★★★ |
| *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)** | 21.9% + | 23.4% + | → | ★★★★★ |
| ***Pediatric Health*** | | | | |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotics*** | | | | |
| *Blood Glucose Testing—Total (1–17 Years)* | — | NA[++] | — | — |
| *Cholesterol Testing—Total (1–17 Years)* | — | NA[++] | — | — |
| *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* | — | NA[++] | — | — |
| ***Oral Evaluation, Dental Services*** | | | | |
| *Total (0–20 Years)* [N] | — | 44.2% | — | — |
| ***Well-Child Visits in the First 30 Months of Life*** | | | | |
| *Six or More Well-Child Visits* | — | NA[++] | — | — |
| *15 Months–30 Months—Two or More Well-Child Visits* | — | NA[++] | — | — |

| Measure | CY 2021 Performance | CY 2022 Performance | 2021–2022 Comparison | 2022 Performance Level[1] |
|---|---|---|---|---|
| ***Preventive Screening*** | | | | |
| ***Breast Cancer Screening*** | | | | |
| *Total (50–74 Years)* | 32.2% | 35.2% | → | ★ |
| ***Cervical Cancer Screening*** | | | | |
| *21–64 Years* | — | 33.1% + | — | ★ |
| ***Appropriate Utilization of Services*** | | | | |
| ***Ambulatory Care*** | | | | |
| *Emergency Department (ED) Visits—Total (0–85+ Years)* [F] | 672.2 | 687.6 | — | — |
| ***Plan All-Cause Readmissions*** | | | | |
| *Observed Readmissions—Total (18–64 Years)* | 10.2% | 12.5% | → | — |
| *Expected Readmissions—Total (18–64 Years)* | — | 15.9% | — | — |
| *Outlier Rate—Total (18–64 Years)* | — | 107.9 | — | — |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)** | 0.6766 | 0.7893 | — | ★★★★★ |

* A lower rate indicates better performance for this measure.
+ Indicates the measure was reported using hybrid methodology.
++ NA indicates the denominator was too small to report a valid rate, based on the applicable measure specification.
Cells shaded green indicate that the rate met or exceeded the MY 2021 and/or MY 2022 national Medicaid mean.
— Indicates a 2021–2022 comparison is not presented in the CYE 2023 Annual Technical Report because either there was a break in trending, the CY 2021 rate was not presented in the CYE 2022 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
↑ Indicates improvement of measure rates.
↓ Indicates decline of measure rates.
→ Indicates stable measure rates.
[1] Performance Levels for CY 2022 were based on comparisons of the HEDIS MY 2022 measure rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks.
Performance Levels for 2022 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile
[N] Measure has no NCQA Medicaid mean for comparison.
[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.

## Strengths, Opportunities for Improvement, and Recommendations

Table 10-19 presents strengths, opportunities for improvement, and recommendations (as applicable) for Mercy Care LTC related to performance measure, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

**Table 10-19—Mercy Care LTC Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| In the Behavioral Health measure group, Mercy Care LTC's performance measure rates for *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total—(18+ Years); Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+Years)* and *30-Day Follow-Up—Total (6+Years);* and *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* were at or above the 75th percentile, indicating strength in providing behavioral health follow-up care to members. **[Quality, Timeliness, Access]**<br><br>In the Care of Acute and Chronic Conditions measure group, all three of Mercy Care LTC's performance measure rates for *Controlling High Blood Pressure (18–85 Years), Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 %)—Total (18–75 Years),* and *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)* met or exceeded the 90th percentile, indicating strength in providing appropriate care of acute and chronic conditions to applicable members. **[Quality]**<br><br>In the Appropriate Utilization of Services measure group, Mercy Care LTC's performance measure rate for *Plan All Cause-Readmissions—Observed/Expected (O/E) Ratio—Total (18–64 Years)* met or exceeded the 90th percentile, indicating strength in utilization of emergency department services. **[Quality]** |
| **Opportunities for Improvement and Recommendations** |
| While Mercy Care LTC was successful in reporting valid rates for all AHCCCS-required performance measures, the audit review identified some considerations and recommendations for future years' reporting. **[Quality]**<br><br>Recommendation: HSAG recommends that Mercy Care LTC continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. Additionally, HSAG recommends that Mercy Care LTC continue to conduct a formal review of its source code followed by a complete test plan, including live system validation of data, prior to reporting any performance measure data. |
| For CY 2022 performance measure reporting, RES was required based on NCQA HEDIS specifications. **[Quality]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| Recommendation: HSAG recommends that Mercy Care LTC explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratification related to RES. Mercy Care LTC should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information. |
| In the Preventive Screening measure group, Mercy Care LTC's performance measure rates for *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* fell below the 25th percentile, indicating that not all women were receiving timely screening for breast or cervical cancer. Early detection reduces the risk of dying from this type of cancer and can lead to a greater range of treatment options and lower healthcare costs. **[Quality]**<br><br>Recommendation: While Mercy Care LTC conducted a root cause analysis and implemented interventions specific to the *Breast Cancer Screening—Total (50–74 Years)* measure, this rate remained low in CY 2022. HSAG therefore recommends that Mercy Care LTC drill down to race, ethnicity, and age stratifications as well as SDOH to help determine gaps in care and continue to implement appropriate interventions to improve the performance related to these preventive screenings. HSAG also recommends that Mercy Care LTC monitor and expand on interventions currently in place to improve performance related to the *Breast Cancer Screening—Total (50–74 Years)* measure. In addition to drilling down into breast cancer screenings, it would also be beneficial to drill down for members who are due for cervical cancer screening to also implement interventions to improve the performance related to preventive cervical cancer screenings. Examples of these interventions include a mobile clinic to conduct the screening, transportation programs, and adjusting hours for screenings to accommodate those with job/childcare concerns. |
| In the Behavioral Health measure group, Mercy Care LTC's performance measure rate for *Use of Opioids at High Dosage (18+ Years)* fell below the 25th percentile. This result provides an opportunity for Mercy Care LTC to monitor prescribing and utilization data and to implement interventions to improve care and services around opioid prescribing. The CDC guideline on opioid prescribing for chronic, nonmalignant pain recommends the use of "additional precautions" when prescribing dosages ≥50 MED and recommends providers avoid or "carefully justify" increasing dosages ≥90 mg MED.[10-11] **[Quality]**<br><br>Recommendation: HSAG recommends that Mercy Care LTC conduct a drill down analysis based on race, ethnicity, and /age stratifications to determine why there is a higher proportion of members receiving prescriptions for opioids. Upon identification of a root cause, HSAG recommends that Mercy Care LTC implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse and potentially implement other treatment options that do not include opioids if possible. |

[10-11] National Committee for Quality Assurance. Use of Opioids at High Dosage (HDO). Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/. Accessed on: Feb 1, 2024.

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

Table 10-20 presents performance measure recommendations made to Mercy Care LTC in the CYE 2022 Annual Technical Report[10-12] and Mercy Care LTC's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 10-20—Mercy Care LTC Follow-Up to CYE 2022 Performance Measure Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| **Recommendation 1:** |
| HSAG recommended that Mercy Care LTC continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. Additionally, HSAG recommended that Mercy Care LTC continue to conduct a formal review of its source code followed by a complete test plan, including live system validation of data, prior to reporting any performance measure data. |
| **Mercy Care LTC's Response:**<br>Historically, Mercy Care LTC has followed the NCQA HEDIS guidelines regarding continuous enrollment, which is required by AHCCCS beginning in MY 2023. As a result, Mercy Care LTC is in compliance with the current requirements.<br><br>The National Medicaid Quality Data team ensures that necessary source code changes are made by the software vendor with the release of any changes to event data, and rates are reviewed monthly. Any anomalies/discrepancies/outliers that are found are reviewed, researched, and tested thoroughly before any data are reported to regulatory bodies. Additionally, monthly event checks using vendor resources as compared to any technical specifications are conducted to ensure that the vendor is accurately capturing the right reporting elements for all core and non-core activities, as well as higher monitoring of internal back-end system integrations to ensure that all data elements are within scope to be captured for reporting. |
| **HSAG's Assessment:** HSAG has determined that Mercy Care LTC has satisfactorily addressed these prior year's recommendations. |
| **Recommendation 2:** |
| HSAG recommended that Mercy Care LTC explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratification related to RES. Mercy Care LTC should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information. |

[10-12] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for Arizona Long Term Care System. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportEPDandDDD.pdf. Accessed on: Feb 1, 2024.

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| **Mercy Care LTC's Response:**<br>Mercy Care LTC is working in collaboration with the Aetna Medicaid Quality & Report team to update the 834 mapping to include all applicable data. Additionally, exploration of leveraging the CMS enrollment files and case/care management data for capturing additional data is planned for 2024. As part of this additional work, Mercy Care LTC and Aetna Medicaid are collaborating with the Health Equity Team to identify whether or not indirect data sources can be captured to supplement the direct data sources.<br><br>Finally, AHCCCS implemented TI and DAP requirements to encourage providers to support data collection and is working with HIE to provide more information. Mercy Care LTC has been working with the HIE on receiving the A08 alerts for race and ethnicity data directly. |
| **HSAG's Assessment:** HSAG has determined that Mercy Care LTC has satisfactorily addressed these prior year's recommendations. |
| **Recommendation 3:** |
| While Mercy Care LTC conducted a root cause analysis and implemented interventions specific to its *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD–Total—Total* measure, this rate remained low in CY 2021. HSAG therefore recommended that Mercy Care LTC continue to implement appropriate interventions to improve performance related to engaging in timely treatment following initiation of treatment. HSAG also recommended that Mercy Care LTC monitor and expand on interventions currently in place to improve performance related to the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD–Total—Total* measure. |
| **Mercy Care LTC's Response:**<br>Mercy Care LTC continued the interventions that were reported in 2022, after completion of a root cause analysis, and also developed and implemented additional interventions to further drive improvement. Those interventions include:<br>• Referral (as needed) to a behavioral health provider and coordination with a behavioral health provider after discharge.<br>• Access Points offering 24/7 intake availability for those with an OUD.<br>• Healthmine Application—Member Web portal to provide educational information regarding gaps in care along with digital and written member outreach.<br>• Intensive Treatment Systems, a 24-7 access point for MAT services, as a Health Home for members with SMI.<br>• Addition of MAT to each of our existing Health Home provider locations.<br>• Survey of the contracted Health Homes completed; workgroups with the Health Homes being hosted by MC SOC to identify additional barriers to members accessing timely AOD services or MAT, as well as successes that may be implemented more broadly.<br>• Mercy Care LTC medical director and psychiatrist provided training regarding opioids to the LTC staff. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| Mercy Care LTC will continue to monitor the plan's performance with this measure through the additional phases of the PDSA cycle and modify existing interventions or implement additional interventions as necessary. |
| **HSAG's Assessment:** HSAG has determined that Mercy Care LTC has satisfactorily addressed these prior year's recommendations; however, due to a break in trending for this measure as a result of measure specification changes, Mercy Care LTC will need to reassess intervention impact on this measure over time. |
| **Recommendation 4:** |
| While Mercy Care LTC conducted a root cause analysis and implemented interventions specific to the *Breast Cancer Screening* measure, this rate remained low in CY 2021. HSAG therefore recommended that Mercy Care LTC continue to implement appropriate interventions to improve the performance related to these preventive screenings. HSAG also recommended that Mercy Care LTC monitor and expand on interventions currently in place to improve performance related to the *Breast Cancer Screening* measure. |
| **Mercy Care LTC's Response:**<br>Mercy Care LTC continued the interventions that were reported in 2022, after completion of a root cause analysis, and also developed and implemented additional interventions to further drive improvement. Those interventions include:<br>• Educational outreach to female members ages 40–74 to encourage well woman exams and mammograms (*BCS*).<br>• Providers are notified via mail of members who are due for a mammogram. They are given an order form to sign and send into Mercy Care LTC. The member is then contacted and assisted with scheduling a mammogram and submitting the order form.<br>• Outreach staff contact members who still have not had a mammogram to assist with scheduling an appointment.<br>• Incentive letter mailed to members who still need a mammogram; once they receive the mammogram and the facility signs the form, members can submit to us for a gift card if met before the deadline.<br>• Providers' outreach educating on the breast cancer screening guideline and provide them with a list of members in need of a mammogram.<br>• Text messaging, email, and IVR outreach to close gaps in care to members with MCA.<br>• Content that is specific to mammogram disparities was included in provider newsletters and the Mercy Care LTC Provider Conference.<br>• This topic was reviewed at the ALTCS Member Council to obtain member feedback to address disparities.<br>• Improved communication to Mercy Care LTC case management team and members about the availability of the incentives for mammograms. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| • Offer additional provider education for those areas identified as under-utilizers and work with those providers to discuss how we can help utilize a mobile mammogram program to reach their members and promote our incentive program for breast cancer screenings.<br>• Partner with Arizona Diagnostics Radiology to outreach members specifically assigned to these providers.<br>• Addition of *BCS* measure to Value-Based Programs.<br>• Collaboration with Native Health by providing targeted gap lists of members in need of mammography screening.<br>• Collection of nonstandard supplemental data, particularly for members with other primary coverage, to close gaps in data.<br>• Improve Value Based Program incentives to include the *Breast Cancer Screening* measure in the VBS contract for Mercy Care LTC's largest ALTCS PCP (PopHealthCare, also known as Emcara).<br>• Pay for Quality (P4Q) program for smaller ALTCS providers and skilled nursing facilities (SNFs) who close gaps in care for members who are in need of a mammogram.<br>• Partner with Mercy Care LTC VBS providers to provide standard supplemental data feeds to improve data capture.<br>• Healthmine Application—Member Web portal to provide educational information regarding gaps in care along with digital and written member outreach.<br><br>Mercy Care LTC will continue to monitor the plan's performance with this measure through the additional phases of the PDSA cycle and modify existing interventions or implement additional interventions as necessary. |
| **HSAG's Assessment:** Mercy Care LTC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that Mercy Care LTC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 5:** |
| HSAG recommended that Mercy Care LTC identify best practices to support children in receiving well-care visits according to recommended schedules. HSAG also recommended that Mercy Care LTC consider conducting a root cause analysis to identify barriers that members are experiencing in accessing care and services in order to implement appropriate interventions to improve performance related to the Pediatric Health measure group. |
| **Mercy Care LTC's Response:**<br>Mercy Care LTC conducted a root cause analysis. As a result of this analysis, Mercy Care LTC developed the following interventions to support children in receiving well-care visits according to recommended schedules:<br>• Telephone outreach to members in need of a well-child visit during the measurement year. For members in need of an appointment, a three-way call with their provider to schedule the visit will be conducted.<br>• EPSDT Reminder cards and 2nd Reminder cards, including information consistent with the AHCCCS periodicity schedule. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| • Written provider outreach process which includes mailings to PCPs for members in need of an EPSDT visit and information pertaining to the members' historical dental care and whether or not members are due for dental care.<br>• Identification of the largest provider groups and schedule meetings/visits to encourage member outreach.<br>• An adolescent immunization reminder card is mailed to the parents/guardians/caregivers of members during the month of the member's 12th birthday, reminding them of the importance of obtaining immunizations.<br>• Mailing to the Native American members in need of a well visit a cover letter and CDC brochure specific to the health of Native Americans.<br>• Provider outreach and education regarding billing codes specific to the well-care measure.<br>• Data sharing between MM EPSDT team and ALTCS Case Management team identifying which ALTCS members are in need of a well-child and/or dental visit.<br>• Inclusion of the measure in the Mercy Care LTC VBS Program.<br>• Healthmine Application—Member Web portal to provide educational information regarding gaps in care along with digital and written member outreach.<br>• Partner with Mercy Care LTC VBS providers to provide standard supplemental data feeds to improve data capture.<br>• EPSDT Back to School Campaign Member Incentive.<br>• Mercy Care LTC pediatric care managers discuss EPSDT visits with the member/family at each scheduled review visit.<br><br>Mercy Care LTC will continue to monitor the plan's performance with this measure through the additional phases of the PDSA cycle and modify existing interventions or implement additional interventions as necessary. |
| **HSAG's Assessment:** Mercy Care LTC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that Mercy Care LTC satisfactorily addressed these prior year's recommendations. |
| **Recommendation 6:** |
| HSAG recommended that Mercy Care LTC conduct a root cause analysis or focus study to determine why there is a higher proportion of members receiving prescriptions for opioids. Upon identification of a root cause, HSAG recommended that Mercy Care LTC implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse. |
| **Mercy Care LTC's Response:**<br><br>Mercy Care LTC conducted a root cause analysis. As a result of this analysis, Mercy Care LTC developed the following interventions aimed at reducing the number and percentage of members who are prescribed high dose opioids:<br>• Pharmacy Risk Prevention Report including members at risk for medication nonadherence and gap in care data (measures: *AMM, HDO, SAA, SPD, SPC, SSD,* and *UOP*). |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| • Opioid/SUD Best Practices Presentation to Mercy Care LTC VBS providers by Mercy Care LTC associate chief medical officer.<br>• Educational Outreach Program (EOP) with provider fax including targeted member information for providers identified as having members on > 90 MME. This also includes an opioid prescriber report card.<br>• Telephonic one-on-one provider outreach to the top 10 high MME prescribers.<br>• SMS (PBM program): This program targets high-risk drug classes, focusing on controlled substances, and inappropriate use and misuse related indicators such as poly-pharmacy, provider shopping, and high-total controlled substance claims volume. Quarterly, clinical pharmacists will evaluate controlled substance claims and any available supporting medical data to identify potential medication misuse and inappropriate claims for appropriate intervention. During subsequent quarters, pharmacists conduct follow-up activities utilizing physician responses and current claim activity. Situations identified as being potentially inappropriate may be referred to the client (plan) for further action.<br>• Creation and distribution of a report of members who are utilizing 50–89 MME for provider awareness and intervention prior to the member reaching 90 MME.<br>• Mercy Care LTC's associate chief medical officer outreach to prescribing providers of members who are in the *HDO* measure numerator.<br>• Mercy Care LTC case managers will outreach members in the *HDO* measure for care coordination.<br><br>Mercy Care LTC will continue to monitor the plan's performance with this measure through the additional phases of the PDSA cycle and modify existing interventions or implement additional interventions as necessary. |
| **HSAG's Assessment:** Mercy Care LTC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that Mercy Care LTC satisfactorily addressed these prior year's recommendations. |

## *Validation of Performance Improvement Projects*

In CYE 2023, Mercy Care LTC continued the *Breast Cancer Screening* PIP, which was initiated in CYE 2019. As this PIP has progressed through Remeasurement 1, PIP validation activities focused on improvement from the baseline results. Mercy Care LTC submitted Remeasurement 1 performance indicator results and interventions improvement during this validation cycle along with the status of interventions, focus, and rationale for changes or discontinuation of the interventions.

HSAG conducted an annual validation of the first remeasurement year reflective of CY 2022 (January 1, 2022, through December 31, 2022) using AHCCCS-calculated and validated indicator rates. HSAG evaluated Mercy Care LTC's performance indicator results based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the

Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

### Validation Results

Table 10-21 displays the overall confidence levels for the Mercy Care LTC *Breast Cancer Screening* PIP.

**Table 10-21—Mercy Care LTC *Breast Cancer Screening* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| Mercy Care LTC | *High Confidence* | 100% | 100% | *No Confidence* | 33% | 100% |

### Measure Results

Table 10-22 provides the *Breast Cancer Screening* PIP baseline, intervention, and Remeasurement Year 1 rates for Mercy Care LTC.

**Table 10-22—Mercy Care LTC *Breast Cancer Screening* PIP Rates**

| Contractor | PIP Indicator: *Breast Cancer Screening* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| Mercy Care LTC | 37.8% | 35.2% |

### Interventions

Table 10-23 presents PIP interventions for Mercy Care LTC. Language in this section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 10-23—Mercy Care LTC *Breast Cancer Screening* PIP Interventions**

| Contractor | Intervention |
|---|---|
| Mercy Care LTC | • Additional provider education for those areas mentioned that are underutilized: |

| Contractor | Intervention |
|---|---|
| | – Work with those providers to discuss how we can help utilize a mobile mammogram program to reach their members.<br>– Work with those providers to promote our incentive program for breast cancer screenings.<br>• Partner with Arizona Diagnostics Radiology to outreach members specifically assigned to these providers.<br>• Develop and implement a written or multi-channel outreach (text/IVR/email) intervention for newly enrolled female members ages 50–74 years, as well as members ages 52–59 years.<br>• Addition of *BCS* measure to Value-Based Programs.<br>• Consideration of partnership with mobile mammography provider in targeted ZIP Codes.<br>• Increase community/tribal outreach and education.<br>• Meet with Native Health and the Phoenix Indian Medical Center to determine if partnership opportunities exist.<br>• Partnering with Mercy Care VBS providers to provide standard supplemental data feeds to close gaps in data.<br>• Collection of non-standard supplemental data for the *BCS* measure, particularly for members with other primary coverage, to close gaps in data. |

## Strengths, Opportunities for Improvement, and Recommendations

Table 10-24 presents strengths, opportunities for improvement, and recommendations (as applicable) for Mercy Care LTC related to the *Breast Cancer Screening* PIP, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

**Table 10-24—Mercy Care LTC Strengths, Opportunities for Improvement, and Recommendations Related to the *Breast Cancer Screening* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG noted that Mercy Care LTC performed accurate statistical testing between the baseline and Remeasurement 1 results. **[Quality, Access]**<br><br>Mercy Care LTC developed and implemented measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 2. **[Quality, Access]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Opportunities for Improvement and Recommendations** |
| Mercy Care LTC had a decline of 2.6 percentage points in the indicator rate between the baseline year and Remeasurement Year 1. **[Quality, Access]**<br><br>Recommendations: As the PIP progresses, HSAG recommends that Mercy Care LTC:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions to facilitate improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

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

Table 10-25 presents PIP recommendations made to Mercy Care LTC in the CYE 2022 Annual Technical Report[10-13] and Mercy Care LTC's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 10-25—Mercy Care LTC Follow-Up to CYE 2022 PIP Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| HSAG recommended that Mercy Care LTC:<br>• Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary.<br>• Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available.<br>• Develop and document a plan for sustaining the improvement for any demonstrated improvement in indicator rates. |
| **Mercy Care LTC's Response:**<br>Mercy Care LTC continues to review the PIP rates at least quarterly, with an annual final measurement year evaluation once the data are finalized. When Mercy Care LTC identifies declines in performance, or that the rates are not on track to reach the defined goal, Mercy Care LTC initiates or continues to the next step in the PDSA cycle. Interventions are assessed for effectiveness, and best |

[10-13] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for Arizona Long Term Care System. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportEPDandDDD.pdf. Accessed on: Feb 1, 2024.

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| practices are identified, documented, and incorporated into the health plan's standard operating procedures. |
| **HSAG's Assessment:** HSAG has determined that the Contractor has satisfactorily addressed these prior year's recommendations. |

## Compliance Reviews

### Results

AHCCCS conducted a compliance review of Mercy Care LTC from May 1, 2023, through May 4, 2023. On July 13, 2023, AHCCCS finalized the report findings; provided Mercy Care LTC with a CAP submission matrix; and required a CAP, due July 27, 2023, for any standard with a total score of less than 95 percent. On September 20, 2023, AHCCCS accepted Mercy Care LTC's proposed CAPs and required the Contractor to submit updated policies, manuals, desktop procedures, and other vital documents to provide evidence of CAP completion by March 20, 2024. Table 10-26 presents the compliance review results for Mercy Care LTC.

**Table 10-26—Mercy Care LTC Compliance Results**

| Focus Areas | CYE 2023 Mercy Care LTC Scores | CYE 2023 Program-Level Average |
|---|---|---|
| CC | 100% | 100% |
| CIS | 97% | 98% |
| CM | 77% | 86% |
| DS | 97% | 94% |
| GA | 100% | 100% |
| GS | 99.7% | 99% |
| MCH | 89% | 92% |
| MM | 97% | 92% |
| MI | 97% | 97% |
| QM | 84% | 89% |
| QI | 99% | 98% |
| RI | 100% | 100% |
| TPL | 100% | 100% |
| ISOC | 98% | 93% |

## Strengths, Opportunities for Improvement, and Recommendations

Table 10-27 presents strengths, opportunities for improvement, and recommendations (as applicable) for Mercy Care LTC related to compliance, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

**Table 10-27—Mercy Care LTC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| Mercy Care LTC scored at or above 95 percent in the following Focus Areas:<br>• Corporate Compliance (CC) **[Quality, Access]**<br>• Claims and Information Standards (CIS) **[Access]**<br>• Delivery Systems (DS) **[Timeliness, Access]**<br>• General Administration (GA) **[Timeliness, Access]**<br>• Grievance Systems (GS) **[Timeliness, Access]**<br>• Medical Management (MM) **[Timeliness, Access]**<br>• Member Information (MI) **[Quality]**<br>• Quality Improvement (QI) **[Quality, Access]**<br>• Reinsurance (RI) **[Quality]**<br>• Third-Party Liability (TPL) **[Quality, Timeliness, Access]**<br>• Integrated Systems of Care (ISOC) **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| Mercy Care LTC scored below 95 percent in the following Focus Areas:<br>• Case Management (CM) **[Quality, Access]**<br>• Adult, EPSDT and Maternal Child Health (MCH) **[Quality, Timeliness, Access]**<br>• Quality Management (QM) **[Quality]**<br><br>Recommendation: HSAG recommends that Mercy Care LTC propose and implement CAPs for the CM, MCH, and QM Focus Areas as approved by AHCCCS. |

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

Table 10-28 presents compliance recommendations made to Mercy Care LTC in the CYE 2022 Annual Technical Report[10-14] and Mercy Care LTC's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 10-28—Mercy Care LTC's Follow-Up to CYE 2022 Compliance Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for Compliance |
|---|
| HSAG recommended that in advance of the forthcoming compliance review, Mercy Care LTC conduct a self-assessment of the CM, DS, MCH, MM, QM, and TPL requirements. |
| **Mercy Care LTC's Response:**<br>Mercy Care LTC continues to review policies, procedures, and processes to ensure compliance with AHCCCS OR standards. Annual and ad hoc reviews are ongoing. |
| **HSAG's Assessment:**<br>Based on the results of the CYE 2023 compliance review activity and the response provided, HSAG determined that Mercy Care LTC has partially addressed this prior year's recommendation, as Mercy Care LTC continued to score less than 95% in the CM, MCH, and QM Focus Areas. |

## *Network Adequacy Validation*

### Results

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

- Central GSA: Gila, Maricopa,[10-15] and Pinal counties
- South GSA: Pima County

Each region-specific table summarizes semiannual validation results containing the percentage of members meeting each time/distance standard by quarter and county, with color-coding to identify whether the time/distance standard was "*Met*" or "*Not Met*."

The value "NA" is shown for time/distance standards that do not apply to the county or program.

[10-14] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for Arizona Long Term Care System. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportEPDandDDD.pdf. Accessed on: Feb 8, 2024.

[10-15] Maricopa County includes the 85342, 85358, and 85390 ZIP Codes; these ZIP Codes are physically located in both Maricopa and Yavapai counties.

The value "NR" is shown for time/distance standards in which no members met the network requirement denominator for the program and county; therefore, HSAG calculated no corresponding time/distance result.

Yellow color-coding identifies instances in which HSAG's time/distance results met the minimum network requirement but differed from the ACOM 436 results.

Red color-coding identifies instances in which HSAG's time/distance results did not meet the compliance standard, regardless of the ACOM 436 results.

An asterisk (*) indicates that fewer than 10 members were included in the denominator of HSAG's results.

A carat (^) indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

**Table 10-29—Mercy Care LTC Time/Distance Validation Results for Central GSA—Percentage of Members Meeting Minimum Network Requirements**

| | Gila | | Maricopa | | Pinal | |
|---|---|---|---|---|---|---|
| Minimum Network Requirement | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0^ | 100.0^ | 99.3^ | 99.3^ | 100.0^ | 100.0^ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 100.0*^ | 100.0*^ | 98.2^ | 98.2^ | 100.0^ | 100.0^ |
| BHRF | NA | NA | 99.7 | 99.7 | NA | NA |
| Cardiologist, Adult | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| Cardiologist, Pediatric | 100.0*^ | 100.0*^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| Dentist, Pediatric | 100.0* | 100.0* | 98.7 | 98.3 | 100.0 | 100.0 |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Nursing Facility | 100.0 | 100.0 | 99.9 | 99.9 | 100.0 | 100.0 |
| OB/GYN | 100.0* | 100.0* | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 100.0 | 100.0 | 99.6 | 99.7 | 100.0 | 100.0 |
| PCP, Adult | 100.0^ | 100.0^ | 99.9^ | 99.9^ | 100.0^ | 100.0^ |
| PCP, Pediatric | 100.0*^ | 100.0*^ | 99.6^ | 99.6^ | 100.0^ | 100.0^ |

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

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

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

NA indicates results are not applicable to the county.

**Table 10-30—Mercy Care LTC Time/Distance Validation Results for South GSA—Percentage of Members Meeting Minimum Network Requirements**

| | Pima | |
|---|---|---|
| Minimum Network Requirement | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 98.7^ | 98.8^ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 90.5^ | 88.2^ |
| BHRF | 98.3 | 98.4 |
| Cardiologist, Adult | 99.8^ | 99.9^ |
| Cardiologist, Pediatric | 100.0^ | 100.0^ |
| Dentist, Pediatric | 100.0 | 100.0 |
| Hospital | 99.8 | 99.8 |
| Nursing Facility | 99.7 | 99.6 |
| OB/GYN | 100.0 | 98.4 |
| Pharmacy | 99.7 | 99.6 |
| PCP, Adult | 99.9^ | 99.6^ |
| PCP, Pediatric | 100.0^ | 100.0^ |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
^indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

## Strengths, Opportunities for Improvement, and Recommendations

Table 10-31 presents strengths, opportunities for improvement, and recommendations (as applicable) for Mercy Care LTC related to NAV, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

**Table 10-31—Mercy Care LTC Strengths, Opportunities for Improvement, and Recommendations Related to NAV**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths:<br>• Mercy Care LTC met all time/distance network standards in all assigned counties for both quarters in CYE 2023. **[Access]**<br>Note: Mercy Care LTC provides coverage in the following counties: Gila, Maricopa, Pima, and Pinal. |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Opportunities for Improvement and Recommendations** |
| HSAG identified no opportunities for improvement for Mercy Care LTC.<br><br>Recommendation: While HSAG did not have any recommendations specific to Mercy Care LTC's existing provider network coverage, Mercy Care LTC should continue to maintain current compliance with network standards. |

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

Table 10-32 presents NAV recommendations made to Mercy Care LTC in the CYE 2022 Annual Technical Report[10-16] and Mercy Care LTC's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 10-32—Mercy Care LTC Follow-Up to CYE 2022 NAV Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for NAV |
|---|
| While HSAG did not have any recommendations specific to its existing provider network coverage, HSAG recommended that Mercy Care LTC continue to maintain current compliance with network standards. |
| **Mercy Care LTC's Response:**<br>Mercy Care LTC continues existing processes to ensure that the plan maintains compliance with the AHCCCS-required network coverage requirements. |
| **HSAG's Assessment:**<br>HSAG has determined that Mercy Care LTC has satisfactorily addressed this prior year's recommendation. |

[10-16] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for Arizona Long Term Care System. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportEPDandDDD.pdf. Accessed on: Feb 8, 2024.

# UHCCP LTC

## *Validation of Performance Measures*

### Results for Information Systems Standards Review

During CYE 2023, HSAG evaluated UHCCP LTC's data system for processing of each data type used for reporting the Contractor's CY 2022 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that UHCCP LTC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 10-33 displays HSAG's PMV findings for each data type reviewed during CYE 2023 in alignment with the CMS EQR Protocol 2 audit requirements.

**Table 10-33—CYE 2023 PMV Findings**

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

### Results for Performance Measures

Table 10-34 presents the CY 2021 and CY 2022 UHCCP LTC performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and MY 2022. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and/or MY 2022. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

**Table 10-34—CY 2021 and CY 2022 UHCCP LTC Performance Measure Results**

| Measure | CY 2021 Performance | CY 2022 Performance | 2021–2022 Comparison | 2022 Performance Level[1] |
|---|---|---|---|---|
| ***Behavioral Health*** | | | | |
| ***Antidepressant Medication Management*** | | | | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | 80.2% | 83.0% | → | ★★★★★ |
| *Effective Continuation Phase Treatment—Total (18+ Years)* | 71.7% | 74.3% | → | ★★★★★ |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 38.0% | 39.6% | → | ★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 48.0% | 66.0% | → | ★★★★ |
| ***Use of Opioids at High Dosage*** | | | | |
| *18+ Years** | 11.4% | 10.8% | → | ★ |
| ***Initiation and Engagement of Substance Use Disorder (SUD) Treatment*** | | | | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | — | 55.8% | — | ★★★★★ |
| *Engagement of SUD Treatment—Total—Total (13+ Years)* | — | 5.3% | — | ★ |
| ***Care of Acute and Chronic Conditions*** | | | | |
| ***Controlling High Blood Pressure*** | | | | |
| *18–85 Years* | 75.9% + | 72.5% + | → | ★★★★★ |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | | | | |
| *HbA1c Control (<8.0 Percent)—Total (18–75 Years)* | — | 64.0% + | — | ★★★★★ |
| *HbA1c Poor Control (>9.0 Percent)—Total (18–75 Years)** | 29.7% + | 27.0% + | → | ★★★★★ |
| ***Pediatric Health*** | | | | |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotics*** | | | | |
| *Blood Glucose Testing—Total (1–17 Years)* | — | NA++ | — | — |
| *Cholesterol Testing—Total (1–17 Years)* | — | NA++ | — | — |
| *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* | — | NA++ | — | — |
| ***Oral Evaluation, Dental Services*** | | | | |
| *Total (0–20 Years) N* | — | 42.7% | — | — |
| ***Well-Child Visits in the First 30 Months of Life*** | | | | |
| *Six or More Well-Child Visits* | — | NA++ | — | — |
| *15 Months–30 Months—Two or More Well-Child Visits* | — | NA++ | — | — |

| Measure | CY 2021 Performance | CY 2022 Performance | 2021–2022 Comparison | 2022 Performance Level[1] |
|---|---|---|---|---|
| ***Preventive Screening*** | | | | |
| ***Breast Cancer Screening*** | | | | |
| *Total (50–74 Years)* | 38.3% | 41.6% | → | ★ |
| ***Cervical Cancer Screening*** | | | | |
| *21–64 Years* | — | 32.6% + | — | ★ |
| ***Appropriate Utilization of Services*** | | | | |
| ***Ambulatory Care*** | | | | |
| *Emergency Department (ED) Visits—Total (0–85+ Years)* [F] | 749.2 | 787.6 | — | — |
| ***Plan All-Cause Readmissions*** | | | | |
| *Observed Readmissions—Total (18–64 Years)* | 10.2% | 9.7% | → | — |
| *Expected Readmissions—Total (18–64 Years)* | — | 15.6% | — | — |
| *Outlier Rate—Total (18–64 Years)* | — | 96.9 | — | — |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)** | 0.6586 | 0.6241 | — | ★★★★★ |

* A lower rate indicates better performance for this measure.
\+ Indicates the measure was reported using hybrid methodology.
++ NA indicates the denominator was too small to report a valid rate, based on the applicable measure specification.
Cells shaded green indicate that the rate met or exceeded the MY 2021 and/or MY 2022 national Medicaid mean.
— Indicates a 2021–2022 comparison is not presented in the CYE 2023 Annual Technical Report because either there was a break in trending, the CY 2021 rate was not presented in the CYE 2022 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.
↑ Indicates improvement of measure rates.
↓ Indicates decline of measure rates.
→ Indicates stable measure rates.

[1] Performance Levels for CY 2022 were based on comparisons of the HEDIS MY 2022 measure rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks.
Performance Levels for 2022 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

[N] Measure has no NCQA Medicaid mean for comparison.

[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.

## Strengths, Opportunities for Improvement, and Recommendations

Table 10-35 presents strengths, opportunities for improvement, and recommendations (as applicable) for UHCCP LTC related to performance measures, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

**Table 10-35—UHCCP LTC Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| In the Behavioral Health measure group, four out of the seven measure indicators were at or above the 75th percentile, indicating strength in providing behavioral health follow-up care to members. **[Quality, Timeliness, Access]**<br>• *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total (18+ Years)*<br>• *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total (6+ Years)*<br>• *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)*<br><br>In the Care of Acute and Chronic Conditions measure group:<br>• UHCCP LTC's performance measure rate for *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)—Total (18–75 Years)* was at or above the 90th percentile, indicating that most members with diabetes had controlled HbA1c levels most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[10-17] **[Quality]**<br>• UHCCP LTC's performance measure rate for *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 %)—Total (18–75 Years)* was at or above the 90th percentile, indicating that most members with diabetes had controlled HbA1c levels most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[10-18] **[Quality]**<br>• UHCCP LTC's performance measure rate for *Controlling High Blood Pressure—18–85 Years* was at or above the 90th percentile, indicating that most members with a diagnosis of hypertension had controlled blood pressure. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[10-19] **[Quality]** |

[10-17] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Feb 1, 2024.
[10-18] Ibid.
[10-19] National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Feb 1, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| In the Appropriate Utilization of Services measure group, UHCCP LTC's *Plan All-Cause Readmissions—O/E Ratio—Total (18–64 Years)* measure rate was at or above the 90th percentile, indicating that members were generally not experiencing unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay. **[Quality]** |
| **Opportunities for Improvement and Recommendations** |
| In the Preventive Screening measure group, UHCCP LTC's performance measure rate for *Breast Cancer Screening—Total (50–74 Years)* and *Cervical Cancer Screening—21–64 Years* fell below the 25th percentile, indicating that women were not always receiving timely screening for breast and cervical cancer. Early detection reduces the risk of dying from cancer and can lead to a greater range of treatment options and lower healthcare costs. **[Quality]**<br><br>Recommendation: While UHCCP LTC conducted a root cause analysis and implemented interventions specific to the *Breast Cancer Screening* measure, this rate remained low in CY 2022. HSAG therefore recommends that UHCCP LTC drill down into age, race, and ethnicity data as well as SDOH to assist in identifying any gaps in preventive care for both breast and cervical cancer screenings and continue to implement appropriate interventions to improve performance related to members' access to timely screenings for breast cancer. HSAG also recommends that UHCCP LTC monitor and expand on interventions currently in place to improve performance related to the *Breast Cancer Screening* measure and implement interventions for cervical cancer screening. |
| In the Behavioral Health measure group, UHCCP LTC's performance measure rate for *Use of Opioids at High Dosage—18+ Years* fell below the 25th percentile. This result provides an opportunity for UHCCP LTC to monitor prescribing and utilization data and to implement interventions to improve care and services around opioid prescribing. The CDC guideline on opioid prescribing for chronic, nonmalignant pain recommends the use of "additional precautions" when prescribing dosages ≥50 MED and recommends providers avoid or "carefully justify" increasing dosages ≥90 mg MED. [10-20] **[Quality]**<br><br>Recommendation: HSAG recommends that UHCCP LTC conduct a drill down analysis or focus study of age, race, and ethnicity and SDOH to determine why there is a higher proportion of members receiving prescriptions for opioids. Upon identification of a root cause, HSAG recommends that UHCCP LTC implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse and potentially implement other treatment options. |

[10-20] National Committee for Quality Assurance. Use of Opioids at High Dosage (HDO). Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/. Accessed on: Feb 1, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| UHCCP LTC's performance measure rate for *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* fell below the 25th percentile. **[Quality, Timeliness, Access]**<br><br>Recommendation: HSAG recommends that UHCCP LTC conduct a drill down analysis based on race, ethnicity, and age stratifications to determine why members were not receiving timely SUD services or MAT following their initiation visit. UHCCP LTC should consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, UHCCP LTC should implement interventions that address the identified root cause of the low rate, targeting the interventions so that UHCCP LTC improves performance related to initiating and engaging in timely treatment following a new episode of SUD dependence. |

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

Table 10-36 presents performance measure recommendations made to UHCCP LTC in the CYE 2022 Annual Technical Report[10-21] and UHCCP LTC's follow-up to the recommendations, as well as an assessment of the degree to which UHCCP LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 10-36—UHCCP LTC Follow-Up to CYE 2022 Performance Measure Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| **Recommendation 1:** |
| HSAG recommended that UHCCP LTC ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. Additionally, HSAG recommended that UHCCP LTC continue to conduct a formal review of its source code followed by a complete test plan, including live system validation of data, prior to reporting any performance measure data**.** |
| **UHCCP LTC's Response:** |
| UHCCP LTC follows the NCQA/CMS guidance on continuous enrollment requirements for measure calculation. Source code for HEDIS measures is reviewed by NCQA, which is confirmed by the certificate received. For non-HEDIS measures, there are multiple audit firms that annually review and approve the performance measure vendor's source code (including HSAG). UHCCP LTC compares |

[10-21] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for Arizona Long Term Care System. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportEPDandDDD.pdf. Accessed on: Feb 1, 2024.

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| prior year results to current year results to confirm any significant discrepancies. UHCCP LTC and HSAG discussed the topic during UHCCP LTC's virtual PMV audit review with HSAG. |
| **HSAG's Assessment:** HSAG has determined that UHCCP LTC has satisfactorily addressed these prior year's recommendations. |
| **Recommendation 2:** |
| HSAG recommended that UHCCP LTC explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratifications related to RES. UHCCP LTC should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information. |
| **UHCCP LTC's Response:**<br>UHCCP LTC is reporting race and ethnicity data on all NCQA HEDIS performance measures requiring race and ethnicity stratification.<br><br>To improve the completion and accuracy of race and ethnicity data, UHCCP LTC has added some functionality to gather race, ethnicity, and language (REL) information from multiple sources under the Health Care Needs Identifier (HCNI) effort. In terms of collaborative efforts, UHCCP LTC has been working with AHCCCS on expanding data feeds. |
| **HSAG's Assessment:** HSAG has determined that UHCCP LTC has satisfactorily addressed these prior year's recommendations; however, HSAG recommends that UHCCP LTC continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race and ethnicity data to support performance measure reporting that requires stratification related to RES. |
| **Recommendation 3:** |
| While UHCCP LTC implemented interventions specific to the CY 2020 *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD–Total—Total* measure, this rate remained low in CY 2021. HSAG therefore continued to recommend that UHCCP LTC conduct a root cause analysis to determine why members were not receiving timely AOD services or MAT. UHCCP LTC should consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, UHCCP LTC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, BUFC LTC should implement interventions that address the identified root cause of the low rate, targeting the interventions so that UHCCP LTC improves performance related to engaging in timely treatment following an initiation visit. |
| **UHCCP LTC's Response:**<br>UHCCP LTC did not meet the 2022 NCQA Medicaid mean (MY 2021) rates for the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement—Total (IET-E)* submeasure. As a result, UHCCP LTC implemented a CAP for the measure in July 2023. The submeasure is also included in UHCCP LTC's 2023 and 2024 LTC Quality Improvement (QI) Work Plans. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| UHCCP LTC and Optum Behavioral Health (OBH) conducted a root cause analysis and identified the following barriers:<br>1. Members may not be aware of telehealth services.<br>2. PCPs may not be referring members they diagnose with cannabis use disorder. Often not deemed an issue due to legalization. Referrals are likely to be made to outpatient behavioral health.<br>3. PCPs may not be using the Diagnostic Screening Manual 5 (DSM 5) criteria and screening tools.<br>4. Providers may not be aware of the appropriate use of SUD remission codes.<br>5. Providers may not be aware of evidence-based practices.<br><br>To address the identified root cause deficiencies, UHCCP LTC implemented the following interventions in 2022 and 2023:<br>• Annual virtual visit email campaign sent to members.<br>• Educated PCPs on referral options for patients with cannabis use disorder to receive cognitive behavioral therapy (including use of motivational interviewing) by focusing on distribution of existing motivational interviewing education materials.<br>• Educational materials created and posted on providerexpress.com and on UHCprovider.com on the importance of using cannabis screening tools and the DSM 5 criteria to diagnose cannabis use disorder.<br>• Provider education on appropriate use of SUD remission codes. Creation of a one-page flyer of SUD remission codes, why they are useful, and when to use them, which will be an Optum handout and added to UHC interactive training (in process).<br>• Educate providers on evidence-based practices for medication assisted treatment (MOUD) for opioid use disorder by creating a provider flyer (2–3 pages), which will be an Optum handout and added to UHC interactive training (implementation TBD).<br>• UHCCP LTC is also implementing processes to monitor and ensure that LTC members with or at risk for SUDs are referred for services and that follow-up occurs to determine if services are received (in process).<br><br>The COVID-19 pandemic presented numerous challenges which impacted access to care for SUD treatment, including limited in-person visits, the transition to telehealth services, reduced treatment options, and overwhelmed resources. At the time of this review, the COVID-19 pandemic access to care factors impacting this measure have largely been resolved.<br>Internal dissemination of CAP findings, progress, and results is communicated at quarterly UHCCP LTC Quality Management Committee (QMC) meetings. External dissemination of CAP findings, progress, and results is communicated to AHCCCS within UHCCP LTC's Performance Measure Monitoring Report & Work Plan/Work Plan Evaluation (PMMR/WP/WPE) submissions to AHCCCS. |
| **HSAG's Assessment:** HSAG has determined that UHCCP LTC has satisfactorily addressed these prior year's recommendations; however, due to a break in trending for this measure as a result of measure specification changes, UHCCP LTC will need to reassess intervention impact on this measure over time. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| **Recommendation 4:** |
| HSAG recommended that UHCCP LTC conduct a root cause analysis to determine why some members were not receiving timely follow-up care with a mental health provider. UHCCP LTC should consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, a lack of mental health service providers, or the need for community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, UHCCP LTC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, UHCCP LTC should implement appropriate interventions to improve performance related to follow-up care following a hospitalization. |
| **UHCCP LTC's Response:** |
| UHCCP LTC did not meet the 2022 NCQA Medicaid mean (MY 2021) rates for the *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total (FUH-30)* performance measure. As a result, UHCCP LTC implemented a CAP for the *FUH* measure in July 2023. The measure is also included in UHCCP LTC's 2023 and 2024 QI Work Plans.<br><br>UHCCP LTC identified the following root causes impacting the *FUH* rate performance for LTC:<br>1. Members may not be aware telehealth services are available.<br>2. Behavioral health and medical integration challenges.<br>3. Providers may not be familiar with behavioral health integrated clinics and/or know the services they provide.<br>4. Some providers do not submit claims to secondary payers.<br><br>To address the identified root cause deficiencies, UHCCP LTC implemented the following new interventions in 2022 and 2023:<br>• Annual virtual visit email campaign sent to members to let them know about the availability of telehealth services.<br>• Behavioral Health Integration Pilot for two ACOs.<br>• Behavioral Health Home Integrated Clinic informational flyer.<br>• To address the secondary payor claims issue, UHCCP LTC is providing regular reports of members with other insurance, called Coordination of Benefits (COB) reports, to select provider groups and ACOs, along with ongoing education on the importance of submitting claims to secondary payers. Discussion to include how secondary claims submissions for COB members could impact incentivized performance measure rates.<br><br>The *FUH* measure has a small denominator (53 in MY 2022) and therefore is prone to more rate variability. In the last four years (2019–2022), the *FUH* submeasure rates have fluctuated between the 20th and 67th percentiles. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| Internal dissemination of CAP findings, progress, and results is communicated at quarterly UHCCP LTC QMC meetings. External dissemination of CAP findings, progress, and results is communicated to AHCCCS within UHCCP LTC's PMMR/WP/WPE submissions to AHCCCS. |
| **HSAG's Assessment:** HSAG has determined that UHCCP LTC has satisfactorily addressed these prior year's recommendations but recommends continuing interventions to assist in improving rates. |
| **Recommendation 5:** |
| While UHCCP LTC conducted a root cause analysis and implemented interventions specific to the *Breast Cancer Screening* measure, this rate remained low in CY 2021. HSAG therefore recommended that UHCCP LTC continue to implement appropriate interventions to improve performance related to members' access to timely screenings for breast cancer. HSAG also recommended that UHCCP LTC monitor and expand on interventions currently in place to improve performance related to the *Breast Cancer Screening* measure. |
| **UHCCP LTC's Response:**<br>UHCCP LTC has an AHCCCS-mandated PIP in place for the *BCS* measure. The BCS PIP workgroup performs an annual review of the initial root cause analysis (RCA) for the *BCS* PIP. The workgroup evaluates whether or not the root causes are still relevant/applicable and if any new root causes have been identified.<br><br>UHCCP LTC identified the following root causes impacting *BCS* rate performance:<br>1. The COVID-19 pandemic occurred during the lookback period for this measure and affected rates.<br>2. Some providers do not submit claims to secondary payors.<br>3. Providers do not submit advanced illness and frailty diagnosis codes for members, which may exclude them from the measure denominator.<br><br>At the time of this review, the COVID-19 pandemic root cause has been largely resolved for the *BCS* measure. To address the other identified root cause deficiencies, UHCCP LTC implemented the following new interventions in 2023:<br>• To address the secondary payor claims issue, UHCCP LTC is providing regular reports of members with other insurance, called COB reports, to select provider groups and ACOs, along with ongoing education on the importance of submitting claims to secondary payers. Discussion to include how secondary claims submissions for COB members could impact incentivized performance measure rates.<br>• To address the lack of claims submissions for advanced illness and frailty diagnosis codes, the PIP workgroup developed a provider-facing Advanced Illness and Frailty document which was emailed to any SNF or assisted living facility (ALF) requesting more information. UHCCP LTC clinical practice consultants (CPCs) also included the topic and document as an agenda item for their CPC Talking Points meetings with provider groups. The document was also posted on the uhcprovider.com currents news/bulletins webpage. Several physician assistants and nurses called for more information and were appreciative that UHCCP LTC made this information available to them. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| UHCCP LTC has achieved year-over-year improvement on its *BCS* measure rate since CYE 2019 and has improved the rate by 7.5 points. |
| **HSAG's Assessment:** HSAG has determined that UHCCP LTC has satisfactorily addressed these prior year's recommendations but recommends continuing interventions to assist in improving rates. |
| **Recommendation 6:** |
| HSAG recommended that UHCCP LTC identify best practices to support children in receiving well-care visits. according to recommended schedules. HSAG recommended that UHCCP LTC consider conducting a root cause analysis to identify barriers that members are experiencing in accessing care and services in order to implement appropriate interventions to improve the performance related to the Pediatric Health measure group. |
| **UHCCP LTC's Response:**<br>UHCCP LTC did not meet the 2022 NCQA Medicaid mean (MY 2021) rates for the *Child and Adolescent Well-Care Visits (WCV)* performance measure. As a result, UHCCP LTC implemented a CAP for the *WCV* measure in July 2023. The measure is also included in UHCCP LTC's 2023 and 2024 QI Work Plans.<br><br>UHCCP LTC identified the following root causes impacting the *WCV* rate performance for LTC:<br>1. Members may not be aware telehealth services are available.<br>2. Financial incentives not motivating providers to outreach members to close gaps in care.<br>3. Some providers do not submit claims to secondary payers.<br><br>To address the identified root cause deficiencies, UHCCP LTC implemented the following new interventions in 2022 and 2023:<br>• Annual virtual visit email campaign sent to members to let them know about the availability of telehealth services.<br>• To incentivize providers, UHCCP LTC increased claims payment-allowed amounts for well visits (*WCV, AAP, W30*) by 50% for dates of service (DOS) 10/1/2022–12/31/2022.<br>• To address the secondary payor claims issue, UHCCP LTC is providing regular COB reports to select provider groups and ACOs, along with ongoing education on the importance of submitting claims to secondary payers. Discussion to include how secondary claims submissions for COB members could impact incentivized performance measure rates.<br><br>Internal dissemination of CAP findings, progress, and results is communicated at quarterly UHCCP LTC QMC meetings. External dissemination of CAP findings, progress, and results is communicated to AHCCCS within UHCCP LTC's PMMR/WP/WPE submissions to AHCCCS. |
| **HSAG's Assessment:** UHCCP LTC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that UHCCP LTC satisfactorily addressed these prior year's recommendations. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| **Recommendation 7:** |
| HSAG recommended that UHCCP LTC conduct a root cause analysis or focus study to determine why there is a higher proportion of members receiving prescriptions for opioids. Upon identification of a root cause, HSAG recommended that UHCCP LTC implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse. |

**UHCCP LTC's Response:**

UHCCP LTC spent much of 2021 doing a deep dive analysis of the *HDO* measure. Ultimately, the findings revealed very little actionable information. Here is an overview of the activities and findings:

Early in MY 2021, UHCCP LTC met with several other UHC state Medicaid plans that perform well in this measure to learn more about what they were doing to impact their rates. All the plans felt their performance was a result of their states' robust public health campaigns on opioids and OUD rather than anything they were doing.

UHCCP LTC also conducted a two-phased MRR audit in late 2021 and early 2022 of prescribers who accounted for most members who are in the measure numerator to identify the root cause of the problem. A UHCCP LTC medical director reviewed the findings with the top 17 pain management provider groups identified in the audit and educated them on opioid prescribing best practices and *HDO* measure technical specifications. Key takeaways:

- All prescribers were pain management providers, and the top providers are generally the same month over month.
- A couple of pain management providers were not aware the measure requires members to be below 90 MME/day. Many thought members could be at or below 90 MME/day.
- Members have usually been taking high dose opioids for many years for chronic pain.

UHCCP LTC did not meet the 2022 NCQA Medicaid mean (MY 2021) rates for the *Use of Opioids at High Dosage (HDO)* performance measure. As a result, UHCCP LTC implemented a CAP for the *HDO* measure in July 2023. The measure is also included in UHCCP LTC' 2023 and 2024 QI Work Plans.

UHCCP LTC identified the following root causes impacting the *HDO* rate performance for LTC:

1. Members may not be aware behavioral health telehealth services are available.
2. Financial incentives not motivating providers to outreach members to close gaps in care.
3. Demographic and SDOH factors might impact members' ability to reduce or discontinue high-dose opioids.

To address the identified root cause deficiencies, UHCCP LTC implemented the following new interventions in 2022 and 2023:

- Annual virtual visit email campaign sent to members, which included messaging about behavioral health telehealth services.

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| • Financial incentive programs offered to provider groups that do not have a value-based contract, to improve performance on the measure. Adapted September MY 2022: MY 2022 Community Plan Primary Care Provider Incentive (CP-PCPi) payment amounts increased for participating providers.<br>• Subpopulation, demographic, and SDOH analyses of compliant members to identify trends for targeted interventions.<br><br>UHCCP LTC has seen a slight rate improvement in the measure. The rate improved almost a point, from 11.7% in 2019 to 10.8% in 2022.<br><br>Internal dissemination of CAP findings, progress, and results is communicated at quarterly UHCCP LTC QMC meetings. External dissemination of CAP findings, progress, and results is communicated to AHCCCS within UHCCP LTC's PMMR/WP/WPE submissions to AHCCCS. |
| **HSAG's Assessment:** UHCCP LTC identified interventions that were implemented for CY 2022 as a result of conducting a root cause analysis; therefore, HSAG determined that UHCCP LTC satisfactorily addressed these prior year's recommendations. |

## *Validation of Performance Improvement Projects*

In CY 2023, UHCCP LTC continued the *Breast Cancer Screening* PIP, which was initiated in CYE 2019. As this PIP had progressed through Remeasurement 1, PIP validation activities focused on improvement from the baseline results. UHCCP LTC submitted Remeasurement 1 performance indicator results and interventions implemented during this validation year along with the status of interventions, focus, and rationale for changes or discontinuation of the interventions.

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

## Validation Results

Table 10-37 displays the overall confidence levels for the UHCCP LTC *Breast Cancer Screening* PIP.

**Table 10-37—UHCCP LTC *Breast Cancer Screening* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| UHCCP LTC | *High Confidence* | 100% | 100% | *High Confidence* | 100% | 100% |

## Measure Results

Table 10-38 provides the *Breast Cancer Screening* PIP baseline, intervention, and Remeasurement Year 1 rates for UHCCP LTC.

**Table 10-38—UHCCP LTC *Breast Cancer Screening* PIP Rates**

| Contractor | PIP Indicator: *Breast Cancer Screening* | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| UHCCP LTC | 34.1% | 41.6% |

## Interventions

Table 10-39 presents PIP interventions for UHCCP LTC. Language in the PIP interventions section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 10-39—UHCCP LTC *Breast Cancer Screening* PIP Interventions**

| Contractor | Intervention |
|---|---|
| UHCCP LTC | • Letter to SNFs and ALFs. The letter identifies members with a BCS gap and provides BCS education information.<br>• High risk nurse manager call outreach and survey to members with gaps in care in the HCBS to provide BCS education. |

| Contractor | Intervention |
|---|---|
| | • Case managers provide BCS education to members with gaps in care during their assessments.<br>• Member gift card incentive/reward letter mailed to members with gaps in care.<br>• LTC member newsletter with BCS education.<br>• QM mailings: BCS reminder letters (July) and follow-up letters (October) to Black or African American members with BCS gaps in care. |

## Strengths, Opportunities for Improvement, and Recommendations

Table 10-40 presents strengths, opportunities for improvement, and recommendations (as applicable) for UHCCP LTC related to the *Breast Cancer Screening* PIP, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

**Table 10-40—UHCCP LTC Strengths, Opportunities for Improvement, and Recommendations Related to the *Breast Cancer Screening* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG noted that UHCCP LTC performed accurate statistical testing between the baseline and Remeasurement 1 results, and the indicator rate showed a statistically significant increase of 7.5 percentage points over the baseline year indicator rate at Remeasurement 1. **[Quality, Access]**<br><br>UHCCP LTC developed and implemented measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 2. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| HSAG did not identify any opportunities for improvement for UHCCP LTC.<br><br>Recommendations: Although HSAG did not identify any opportunities for improvement, as the PIP progresses, to sustain the improvement achieved, HSAG recommends that UHCCP LTC:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions as necessary to sustain improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

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

Table 10-41 presents PIP recommendations made to UHCCP LTC in the CYE 2022 Annual Technical Report[10-22] and UHCCP LTC's follow-up to the recommendations, as well as an assessment of the degree to which UHCCP LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 10-41—UHCCP LTC Follow-Up to CYE 2022 PIP Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| HSAG recommended that UHCCP LTC:<br>• Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary.<br>• Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available.<br>• Develop and document a plan for sustaining the improvement for any demonstrated improvement in indicator rates. |
| **UHCCP LTC's Response:**<br>The UHCCP LTC quality manager monitors the BCS PIP performance measure rates monthly and reviews them with the BCS PIP workgroup quarterly (at a minimum). The BCS PIP workgroup is composed of various stakeholders and subject matter experts from within the plan. The workgroup meets regularly to review PIP performance measure rates, evaluate the effectiveness of current PIP interventions, and identify root causes of performance deficiencies and new opportunities for improvement.<br><br>UHCCP LTC has achieved year-over-year improvement on its LTC *BCS* measure rate since the PIP baseline year, and the Remeasurement Year 1 rate exceeded the LTC *BCS* PIP goal rate of 39.0% by 2.6 points:<br>• Baseline (CYE 2019): 34.1%<br>• Intervention Year 1 (MY 2020): 37.2%<br>• Interventions Year 2 (MY 2021): 38.3%<br>• Remeasurement Year 1 (MY 2022): 41.6%<br><br>The *BCS* PIP workgroup collaborates on adjusting interventions for continued improvement, as needed, based on root cause analysis intervention success. The workgroup utilizes the PDSA method |

[10-22] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for Arizona Long Term Care System. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportEPDandDDD.pdf. Accessed on: Feb 8, 2024.

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| to evaluate interventions and determine next steps: adopt, adapt, or abandon. Many interventions have been revamped/improved to meet the changing needs for member health outcomes and rate improvement. Some interventions undergo an effectiveness analysis to evaluate the before and after effects by comparing members with open gaps in care to those with closed gaps in care after the completion of the interventions. The PIP workgroup continues the PDSA process and collaborating to improve the *BCS* measure rates. A few examples of UHCCP LTC MY 2022 (Remeasurement Year 1) and MY 2023 (Remeasurement Year 2) interventions are provided below:<br>• During MY 2022, the PIP workgroup evaluated the LTC *BCS* member data and found that 32% of the members were dual eligible and had Medicare primary insurance with another payor. Providers do not do secondary insurance claims, so UHCCP LTC does not have the administrative claims data to close the member gaps in care. This information led the team to focus on and develop priorities for the interventions, the first priority being LTC members with UHCCP LTC Medicaid as primary. Additionally, during MY 2023, UHCCP LTC is providing regular COB reports to select provider groups and ACOs, along with ongoing education on the importance of submitting claims to secondary payers. Discussion with groups includes how secondary claims submissions for COB members could impact incentivized performance measure rates.<br>• During MY 2022, the ALF/SNF Letter intervention revealed that some members were in the denominator that should not (i.e., member bedridden and on a ventilator). The PIP workgroup revised the letter to include information on the NCQA HEDIS Advanced Illness and Frailty exclusion and encouraged SNFs/ALFs to ensure the provider rounding on the patients document the appropriate Advanced Illness and Frailty codes on the claim to obtain the exclusion. During MY 2023, the PIP workgroup developed a provider-facing Advanced Illness and Frailty document which was emailed to any SNF or ALF requesting more information. The document was also posted on the uhcprovider.com current news/bulletins webpage and the link given to anyone who needed it. Several physician assistants and nurses called for more information and were appreciative that we had this information.<br>• The PIP workgroup continues to work on ensuring the BCS Member Rewards Program is available to members. The quality manager works closely with LTC ensuring the list of members eligible for the rewards and the member materials are available so that the care and case managers can inform and assist the members to obtain their BCS and their gift card.<br>• The HCBS manager performs member outreach to educate and remind members they need their BCS. The case managers receive annual BCS training and then during their member assessments, they remind and assist members in getting their BCS scheduled.<br><br>UHCCP LTC's plans for sustaining improvement for any demonstrated improvement in indicator rates are outlined in the other two bullets. Detailed plans are documented in the *BCS* PIP workgroup's meeting minutes, the intervention analysis template, and the annual PIP report. |
| **HSAG's Assessment:** HSAG has determined that the Contractor has satisfactorily addressed these prior year's recommendations. |

## Compliance Reviews

### Results

AHCCCS conducted a compliance review of UHCCP LTC from February 6, 2023, through February 9, 2023. On April 21, 2023, AHCCCS finalized the report findings; provided UHCCP LTC with a CAP submission matrix; and required a CAP, due May 5, 2023, for any standard with a total score of less than 95 percent. On June 2, 2023, AHCCCS accepted UHCCP LTC's proposed CAPs and required the Contractor to submit updated policies, manuals, desktop procedures, and other vital documents to provide evidence of CAP completion by December 4, 2023. Table 10-42 presents the compliance review results for UHCCP LTC.

**Table 10-42—UHCCP LTC Compliance Review Results**

| Focus Areas | CYE 2023 UHCCCP LTC Scores | CYE 2023 Program-Level Average |
|---|---|---|
| CC | 100% | 100% |
| CIS | 99% | 98% |
| CM | 87% | 86% |
| DS | 98% | 94% |
| GA | 100% | 100% |
| GS | 100% | 99% |
| MCH | 90% | 92% |
| MM | 96% | 92% |
| MI | 97% | 97% |
| QM | 95% | 89% |
| QI | 100% | 98% |
| RI | 100% | 100% |
| TPL | 100% | 100% |
| ISOC | 85% | 93% |

### Strengths, Opportunities for Improvement, and Recommendations

Table 10-43 presents strengths, opportunities for improvement, and recommendations (as applicable) for UHCCP LTC related to compliance, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

**Table 10-43—UHCCP LTC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| UHCCP LTC scored at or above 95 percent in the following Focus Areas:<br>• Corporate Compliance (CC) **[Quality, Access]**<br>• Claims and Information Standards (CIS) **[Access]**<br>• Delivery Systems (DS) **[Timeliness, Access]**<br>• General Administration (GA) **[Timeliness, Access]**<br>• Grievance Systems (GS) **[Timeliness, Access]**<br>• Medical Management (MM) **[Timeliness, Access]**<br>• Member Information (MI) **[Quality]**<br>• Quality Management (QM) **[Quality]**<br>• Quality Improvement (QI) **[Quality, Access]**<br>• Reinsurance (RI) **[Quality]**<br>• Third-Party Liability (TPL) **[Quality, Timeliness, Access]** |
| **Opportunities for Improvement and Recommendations** |
| UHCCP LTC scored below 95 percent in the following Focus Areas:<br>• Case Management (CM) **[Quality, Access]**<br>• Adult, EPSDT and Maternal Child Health (MCH) **[Quality, Timeliness, Access]**<br>• Integrated Systems of Care (ISOC) **[Quality, Access]**<br><br>Recommendation: HSAG recommends that UHCCP LTC propose and implement CAPs for the CM, MCH, and ISOC Focus Areas as approved by AHCCCS. |

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

Table 10-44 presents compliance recommendations made to UHCCP LTC in the CYE 2022 Annual Technical Report[10-23] and UHCCP LTC's follow-up to the recommendations, as well as an assessment of the degree to which UHCCP LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

[10-23] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for Arizona Long Term Care System. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportEPDandDDD.pdf. Accessed on: Feb 8, 2024.

**Table 10-44—UHCCP LTC's Follow-Up to CYE 2022 Compliance Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for Compliance |
|---|
| HSAG recommended that in advance of the forthcoming compliance review, UHCCP LTC conduct a self-assessment of the CM, DS, MCH, MM, MI, and QM requirements. |
| **UHCCP LTC's Response:**<br>Prior to the UHCCP LTC Operational Review in 2023, UHCCP LTC had two additional Operational Reviews (ORs) in 2022 for its DDD and ACC Programs. These ORs provided UHCCP LTC the opportunity to conduct self-assessments of the CM, DS, MCH, MM, MI, and QM requirements to ensure compliance with requirements and to address and correct any areas of deficiency identified during the ORs.<br><br>AHCCCS conducted an OR for the UHCCP LTC Program in February 2023 and determined that UHCCP LTC did not meet compliance in the following areas: CM, CIS, DS, MCH, MM, MI, QM, and ISCOC, resulting in 31 CAPs. UHCCP LTC implemented CAPs for areas of noncompliance and has been providing progress updates to ACC over the last six months. |
| **HSAG's Assessment:**<br>Based on the results of the CYE 2023 compliance review activity and the response provided, HSAG determined that UHCCP LTC has partially addressed this prior year's recommendation, as UHCCP LTC continued to score less than 95% in the CM and MCH Focus Areas. |

## *Network Adequacy Validation*

### Results

HSAG evaluated UHCCP LTC's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents semiannual validation findings specific to the ALTCS-EPD Program, with one results table for each of the following GSAs:

- Central GSA: Gila, Maricopa,[10-24] and Pinal counties
- North GSA: Apache, Coconino, Mohave, Navajo, and Yavapai counties

Each Contractor-specific table summarizes semiannual validation results containing the percentage of members meeting each time/distance standard by quarter and county, with color-coding to identify whether the time/distance standard was "*Met*" or "*Not Met*."

The value "NA" is shown for time/distance standards that do not apply to the county or program.

The value "NR" is shown for time/distance standards in which no members met the network requirement denominator for the program and county; therefore, HSAG calculated no corresponding time/distance result.

[10-24] Maricopa County includes the 85342, 85358, and 85390 ZIP Codes; these ZIP Codes are physically located in both Maricopa and Yavapai counties.

Yellow color-coding identifies instances in which HSAG's time/distance results met the minimum network requirement but differed from the ACOM 436 results.

Red color-coding identifies instances in which HSAG's time/distance results did not meet the compliance standard, regardless of the ACOM 436 results.

An asterisk (*) indicates that fewer than 10 members were included in the denominator of HSAG's results.

A carat (^) indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

**Table 10-45—UHCCP LTC Time/Distance Validation Results for Central GSA—Percentage of Members Meeting Minimum Network Requirements**

| | Gila | | Maricopa | | Pinal | |
|---|---|---|---|---|---|---|
| Minimum Network Requirement | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0^ | 100.0^ | 97.7^ | 98.0^ | 100.0^ | 100.0^ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | NR*^ | NR*^ | 97.6^ | 98.7^ | 100.0*^ | 100.0*^ |
| BHRF | NA | NA | 98.7 | 98.5 | NA | NA |
| Cardiologist, Adult | 100.0^ | 100.0^ | 99.9^ | 99.9^ | 100.0^ | 100.0^ |
| Cardiologist, Pediatric | NR*^ | NR*^ | 100.0^ | 100.0^ | 100.0*^ | 100.0*^ |
| Dentist, Pediatric | NR* | NR* | 100.0 | 99.0 | 100.0* | 100.0* |
| Hospital | 100.0 | 100.0 | 99.9 | 99.8 | 100.0 | 100.0 |
| Nursing Facility | 100.0 | 100.0 | 99.8 | 99.7 | 100.0 | 100.0 |
| OB/GYN | 100.0* | 100.0* | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 100.0 | 100.0 | 99.3 | 99.5 | 100.0 | 100.0 |
| PCP, Adult | 100.0^ | 100.0^ | 99.8^ | 99.8^ | 100.0^ | 100.0^ |
| PCP, Pediatric | NR*^ | NR*^ | 100.0^ | 100.0^ | 100.0*^ | 100.0*^ |

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

NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.

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

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

NA indicates results are not applicable to the county.

**Table 10-46—UHCCP LTC Time/Distance Validation Results for North GSA—Percentage of Members Meeting Minimum Network Requirements**

| | Apache | | Coconino | | Mohave | | Navajo | | Yavapai | |
|---|---|---|---|---|---|---|---|---|---|---|
| Minimum Network Requirement | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 97.5^ | 96.1^ | 93.5^ | 93.3^ | 98.7^ | 98.8^ | 99.6^ | 99.6^ | 100.0^ | 100.0^ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 100.0*^ | 100.0*^ | 100.0*^ | 100.0*^ | 100.0*^ | 100.0*^ | 100.0*^ | 100.0*^ | 100.0^ | 100.0^ |
| BHRF | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Cardiologist, Adult | 96.3^ | 94.7^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 99.6^ | 99.6^ | 100.0^ | 100.0^ |
| Cardiologist, Pediatric | 100.0*^ | 100.0*^ | 100.0*^ | 100.0*^ | 100.0*^ | 100.0*^ | 100.0*^ | 100.0*^ | 100.0^ | 100.0^ |
| Dentist, Pediatric | 100.0* | 100.0* | 100.0* | 100.0* | 100.0* | 100.0* | 100.0* | 100.0* | 100.0 | 100.0 |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 | 99.9 | 99.9 | 100.0 | 100.0 | 100.0 | 100.0 |
| Nursing Facility | 96.2 | 95.6 | 89.3 | 90.3 | 97.2 | 97.6 | 99.3 | 99.3 | 100.0 | 100.0 |
| OB/GYN | 100.0* | 100.0* | 100.0* | 100.0* | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 98.8 | 96.1 | 99.6 | 99.2 | 99.9 | 99.9 | 100.0 | 100.0 | 99.9 | 100.0 |
| PCP, Adult | 100.0^ | 98.7^ | 99.6^ | 100.0^ | 99.9^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| PCP, Pediatric | 100.0*^ | 100.0*^ | 100.0*^ | 100.0*^ | 100.0*^ | 100.0*^ | 100.0*^ | 100.0*^ | 100.0^ | 100.0^ |

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

## Strengths, Opportunities for Improvement, and Recommendations

Table 10-47 presents strengths, opportunities for improvement, and recommendations (as applicable) for UHCCP LTC related to NAV, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

**Table 10-47—UHCCP LTC Strengths, Opportunities for Improvement, and Recommendations Related to NAV**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths:<br>• UHCCP LTC met all time/distance network standards in all assigned counties for CYE 2023 except Coconino County. **[Access]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| • UHCCP LTC met time/distance network standards for BHRF; Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; Cardiologist, Adult and Pediatric; Dentist, Pediatric; Hospital; OB/GYN; PCP, Adult and Pediatric; and Pharmacy. **[Access]**<br>Note: UHCCP LTC provides coverage in the following counties: Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal, and Yavapai. |
| **Opportunities for Improvement and Recommendations** |
| HSAG identified the following opportunities for improvement:<br>• UHCCP LTC failed to meet the time/distance standard for at least one quarter and/or county for the Nursing Facility standard. **[Access]**<br><br>Recommendation: HSAG recommends that UHCCP LTC maintain current compliance with network standards but continue to address network gaps, as applicable. |

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

Table 10-48 presents NAV recommendations made to UHCCP LTC in the CYE 2022 Annual Technical Report[10-25] and UHCCP LTC's follow-up to the recommendations, as well as an assessment of the degree to which UHCCP LTC has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 10-48—UHCCP LTC Follow-Up to CYE 2022 NAV Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for NAV |
|---|
| HSAG recommended the following to UHCCP LTC:<br>• Continue to monitor processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.<br>• Continue to monitor and maintain existing provider network coverage with specific attention to ensuring the availability of nursing facilities in Coconino County. |
| **UHCCP LTC's Response:**<br>UHCCP LTC will continue to monitor and review the PAT file quarterly. Although UHCCP LTC only submits biannually to the State of Arizona, UHCCP LTC runs the PAT process quarterly to ensure any data discrepancies, as well as internal/external errors, and root cause analyses are |

[10-25] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for Arizona Long Term Care System. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportEPDandDDD.pdf. Accessed on: Feb 8, 2024.

| Prior Year's Recommendation from the EQR Technical Report for NAV |
| --- |
| addressed. In addition, UHCCP LTC performs monthly reviews and audits of provider data to ensure the highest level of accuracy is maintained.<br><br>UHCCP LTC evaluates the contracted network quarterly. When gaps in the network are identified, UHCCP LTC conducts a review of the area and category that has underperformed. A thorough audit of the provider community is conducted to include noncontracted providers and any new providers that enter the county. |
| **HSAG's Assessment:**<br>HSAG has determined that UHCCP LTC has satisfactorily addressed these prior year's recommendations. |

# 11. ALTCS-DD Program Results

The **ALTCS-DD Program** Contractor, DES/DDD provides integrated physical health and behavioral health services through two subcontracted health plans, Mercy Care DD and UHCCP DD.

This section provides, by EQR activity, ALTCS-DD activity-specific strengths, opportunities for improvement, and HSAG's recommendations for performance improvement. This section also includes information about the extent to which DES/DDD was able to address the prior's year recommendations for each activity.

## ALTCS-DD Program

### *Validation of Performance Measures*

#### Results for Information Systems Standards Review

During CYE 2023, HSAG evaluated DES/DDD's data system for processing of each data type used for reporting the Contractor's CY 2022 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. HSAG determined that DES/DDD followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 11-1 displays HSAG's PMV findings for each data type reviewed during CYE 2023 in alignment with the CMS EQR Protocol 2 audit requirements.

**Table 11-1—CYE 2023 PMV Findings**

| Data Type | HSAG Findings |
|---|---|
| **Medical Services Data** | *No identified concerns* |
| **Enrollment Data** | *No identified concerns* |
| **Provider Data** | *No identified concerns* |
| **Medical Record Review Process** | *No identified concerns with the MRR process; however, DES/DDD was unable to report any data for three AHCCCS-required LTSS measures that were dependent on case management record review (CMRR); therefore, the CMRR process could not be assessed.* |
| **Supplemental Data** | *No identified concerns* |

| Data Type | HSAG Findings |
|---|---|
| **Data Integration** | *DES/DDD was unable to report three AHCCCS-required LTSS measures due to issues with capturing and identifying necessary information in the case management records and limitations in developing a clear process to calculate the measures.* |

## Results for Performance Measures

Table 11-2 presents the CY 2022 performance measure results for ALTCS-DD. Performance measure rate cells shaded green indicate that DES/DDD met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

**Table 11-2—CY 2022 Performance Measure Results for DES/DDD**

| Measure | CY 2022 Performance |
|---|---|
| ***Behavioral Health*** | |
| ***Antidepressant Medication Management*** | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | 67.5% |
| *Effective Continuation Phase Treatment—Total (18+ Years)* | 55.8% |
| ***Follow-Up After Hospitalization for Mental Illness*** | |
| *7-Day Follow-Up—Total (6+ Years)* | 69.7% |
| *30-Day Follow-Up—Total (6+ Years)* | 85.0% |
| ***Use of Opioids at High Dosage*** | |
| *18+ Years** | 3.6% |
| ***Initiation and Engagement of Substance Use Disorder (SUD)*** | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | 41.3% |
| *Engagement of SUD Treatment—Total—Total (13+ Years)* | 8.7% |
| ***Care of Acute and Chronic Conditions*** | |
| ***Controlling High Blood Pressure*** | |
| *18–85 Years* | 78.0%+ |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | |
| *HbA1c Control (<8.0 %)—Total (18–75 Years)* | 72.3%+ |
| *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)** | 20.6%+ |
| ***Pediatric Health*** | |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotics*** | |
| *Blood Glucose Testing—Total (1–17 Years)* | 60.5% |

| Measure | CY 2022 Performance |
|---|---|
| *Cholesterol Testing—Total (1–17 Years)* | 52.0% |
| *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* | 50.4% |
| ***Childhood Immunization Status**** | |
| *Combination 3* | 62.0%+ |
| *Combination 7* | 30.0%+ |
| *Combination 10* | 22.0%+ |
| ***Developmental Screening in the First Three Years of Life*** | |
| *Total (0–3 Years)* N | 49.7% |
| ***Immunizations for Adolescents*** | |
| *Combination 1 (Meningococcal, Tdap)* | 80.5%+ |
| *Combination 2 (Meningococcal, Tdap, HPV)* | 32.8%+ |
| ***Oral Evaluation, Dental Services*** | |
| *Total (0–20 Years)* N | 49.9% |
| ***Well-Child Visits in the First 30 Months of Life*** | |
| *Six or More Well-Child Visits* | NA++ |
| *15 Months–30 Months—Two or More Well-Child Visits* | 63.8% |
| ***Child and Adolescent Well-Care Visits*** | |
| *Total (3–21 Years)* | 54.4% |
| ***Preventive Screening*** | |
| ***Breast Cancer Screening*** | |
| *Total (50–74 Years)* | 51.4% |
| ***Cervical Cancer Screening*** | |
| *Total (21–64 Years)* | 20.7%+ |
| ***Appropriate Utilization of Services*** | |
| ***Ambulatory Care*** | |
| *Emergency Department (ED) Visits—Total (0–85+ Years)* F | 412.1 |
| ***Plan All-Cause Readmissions*** | |
| *Observed Readmissions—Total (18–64 Years)* | 8.6% |
| *Expected Readmissions—Total (18–64 Years)* | 9.8% |
| *Outlier Rate—Total (18–64 Years)* | 61.9 |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)** | 0.8769 |

* A lower rate indicates better performance for this measure.
** Table A-1 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
+ Indicates the measure was reported using hybrid methodology.
++ NA indicates the denominator was too small to report a valid rate, based on the applicable measure specification.
N Measure has no NCQA Medicaid mean for comparison.
F NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months.
Cells shaded green indicate that the rate met or exceeded the MY 2022 national Medicaid mean.

Table 11-3 presents the CY 2021 and CY 2022 DES/DDD results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2022. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

**Table 11-3—CY 2021 and CY 2022 Performance Measure Results for DES/DDD**

| Measure | CY 2021 Performance | CY 2022 Performance | 2021–2022 Comparison | 2022 Performance Level[1] |
|---|---|---|---|---|
| ***Behavioral Health*** | | | | |
| ***Antidepressant Medication Management*** | | | | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | 73.8% | 67.5% | → | ★★★★ |
| *Effective Continuation Phase Treatment—Total (18+ Years)* | 62.2% | 55.8% | → | ★★★★ |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total (6+ Years)* | 68.0% | 69.7% | → | ★★★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | 85.6% | 85.0% | → | ★★★★★ |
| ***Use of Opioids at High Dosage*** | | | | |
| *18+ Years** | 4.6% | 3.6% | → | ★★★ |
| ***Initiation and Engagement of Substance Use Disorder (SUD) Treatment*** | | | | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | — | 41.3% | — | ★★ |
| *Engagement of SUD Treatment—Total—Total (13+ Years)* | — | 8.7% | — | ★ |
| ***Care of Acute and Chronic Conditions*** | | | | |
| ***Controlling High Blood Pressure*** | | | | |
| *18–85 Years* | 75.6% + | 78.0% + | → | ★★★★★ |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | | | | |
| *HbA1c Control (<8.0 Percent)—Total (18–75 Years)* | — | 72.3% + | — | ★★★★★ |
| *HbA1c Poor Control (>9.0 Percent)—Total (18–75 Years)** | 21.8% + | 20.6% + | → | ★★★★★ |
| ***Pediatric Health*** | | | | |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotics*** | | | | |
| *Blood Glucose Testing—Total (1–17 Years)* | 57.0% | 60.5% | ↑ | ★★★★ |
| *Cholesterol Testing—Total (1–17 Years)* | 47.3% | 52.0% | ↑ | ★★★★ |

| Measure | CY 2021 Performance | CY 2022 Performance | 2021–2022 Comparison | 2022 Performance Level[1] |
|---|---|---|---|---|
| *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* | 45.2% | 50.4% | ↑ | ★★★★ |
| ***Childhood Immunization Status**** | | | | |
| *Combination 3* | 77.5% + | 62.0% + | ↓ | ★★ |
| *Combination 7* | 38.7% + | 30.0% + | → | ★ |
| *Combination 10* | 31.0% + | 22.0% + | → | ★ |
| ***Developmental Screening in the First Three Years of Life*** | | | | |
| *Total (0–3 Years)* [N] | 47.8% | 49.7% | → | — |
| ***Immunizations for Adolescents*** | | | | |
| *Combination 1 (Meningococcal, Tdap)* | 83.5% | 80.5% | → | ★★ |
| *Combination 2 (Meningococcal, Tdap, HPV)* | 31.8% | 32.8% | → | ★★ |
| ***Oral Evaluation, Dental Services*** | | | | |
| *Total (0–20 Years)* [N] | — | 49.9% | — | — |
| ***Well-Child Visits in the First 30 Months of Life*** | | | | |
| *Six or More Well-Child Visits* | 40.0% | NA[++] | — | — |
| *15 Months–30 Months—Two or More Well-Child Visits* | — | 63.8% | — | ★★ |
| ***Child and Adolescent Well-Care Visits*** | | | | |
| *Total (3–21 Years)* | 50.4% | 54.4% | ↑ | ★★★ |
| ***Preventive Screening*** | | | | |
| ***Breast Cancer Screening*** | | | | |
| *Total (50–74 Years)* | 48.9% | 51.4% | → | ★★ |
| ***Cervical Cancer Screening*** | | | | |
| *Total (21–64 Years)* | 19.5% + | 20.7% + | → | ★ |
| ***Appropriate Utilization of Services*** | | | | |
| ***Ambulatory Care*** | | | | |
| *Emergency Department (ED) Visits—Total (0–85+ Years)* [F] | 358.6 | 412.1 | — | — |
| ***Plan All-Cause Readmissions*** | | | | |
| *Observed Readmissions—Total (18–64 Years)* | 10.5% | 8.6% | → | — |
| *Expected Readmissions—Total (18–64 Years)* | — | 9.8% | — | — |
| *Outlier Rate—Total (18–64 Years)* | — | 61.9 | — | — |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)** | 1.0615 | 0.8769 | — | ★★★★ |

* A lower rate indicates better performance for this measure.
** Table A-1 in *Appendix A. Methodology* outlines which immunizations are included within each combination.
+ Indicates the measure was reported using hybrid methodology.

++ NA indicates the denominator was too small to report a valid rate, based on the applicable measure

Cells shaded green indicate that the rate met or exceeded the MY 2021 and/or MY 2022 national Medicaid mean.

— Indicates a 2021-2022 comparison is not presented in the CYE 2023 Annual Technical Report because either there was a break in trending, the CY 2021 rate was not presented in the CYE 2022 Annual Technical Report, or no significance testing could be applied due to the performance being expressed numerically instead of as a percentage.

↑ Indicates improvement of measure rates.

↓ Indicates decline of measure rates.

⟶ Indicates stable measure rates.

[1] Performance Levels for CY 2022 were based on comparisons of the HEDIS MY 2022 measure rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks.

Performance Levels for 2022 represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

[N] Measure has no NCQA Medicaid mean for comparison.

[F] NCQA updated the format of this rate to per 1,000 member years from per 1,000 member months. Historical rates have been adjusted for comparison.

Table 11-4 highlights DES/DDD's performance for the current year by measure group. The table illustrates the Contractor's CY 2022 measure rates and their performance relative to the NCQA national Medicaid Quality Compass HEDIS MY 2022 percentiles, where applicable. The performance level star ratings are defined as follows:

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

**Table 11-4—CY 2022 National Percentiles Comparison for DES/DDD**

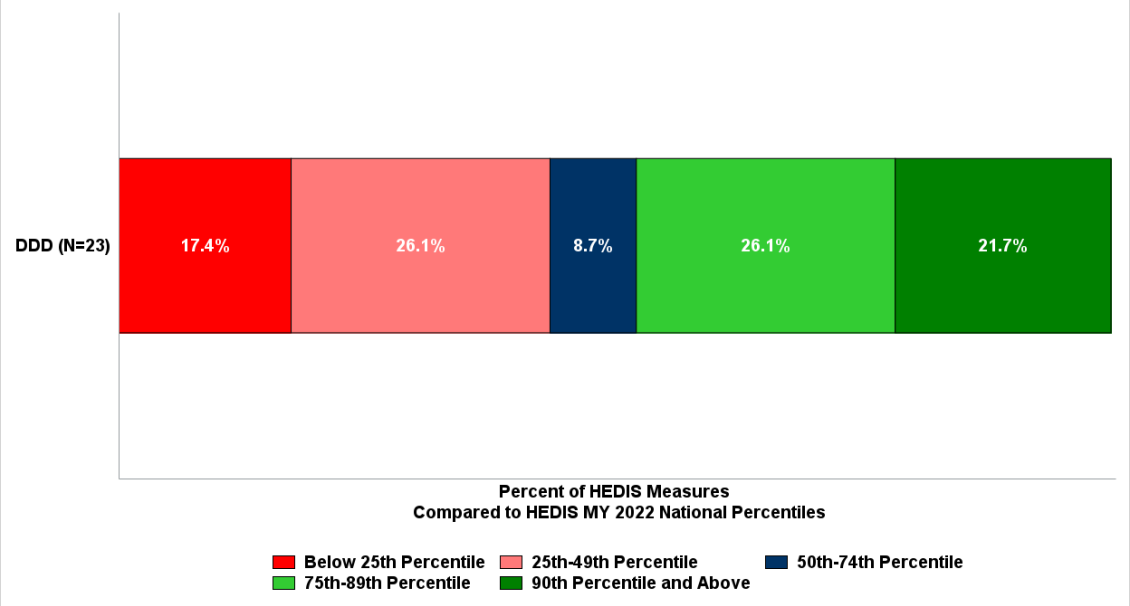
| Performance Measure | CY 2022 Performance |
|---|---|
| ***Behavioral Health*** | |
| ***Antidepressant Medication Management*** | |
| *Effective Acute Phase Treatment—Total (18+ Years)* | ★★★★ |
| *Effective Continuation Phase Treatment—Total (18+ Years)* | ★★★★ |
| ***Follow-Up After Hospitalization for Mental Illness*** | |
| *7-Day Follow-Up—Total (6+ Years)* | ★★★★★ |
| *30-Day Follow-Up—Total (6+ Years)* | ★★★★★ |
| ***Use of Opioids at High Dosage*** | |
| *18+ Years* | ★★★ |
| ***Initiation and Engagement of Substance Use Disorder (SUD)*** | |
| *Initiation of SUD Treatment—Total—Total (13+ Years)* | ★★ |
| *Engagement of SUD Treatment—Total—Total (13+ Years)* | ★ |

| Performance Measure | CY 2022 Performance |
|---|---|
| ***Care of Acute and Chronic Conditions*** | |
| ***Controlling High Blood Pressure*** | |
| *18–85 Years* | ★★★★★ |
| ***Hemoglobin A1c Control for Patients With Diabetes*** | |
| *HbA1c Control (<8.0 %)—Total (18–75 Years)* | ★★★★★ |
| *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)* | ★★★★★ |
| ***Pediatric Health*** | |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotics*** | |
| *Blood Glucose Testing—Total (1–17 Years)* | ★★★★ |
| *Cholesterol Testing—Total (1–17 Years)* | ★★★★ |
| *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* | ★★★★ |
| ***Childhood Immunization Status*** | |
| *Combination 3* | ★★ |
| *Combination 7* | ★ |
| *Combination 10* | ★ |
| ***Immunizations for Adolescents*** | |
| *Combination 1 (Meningococcal, Tdap)* | ★★ |
| *Combination 2 (Meningococcal, Tdap, HPV)* | ★★ |
| ***Well-Child Visits in the First 30 Months of Life*** | |
| *Six or More Well-Child Visits* | NA[++] |
| *15 Months–30 Months—Two or More Well-Child Visits* | ★★ |
| ***Child and Adolescent Well-Care Visits*** | |
| *Total (3–21 Years)* | ★★★ |
| ***Preventive Screening*** | |
| ***Breast Cancer Screening*** | |
| *Total (50–74 Years)* | ★★ |
| ***Cervical Cancer Screening*** | |
| *Total (21–64 Years)* | ★ |
| ***Appropriate Utilization of Services*** | |
| ***Ambulatory Care*** | |
| *Emergency Department (ED) Visits—Total (0–85+ Years)* | — |
| ***Plan All-Cause Readmissions*** | |
| *Observed/Expected (O/E) Ratio—Total (18–64 Years)* | ★★★★ |

[++] NA indicates the denominator was too small to report a valid rate, based on the applicable measure specification.

Figure 11-1 displays DES/DDD's HEDIS MY 2022 performance compared to benchmarks. HSAG analyzed results from 15 performance measures for HEDIS MY 2022 for a total of 23 measure rates.

**Figure 11-1—Comparison of Measure Indicators to HEDIS Medicaid National Percentiles for DES/DDD**




## Strengths, Opportunities for Improvement, and Recommendations

Table 11-5 presents strengths, opportunities for improvement, and recommendations for DES/DDD, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

**Table 11-5—DES/DDD Strengths, Opportunities for Improvement, and Recommendations for Performance Measures**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| In the Behavioral Health measure group, DES/DDD's performance measure rates for *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total (18+ Years)* were at or above the 75th percentile, and *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* were at or above the 90th percentile, indicating strength in providing behavioral health follow-up care to members. **[Quality, Timeliness, Access]**<br><br>In the Care of Acute and Chronic Conditions measure group, DES/DDD's performance measure rates for *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0 %)—Total (18–75 Years)* and *HbA1c Poor Control (>9.0 %)—Total (18–75 Years)* were at or above the 90th percentile, indicating that most members with diabetes had controlled HbA1c levels most of the time. |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[11-1] **[Quality]**<br><br>DES/DDD's performance measure rate for *Controlling High Blood Pressure—18–85 Years* was at or above the 90th percentile, indicating that most members with a diagnosis of hypertension had controlled blood pressure. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[11-2] **[Quality]**<br><br>In the Pediatric Health measure group, DES/DDD's performance measure rates for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total (1–17 Years), Cholesterol Testing—Total (1–17 Years),* and *Blood Glucose and Cholesterol Testing—Total (1–17 Years)* were at or above the 75th percentile, indicating that most members with antipsychotics had metabolic monitoring most of the time. Proper diabetes monitoring is essential to identify blood glucose concerns, reduce risks for complications, and prolong life.[11-3] **[Quality]** |
| **Opportunities for Improvement and Recommendations** |
| While DES/DDD was successful in reporting valid rates for all AHCCCS-required performance measures for its ALTCS-DD population, and HSAG did not identify specific opportunities for DES/DDD to improve RES, DES/DDD could benefit from continuing to focus on refining RES reporting where required per measure specifications. **[Quality]**<br><br>Recommendation: HSAG recommends that DES/DDD explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratifications related to RES. DES/DDD should continue working with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information. |
| DES/DDD's performance measure rate for *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* fell below the 25th percentile. **[Quality, Timeliness, Access]**<br><br>Recommendation: HSAG recommends that DES/DDD conduct a drill down analysis based on race, ethnicity, and age stratifications to determine why members were not receiving timely SUD services or MAT following their initiation visit. DES/DDD should consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, a lack of service providers, |

[11-1] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Feb 1, 2024.
[11-2] National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Feb 1, 2024.
[11-3] National Committee for Quality Assurance. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM). Available at: https://www.ncqa.org/hedis/measures/metabolic-monitoring-for-children-and-adolescents-on-antipsychotics/. Accessed on: Feb 1, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| or the need for community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, DES/DDD should implement interventions that address the identified root cause of the low rate, targeting the interventions so that DES/DDD improves performance related to initiating and engaging in timely treatment following a new episode of SUD dependence. |
| In the Preventive Screening measure group, DES/DDD's performance measure rate for *Cervical Cancer Screening—Total (21–64 Years)* fell below the 25th percentile, suggesting that female members were not always receiving timely access to screening for cervical cancer. Prolonged delays in screening related to the COVID-19 PHE may lead to delayed diagnoses, poor health consequences, and an increase in cancer disparities among women already experiencing health inequities.[11-4] **[Quality]**<br><br>Recommendation: HSAG recommends that DES/DDD consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended cancer screenings and make appropriate health decisions. In addition, HSAG recommends that DES/DDD work with its subcontracted health plans to analyze their data and consider if there are disparities within DES/DDD's populations that contributed to lower screening rates. Upon identification of a root cause, HSAG recommends that DES/DDD implement appropriate interventions to improve access to and timeliness of cancer screenings. |
| In the Pediatric Health measure group, DES/DDD's performance measure rate for *Childhood Immunization Status—Combination 7* and *Combination 10* fell below the 25th percentile, suggesting that some children were not receiving these immunizations, which are a critical aspect of preventive care for children. Childhood vaccines protect children from a number of serious and potentially life-threatening diseases, such as diphtheria, measles, meningitis, polio, tetanus, and whooping cough, at a time in their lives when they are most vulnerable to disease.[11-5] The COVID-19 PHE is a reminder of the importance of vaccination. The identified declines in routine pediatric vaccine ordering and doses administered might indicate that children in the United States and their communities face increased risks for outbreaks of vaccine-preventable diseases. Continued coordinated efforts between healthcare providers and public health officials at the local, state, and federal levels will be necessary to achieve rapid catch-up vaccination.[11-6] **[Quality]** |

[11-4] Centers for Disease Control and Prevention. Sharp Declines in Breast and Cervical Cancer Screening. https://www.cdc.gov/media/releases/2021/p0630-cancer-screenings.html. Accessed on: Feb 1, 2024.
[11-5] National Committee for Quality Assurance. Childhood Immunization Status. Available at: https://www.ncqa.org/hedis/measures/childhood-immunization-status/. Accessed on: Feb 1, 2024.
[11-6] The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Feb 1, 2024.

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| Recommendation: HSAG continues to recommend that DES/DDD identify best practices to support children in receiving preventive vaccinations according to recommended schedules. HSAG also recommends that DES/DDD consider conducting a root cause analysis to identify barriers that members are experiencing in accessing care and services in order to implement appropriate interventions to improve the performance related to the Pediatric Health measure group. |

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

Table 11-6 presents performance measure recommendations made to DES/DDD in the CYE 2022 Annual Technical Report[11-7] and DES/DDD's follow-up to the recommendations, as well as an assessment of the degree to which DES/DDD has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 11-6—DES/DDD Follow-Up to CYE 2022 Performance Measure Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| **Recommendation 1:** |
| While both subcontracted health plans have multiple years of extensive experience in ongoing performance measure production and reporting, and DES/DDD indicated that it implemented a new tool to conduct routine monitoring of its subcontracted health plans, the opportunity remains to further enhance oversight efforts. In addition to use of the newly developed oversight tool, on an ongoing basis, HSAG recommended that DES/DDD implement steps to validate and confirm the reported rates of each subcontractor to identify trends in the individual subcontractor's rates. Through use of its new tool, DES/DDD should review and compare quarterly performance rates across both subcontracted health plans and over time to identify any potential differences in services/results, areas for improvement, and best practices to integrate for all DES/DDD members. Furthermore, DES/DDD should review and confirm the final combined calculations of the DES/DDD HEDIS and CMS measures prior to submission for auditor review. |
| **DES/DDD's Response:** |
| In 2023 DES/DDD's performance improvement team initiated development of a new standard process for evaluating each health plan's PMMR and workplan submission for trends and QI/PI effectiveness. |

[11-7] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for Arizona Long Term Care System. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportEPDandDDD.pdf. Accessed on: Feb 1, 2024.

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
| --- |
| This new process will be documented in a desktop procedure by December 31, 2023, for use as a regular QI practice when DES/DDD receives a health plan's quarterly PMMR and Workplan Evaluation.<br><br>This new process will include developing the analysis into a final report and presentations to be shared with the Performance Improvement and Monitoring (PIM) Committee, Health Plan Oversight Committee, Substance Use Disorder Committee, Health Equity Committee, and QM Leadership—with domain-specific reports also going to Behavioral Health, EPSDT, and Dental for input and cross-functional collaboration on assessing and responding to health plan performance trends. The procedure will also include standard document storage and tracking for the internal report, health plan and DES/DDD PMMR and workplan evaluations, and any items created from the internal/preliminary report, which will help support consistency of process and continuous improvement of the newly implemented process.<br><br>In addition to bringing on a dedicated performance improvement manager in November 2022, DES/DDD also hired a performance improvement data analyst in June 2023 to support development of a business intelligence dashboard that will provide on-demand data analysis and trending visualization for DES/DDD and subcontracted health plan performance in PMMR measures. The aim will be to increase data visibility, access, and understanding to DES/DDD's internal teams for alignment on health plan oversight efforts and ensuring clinical and other key stakeholder input on responding to health plan performance and trends. The dashboard is currently in testing in Tableau and Looker with an anticipated completion date of February 1, 2024.<br><br>Standard data validation processes include lessons learned and key items to look out for in detecting data errors, anomalies, and other data issues prior to them making it into DES/DDD's submission to AHCCCS and data reporting to stakeholders. The QM PI team will also cross reference data with DES/DDD's CMO data team which supports DES/DDD's healthcare services (HCS) and QM. Data from PMMR measures overlapping with HCS data will be compared to help ensure consistency of data and early intervention on potential data issues. Through this process several issues in the 2022 reports from both health plan and DES/DDD calculation, date entry, and coding errors were corrected, and steps are being implemented through this process to help ensure accuracy and prevent erroneous submissions.<br><br>DES/DDD's performance improvement team reviews the quarterly PMMR and QM workplan evaluations submitted by DES/DDD's subcontracted health plans to identify trends and progress on the implementation of the goals. The results will be shared with DES/DDD's CMO, QM leadership, and healthcare services domain leads/medical directors (EPSDT, behavioral health, dental) within two weeks of receipt of the deliverables and completion of analysis. The review and corresponding reports will also be presented at DES/DDD's PIM committee and QMPI committees by the performance improvement manager or delegate. Additional insight and recommendations based on the presented |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| data trends and workplan evaluations will be procured during these meetings. These findings and recommendations will also be presented to DES/DDD's monthly Health Plan Oversight Committee to discuss the findings for inclusion in the quarterly compliance meetings with the health plans.<br><br>This new data analysis and validation process will support managing DES/DDD's PDSA cycles for performance improvement and oversight of the health plan PDSA cycles, with a standardized way to utilize data and qualitative feedback to assess the robustness and effectiveness of each PDSA phase for continuous quality improvement. |
| **HSAG's Assessment:** HSAG has determined that DES/DDD has satisfactorily addressed these prior year's recommendations. |
| **Recommendation 2:** |
| HSAG recommended that DES/DDD explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratifications related to race and ethnicity. DES/DDD should continue working with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information. |
| **DES/DDD's Response:**<br>In 2022 DES/DDD started planning the development of a committee to study health disparities for DES/DDD's population and to identify ways to collect the data need to identify these disparities. In 2023 the Health Equity Committee was launched with cross-functional representation across DES/DDD's key departments with oversight and support of DES/DDD's members. The committee includes the following required participants; CMO, chief quality officer, healthcare services administrator, quality management manager, QI/PI manager (performance improvement manager), behavioral health administrator, maternal child health & EPSDT coordinator, cultural competency manager or designee, and the system and practice improvement administrator.<br><br>The committee will be responsible for identifying health inequities among DES/DDD members by using informed data analytics across the health plans and DES/DDD data management system including demographics, National Core Indicators of Health/healthcare disparities and network saturation in geographically determined rural areas, and utilization data including the Z series ICD 10 codes/SDOH. The subcommittee will communicate identified health equity strategies, evaluate key indicators/metrics, and focus efforts on QI to decrease health disparities.<br><br>Using the data collected through the PMV process, DES/DDD assessed the opportunities and challenges with the 2022 race and ethnicity data for *Controlling High Blood Pressure (CBP)*, *HbA1c Control (HBD)*, and *Child and Adolescent Well-Care Visits (WCV)*. While analyzing the data in the PMV final rate reports, it was observed that 60–65% of the members in the denominator were identified as Race "Unknown." severely limiting the usefulness of the report's data for members with an identified race. It was also observed that no members were identified as having two or more races. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
|---|
| The committee discussed the limitations and the challenges with data collection on race as both health plans reported that these data come from the 834 file received from AHCCCS and that there may be limitations on collecting racial identity data. DES/DDD is continuing to work on increasing use of Z-codes and other means to support identifying race and ethnic stratifications to support identifying and addressing health disparities. |
| **HSAG's Assessment:** HSAG has determined that DES/DDD has satisfactorily addressed these prior year's recommendations. |
| **Recommendation 3:** |
| While DES/DDD's subcontracted health plans implemented interventions specific to the CY 2020 *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD—Total—Total* rate, the DES/DDD rate remained low in CY 2021. HSAG therefore continued to recommend that DES/DDD conduct a root cause analysis to determine why some members were not receiving timely AOD services or MAT. DES/DDD should consider the nature and scope of the issues (e.g., the issues are related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, DES/DDD should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, DES/DDD should implement interventions that address the identified root cause of the low rate, targeting the interventions so that DES/DDD improves performance related to initiating and engaging in timely treatment following a new episode of AOD dependence. |
| **DES/DDD's Response:**<br>DES/DDD's Performance Improvement team conducted a study of individual *IET* measure performance to find the primary gaps causing the deficiencies and identified that challenges within the *Other Drug Abuse or Dependance* subcategory (31.6% initiation and 7.7% engagement in 2021) had the lowest rates and the largest denominator, leading to a high impact on *IET* total rates.<br><br>Interventions were implemented to improve rates in 2022 leading to an 8.7% increase in *IET* initiation; however, there was no change in DES/DDD's *IET* engagement rate comparing 2021 to 2022 performance. Through Q3 (September 30, 2023), DES/DDD's IET engagement rate is 10.7%, which is 1.1 percentage points higher than the Q3 2022 rate.<br><br>DES/DDD's Performance Improvement team provided this information to DES/DDD's PIM Committee, which assesses performance trends and provides recommendations for continued QI. DES/DDD also launched the Substance Use Disorder Committee in 2023, which meets monthly to discuss SUD and related performance measures including *IET*, and includes DES/DDD's CMO, representatives from healthcare services, CMO data team, and QM's Performance Improvement team. During the July 2023 meeting, DES/DDD's Performance Improvement team informed the committee of the upcoming IET Corrective Action Plan (see below) and provided the participants (CMO, medical directors from healthcare services, behavioral health, and pharmacy, and the CMO data team) |

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

with technical specifications and PMMR data related to *IET* performance measures. The committee will develop DES/DDD's interventions and recommendations on the health plan interventions for SUD QI/PI. The Substance Use Disorder Committee meets monthly and will continue to monitor progress on interventions and provide recommendations and feedback to the health plans for continued QI.

In 2023 DES/DDD developed a CAP to address deficiencies in *IET* performance, including requiring both subcontracted health plans to submit corresponding CAPs to DES/DDD. Using a fishbone diagram and additional root cause analysis tools, the following root causes were identified:

- Members may not be aware telehealth services are available.
- PCPs may not be referring members they diagnose with cannabis use disorder. Often not deemed an issue due to legalization. Referrals likely to be made to outpatient behavior health.
- PCPs may not use the DSM 5 criteria and cannabis use disorder screening tools to screen members for cannabis use disorder.
- Providers may not be aware of the appropriate use of SUD remission codes.
- Providers may not be aware of evidence-based practices for MOUD for OUD.
- Member: Hesitancy and stigmas related to SUD diagnosis and treatment, need for frequent (sometimes daily) transportation for some treatments.
- Health plan: CFR Part 2 data limitations; limited number of MAT/MOUD providers may cause high wait times.
- Providers: Provider stigma related to MAT, coordination challenges due to HIPAA limitations, lack of documentation related to initiation of SUD treatment services, challenges with claims/coding MAT services, efficacy of MAT/MOUD medication dosage due to fentanyl increased tolerance.
- SDOH: Tolerance levels of members after discharge or release from facilities.

<u>Mercy Care</u>

Mercy Care continued the interventions that were reported in 2022, after completion of a root cause analysis. Those interventions include:

- Mercy Care is offering Intensive Treatment Systems, a 24/7 access point for MAT services, as a Health Home for members with SMI, and Mercy Care added MAT to each of Mercy Care's existing Health Home provider locations.
- Mercy Care conducted a survey of the contracted Health Homes and hosted workgroups with them to identify additional barriers to members accessing timely AOD services or MAT, as well as successes that may be implemented more broadly.
- Report created to assist with identifying providers for DES/DDD members who are non-verbal and experiencing substance abuse issues, so that Mercy Care can funnel members to them as appropriate. The report may also can be used to identify network deficiencies/needs.

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| However, Mercy Care's performance with both submeasures of the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement* measure continues to fall below the NCQA HEDIS Medicaid mean, resulting in Mercy Care returning to the "plan" phase of the PDSA cycle, where an additional intervention was developed for implementation:<br>• Healthmine Application—Member Web portal to provide educational information regarding gaps in care along with digital and written member outreach.<br><br><u>UHCCP</u><br>UHCCP did not meet the 2022 NCQA Medicaid mean (MY 2021) rates for the two reported *Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)* submeasures. As a result, UHCCP implemented CAPs for the submeasures in July 2023. UHCCP and Optum Behavioral Health (OBH) conducted a root cause analysis and identified the following barriers:<br>• Members may not be aware of telehealth services.<br>• PCPs may not be referring members they diagnose with cannabis use disorder. Often not deemed an issue due to legalization. Referrals likely to be made to outpatient behavioral health.<br>• PCPs may not be using the DSM 5 criteria and screening tools.<br>• Providers may not be aware of the appropriate use of SUD remission codes.<br>• Providers may not be aware of evidenced-based practices.<br><br>To address the identified root cause deficiencies, UHCCP implemented the following interventions in 2022 and 2023:<br>• Annual virtual visit email campaign sent to members.<br>• Educate PCPs on referral options for patients with cannabis use disorder to receive cognitive behavioral therapy (including use of motivational interviewing) by focusing on distribution of existing motivational interviewing education materials.<br>• Educational material created and posted on providerexpress.com and on UHCprovider.com on the importance of using cannabis screening tools and the DSM 5 criteria to diagnose cannabis use disorder.<br>• Provider education on appropriate use of SUD remission codes. Create one-page flyer of SUD remission codes, why they are useful, and when to use them, which will be an Optum handout and added to UHC interactive training (in process).<br>• Educate providers on evidence-based practices for medication assisted treatment (MOUD) for opioid use disorder by creating a provider flyer (2–3 pages), which will be an Optum handout and added to UHC interactive training (implementation TBD). Internal dissemination of CAP findings, progress, and results are communicated at quarterly UHCCP QMC meetings. External dissemination of CAP findings, progress, and results is communicated to DES/DDD within UHCCP's PMMR/WP/WPE submissions to DES/DDD. |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| **HSAG's Assessment:** Due to a break in trending for this measure indicator as a result of measure specification changes, it is difficult to assess whether or not DES/DDD has satisfactorily addressed these prior year's recommendations. |
| **Recommendation 4:** |
| While DES/DDD conducted a root cause analysis and implemented interventions specific to the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure, this rate remained low in CY 2021. HSAG therefore recommended that DES/DDD continue to implement appropriate interventions to improve performance related to children accessing well-care visits. HSAG also recommended that DES/DDD monitor and expand on interventions currently in place to improve performance related to the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure. |
| **DES/DDD's Response:**<br>DES/DDD's 2022 denominator for *W30—Well-Child Visits in the First 15 Months* was 27 members and below the threshold for reporting for MY 2022 however, performance improvement efforts were still engaged to address the identified performance gaps. Through Q3 2023, DES/DDD's *W30—Well-Child Visits in the First 15 Months* is 22.2%, outpacing 2022 performance in the same period (20%) and equaling DES/DDD's final 2022 rate.<br><br>DES/DDD's Performance Improvement (PI) team provided the analysis of *W30* gaps to DES/DDD's PIM Committee, which assesses performance trends and provides recommendations for continued QI. The PI team has also worked with healthcare services medical directors and the EPSDT manager to remove data siloes and strengthen coordination of QI activities for DES/DDD's children and adolescents. The PI team provides an analysis of the PMMR data and corresponding technical specifications in these targeted areas and supports clinical recommendations for QI and oversight of health plan QI/PI activities for these measures. The PIM committee and Pediatric workgroup will continue to monitor and make recommendations based on the trends identified and sufficiency of the health plan's PDSA cycles to address *W30* performance gaps.<br><br>In 2023 DES/DDD developed a CAP to address deficiencies in *W30* performance, including requiring both subcontracted health plans to submit corresponding CAPs to DES/DDD. Using a fishbone diagram and additional root cause analysis tools, the following root causes were identified:<br>• Very small denominators/eligible population.<br>• Members may not be aware telehealth services are available.<br>• Financial incentives not motivating providers to outreach members to close gaps in care.<br>• Some providers do not submit claims to secondary payers.<br>• COVID-19/PHE impact: Postponed immunization visits, limited clinical appointments, staffing shortages, required spacing reduced number of patients that can be seen in a day, transportation issues. |

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

- Provider/Onsites: Data not being imputed in State registry, staff not providing past screenings/results in patient history, staff have limited knowledge on *W30* measures and measure time periods.
- Outreach/Education: Lack of outreach to members and physicians, miseducation regarding vaccine/immunization complications, focus on COVID vaccine, lack of physician education on members having immunizations completed.

Mercy Care

Mercy Care continued the interventions that were reported in 2022 after completion of a root cause analysis. Those interventions include:

- EPSDT coordinator enhanced provider education on:
  - The AHCCCS periodicity schedule which requires 8 well-visits by age 15 months and annual well-visits after 24 months of age.
  - Well-child visit codes.
  - Sick and well-visit combination and coding (modifier 25).
  - Mercy Care's "unlimited" well-child visit policy. Status: implemented and ongoing.
- Implementation of year-round MRR processes to gather compliant data for members with other primary coverage.

The denominator for the Mercy Care DES/DDD membership within the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure remains less than the 30 minimum that is required for reporting by AHCCCS and NCQA. Mercy Care continues the interventions above as well as those previously implemented.

*W30* (Rate 1) rate with claims through 09/30/2023: 23.08% (a 3.2% improvement over the 2022 rates for the same time period).

UHCCP

UHCCP has heavily focused on the *W30*-Rate 1 measure for several years and prioritizes considerable resources toward improving rate performance. Although UHCCP's DD population is not sufficient to provide accurate rate reporting, UHCCP initiated a CAP for the measure based on DES/DDD's MY 2021 rate performance, which did not meet the 2022 NCQA Medicaid mean (MY 2021) rate of 65.9%.

UHCCP identified the following root causes impacting *W30*-Rate 1 performance:

1. Members may not be aware telehealth services are available.
2. Providers offered the PCPi incentive for *W30*-Rate 1 may not be aware of potential incentive earnings or number of *WCV* needed to meet PCPI incentive goals.
3. Financial incentives not motivating providers to outreach members to close gaps in care.

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| 4. Some providers do not submit claims to secondary payers.<br><br>To address the identified root cause deficiencies, UHCCP implemented the following interventions in 2022 and 2023:<br>• Annual virtual visit email campaign sent to members.<br>• CPCs share with provider groups participating in the PCPi Program their *W30*-Rate 1 incentive targets and potential earnings, along with the number of well visits still needed to meet the target.<br>• Financial incentive programs (PCPi) offered to provider groups that do not have a value-based contract, to improve performance on the measure. Adapted September MY 2022: MY 2022 CP-PCPi payment amounts increased for participating providers. Claims payment allowed amount for well visits (*WCV, AAP, W30*) increased by 50% for DOS 10/1/2022–12/31/2022.<br>• UHCCP will provide 6 regular COB reports to select provider groups and ACOs and ongoing education on the importance of submitting claims to secondary payors. Discussion to include how secondary claims submissions for COB members could impact incentivized performance measure rates.<br><br>Internal dissemination of CAP findings, progress, and results is communicated at quarterly UHCCP Quality Management Committee (QMC) meetings. External dissemination of CAP findings, progress, and results is communicated to DES/DDD within UHCCP's PMMR/WP/WPE submissions to DES/DDD. |
| **HSAG's Assessment:** HSAG has determined that the denominator was too small to report this measure indicator; therefore, HSAG is unable to determine whether or not the Contractor satisfactorily addressed these prior year's recommendations. |
| **Recommendation 5:** |
| HSAG recommended that DES/DDD identify best practices to support children in receiving preventive vaccinations according to recommended schedules. HSAG also recommended that DES/DDD consider conducting a root cause analysis to identify barriers that members are experiencing in accessing care and services in order to implement appropriate interventions to improve the performance related to the Pediatric Health measure group. |
| **DES/DDD's Response:**<br>In 2023 DES/DDD's Performance Improvement team conducted an analysis of individual *CIS* measures performance to find the primary gaps causing the combination deficiencies. The analysis identified that low Rotavirus vaccination (34% in 2022) rates were impacting the *CIS* 7 and 10 Combination rates.<br><br>Interventions were implemented to improve rates in 2022 and DES/DDD's 2022 rate for *CIS* Combination 7 is 30% representing an 8.7% decrease in the Combination 7 rate from 2021. DES/DDD had a relatively low denominator, and this increases the impact of each gap in care. Through Q3 2023 (September 30, 2023), DES/DDD's *CIS* Combination 7 rate (admin only) is 20%, |

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

which is 2.8 percentage points higher than DES/DDD's rate in Q3 2022. DES/DDD's Q3 2023 (admin only) rate for Rotavirus is 33.6%, 1.2 percentage points higher than DES/DDD's Q3 2022 rate.

This information was provided to DES/DDD's PIM Committee, which assesses performance trends and provides recommendations for continued QI. As a key childhood wellness and prevention measure, the committee has discussed the subcontracted health plans' current interventions and performance for *CIS* throughout 2023. During the PIM committee meeting review, DES/DDD's quality management medical director and EPSDT manager noted that Rotavirus rates have a tendency to be low, and the Performance Improvement team presented data confirming these observations, leading to further discussion on improving individual immunization rates that may have significant impact on combination performance. An additional workgroup has been formed with DES/DDD's PI team, healthcare services medical director, dental director, and EPSDT manager to increase collaboration, data visibility, and coordination of health plan oversight to support all pediatric measures for DES/DDD members.

In 2023 DES/DDD developed a CAP to address deficiencies in *CIS* Combinations 7 and 10 performance, including requiring both subcontracted health plans to submit corresponding CAPs to DES/DDD. DES/DDD also informed the health plans that their *CIS* CAP submissions needed to include interventions to address the Rotavirus performance gap.

Using a fishbone diagram and additional root cause analysis tools, the following root causes were identified:

- ASIIS is used for supplemental data to close *CIS* gaps in care, but immunizations may not be accurately documented in the system or may not be entered into the system at all.
- Some providers do not submit claims to secondary payers.
- COVID-19/PHE impact: Postponed immunization visits, limited clinical appointments, staffing shortages, required spacing reduced number of patients that can be seen in a day, transportation issues.
- Provider/Onsites: Data not being imputed in State registry, staff not providing past screenings/results in patient history, staff have limited knowledge on *CIS* measures and measure time periods.
- Outreach/Education: Lack of outreach to members and physicians, miseducation regarding vaccine/immunization complications, focus on COVID vaccine, lack of physician education on members having immunizations completed.

Mercy Care

Mercy Care used a fishbone diagram to conduct a root cause analysis of *CIS* Combinations 7 and 10 performance gaps.

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

As a result of this analysis, Mercy Care developed the following interventions aimed at increasing the number and percentage of children who receive preventive vaccinations according to recommended schedules:

- Healthmine Application—Member Web portal to provide educational information regarding gaps in care along with digital and written member outreach.
- Distribution of the latest AHCCCS Periodicity schedule to MC care managers to remind caregivers of the required visit intervals.
- Partnership and collaboration with PCCN and EHN to promote EPSDT awareness.
- EPSDT Back to School Incentive.

*Childhood Immunization Status (Combination 3)* rate with claims through 09/30/2023: 61.64% (a 12.3% improvement over the 2022 rates for the same time period).

*Childhood Immunization Status (Combination 7)* rate with claims through 09/30/2023: 24.66% (a 25.8% improvement over the 2022 rates for the same time period).

*Childhood Immunization Status (Combination 10)* rate with claims through 09/30/2023: 30.14% (an 18.2% improvement over the 2022 rates for the same time period).

UHCCP

UHCCP did not meet the 2022 NCQA Medicaid mean (MY 2021) rates for *Childhood Immunization Status—Combination 7 (CIS-7)* performance measure. As a result, UHCCP implemented CAPs for the *CIS-7* and *CIS-10* measures in July 2023.

UHCCP identified the following root causes impacting *CIS-7* rate performance:

- ASIIS is used for supplemental data to close *CIS* gaps in care, but immunizations may not be accurately documented in the system or may not be entered into the system at all.
- Some providers do not submit claims to secondary payers.
- To address the identified root cause deficiencies, UHCCP implemented the following new interventions in 2023:
  - UHCCP is auditing providers annually to determine if they are entering immunization claims information into ASIIS and educating providers.
  - UHCCP CPCs are also providing the COB Reports to providers to help identify those members with UHCCP as a secondary payor and educating providers to submit secondary claims to close the quality gaps in care and improve measure rates as well as incentive payments.
  - UHCCP CPCs also share recommended vaccine schedules with provider groups at least once a year. UHCCP also performs live outreach call reminders to members with immunization gaps in care.

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| Internal dissemination of CAP findings, progress, and results is communicated at quarterly UHCCP QMC meetings. External dissemination of findings, progress, and results is communicated to DES/DDD within UHCCP's PMMR/WP/WPE submissions to DES/DDD. |
| **HSAG's Assessment:** While the Contractor has implemented interventions to address the recommendations, the rates have declined and the overall performance level remains at or below the 49th percentile. HSAG recommends looking deeper into how SDOH may have impacted the rates as well as evaluating race, ethnicity, and age stratifications to identify gaps in preventive care as a means to implement programs to address those issues. Some of these programs could include a mobile clinic to conduct the immunization, transportation programs, and adjusting hours for applicable visits to accommodate those with job concerns. |
| **Recommendation 6:** |
| HSAG recommended that DES/DDD consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended cancer screenings and make appropriate health decisions. In addition, HSAG recommended that DES/DDD work with its subcontracted health plans to analyze their data and consider whether or not there are disparities within DES/DDD's populations that contributed to lower screening rates. Upon identification of a root cause, HSAG recommended that DES/DDD request that its subcontracted health plans implement appropriate interventions to improve access to and timeliness of cancer screenings. |
| **DES/DDD's Response:**<br>In 2022 through 2023, DES/DDD interventions were implemented to address performance gaps in these critical cancer screening measures. DES/DDD finished 2022 with a rate of 51.4% in *BCS*, a 2.5 percentage point improvement from 2021's rate, and is at 45.6% through Q3 2023, on par with 2022's Q3 rate (46.9%). DES/DDD finished 2022 with a rate of 20.7% in CCS, a 1.2 percentage point improvement from 2021's rate and is at 18.9% (admin only) through Q3 2023, 0.4 percentage points higher than 2022's Q3 rate, approximately the same pace as 2022. Based on this analysis, additional efforts will be needed in Q4 to see an overall improvement in *CCS* performance versus 2022's rate. This information was presented to DES/DDD'S PIM Committee for review and recommendations as a part of DES/DDD's 2021 CAP.<br><br>An additional analysis was conducted in October 2023 for the Health Equity Committee to identify opportunities for reducing health disparities. Using preliminary statewide means provided on PMV's final rate review sheet, DES/DDD identified that *BCS* performance for 2022 appeared to be within range of both statewide and NCQA Medicaid means for the measure and that population-wide disparities were not apparent in the final PMMR results. *CCS*, however, showed a 32.5% gap versus the preliminary statewide mean rate and a 35.2% gap versus the NCQA Medicaid mean/PMPS. As a result, *CCS* was selected for target intervention and further study to address health disparities and has been recommended by the PIM committee as a priority quality management workplan measure. |

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

In 2023 DES/DDD developed a CAP to address deficiencies in breast cancer and cervical cancer screening performance, including requiring both subcontracted health plans to submit corresponding CAPs to DES/DDD. Using a fishbone diagram and additional root cause analysis tools, the following root causes were identified:

*Breast Cancer Screening*

- COVID-19 created barriers to office visits/provider access.
- Lack of urgency or age-specific outreaches for the eligible population's younger members.
- Some providers do not submit claims to secondary payers.
- Providers do not submit advanced illness and frailty diagnosis codes for members that could exclude them from the measure denominator.
- Challenges with distance to screening locations in some parts of the Phoenix metropolitan area.

*Cervical Cancer Screening*

- COVID-19 created barriers to office visits/provider access; illness, fears, transportation barriers, and focus on more urgent factors or critical illnesses.
- Lack of urgency or age-specific outreaches for the eligible population's younger members.
- Some providers do not submit claims to secondary payers.
- If a member is newly enrolled to the plan and had a CCS within the measure lookback period, there is not a code providers can submit indicating a history of the screening to close the gap.
- ACOs that do not have CCS in their value-based contracts (VBCs) may not focus on *CCS* measure rates.
- DES/DDD-specific challenges with getting cervical cancer screenings completed. DES/DDD's performance team and PIM committee noted that the root causes provided by the subcontracted health plans appeared to be generic to the Medicaid population and did not address specific barriers for the DES/DDD's population, and that this may be due to limited health plan and provider understanding of IDD-specific needs and barriers. A provider survey indicated gaps in the number of providers who have specific training for and/or understanding of the IDD population.

<u>Mercy Care</u>

In comparing the rate of mammograms to screen for breast cancer in the DES/DDD population to that of the Mercy Care ACC population, the DES/DDD membership demonstrated a statistically lower rate of screening. Additionally, Mercy Care identified a statistically significant disparity in the rate of mammograms to screen for breast cancer for Alaska/American Indian/Native American members (11.1%) as compared to Caucasian members (36.6%).

Mercy Care performed a subpopulation/health disparity analysis for the *CCS* measure specific to the DES/DDD population and the findings are as follows:

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| The Hispanic/No Ethnicity/Other population represents the largest majority of the total eligible population at 47.9% but demonstrates a higher rate of noncompliance (80.6%), as compared to the Caucasian, Native American, and Asian populations. This rate is also higher than the noncompliance rate for the entire eligible population of 75.8%. The difference in the rate of compliance between the Hispanic/No Ethnicity/Other population and the Caucasian population is statistically significant.<br><br>The Hispanic population represents 24.8% of the total eligible population and demonstrates a higher rate of noncompliance (79.2%), as compared to the Caucasian/African American/Asian/Native American population. This rate is also higher than the noncompliance rate for the entire eligible population of 75.8%. The difference in the rate of compliance between the Hispanic population and the Caucasian/African American/Asian/Native American population is statistically significant.<br><br>Mercy Care implemented the following interventions to address the identified disparities:<br>• Member incentives<br>• Collaboration with Native Health<br>• Care manager outreach<br>• *BCS* measure added to VBS contracts.<br>• Provider education via the Mercy Care Provider Conference<br><br><u>UHCCP</u><br>UHCCP did not meet the 2022 NCQA Medicaid mean (MY 2021) rates for *CCS* performance measure. As a result, UHCCP implemented a CAP for the *CCS* measure in July 2023.<br><br>UHCCP identified the following root causes impacting the *CCS* rate performance:<br>• The COVID pandemic occurred during the lookback period for this measure and affected rates.<br>• Some providers do not submit claims to secondary payors.<br>• If a member is newly enrolled to the plan and had a CCS within the measure lookback period, there is not a code providers can submit indicating a history of the screening to close the gap.<br>• ACOs that do not have the measure in their VBCs may not focus on measure rates.<br><br>To address the identified root cause deficiencies, UHCCP implemented the following new interventions in 2023:<br>• UHCCP is providing COB reports to select provider groups and ACOs, along with ongoing education on the importance of submitting claims to secondary payors.<br>• UHCCP increased the number of ACOs with the measure included in their VBCs from nine in MY 2022 to 11 in MY 2023.<br>• UHCCP is funding additional data aggregators as a way to improve rates by increasing the number of providers form which the plan receives supplemental data. UHCCP also continues to work with |

| Prior Year's Recommendation from the EQR Technical Report for Performance Measures |
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| provider groups and ACOs to get their EMR set up, so they are connected to data aggregators used by UHCCP to ingest supplemental data.<br><br>Internal dissemination of CAP findings, progress, and results is communicated at quarterly UHCCP QMC meetings. External dissemination of CAP findings, progress, and results is communicated to DES/DDD within UHCCP's PMMR/WP/WPE submissions to DES/DDD. UHCCP also performed a disparity analysis on this measure in late 2021 for the Health Disparity Summary and Evaluation Report that is submitted to DES/DDD annually. The analysis identified that Black or African American members had lower *CCS* rates than other races. As a result of these findings, UHCCP implemented interventions to address the disparity in 2022, which include targeted outreach calls and mailers to Black or African American members with gaps in care for CCS. The interventions remain in place in MY 2023. UHCCP has kept this measure and disparity population in its Health Disparity Summary and Evaluation Report and will be reporting on MY 2023 progress in the next report submission due to DES/DDD in July 2024. |
| **HSAG's Assessment:** HSAG determined that DES/DDD has addressed these prior year's recommendations and as a result implemented strategies to help improve rates; however, the rates improved minimally, and the overall performance level remains at or below the 49th percentile. HSAG recommends looking deeper into how SDOH may have impacted the rates as well as evaluating race, ethnicity, and /age stratifications to identify gaps in preventive care as a means to implement programs to address those issues. Some of these programs could include a mobile clinic to conduct the screening, transportation programs, and adjusting hours for screenings to accommodate those with job/childcare concerns. |

## *Validation of Performance Improvement Projects*

Well-care visits for children and adolescents aim to promote optimal health and development. Ensuring that children and adolescents receive regular well-care visits is critical in disease prevention, early detection, and treatment. There are many benefits of well-child/well-care visits, including disease prevention, tracking growth and development, raising concerns, and establishing a team approach to assist with the development of optimal physical, mental, and social health of a child.[11-8] Adolescence is a critical stage of development during which physical, intellectual, emotional, and psychological changes occur.[11-9] Adolescent well-care visits assist with promoting healthy choices and behaviors, preventing risky behaviors, and detecting early the conditions that can inhibit an adolescent's development.

[11-8] American Academy of Pediatrics. AAP Schedule of Well-Child Care Visits. Available at: https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx. Accessed on: Feb 12, 2024.

[11-9] Centers for Disease Control and Prevention. Adolescence: Preparing for Lifelong Health and Wellness. Available at: https://www.cdc.gov/grand-rounds/pp/2015/20150818-adolescent-wellness.html. Accessed on: Feb 12, 2024.

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Back to Basics* PIP for the ALTCS-DD population. The objective of the *Back to Basics* PIP is to increase the number of child and adolescent well-child/well-care visits.

As this PIP had progressed through Remeasurement 1, PIP validation activities focused on improvement from the baseline results. DES/DDD submitted Remeasurement 1 performance indicator results and interventions implemented during this validation cycle along with the status of interventions, focus, and rationale for changes or discontinuation of the interventions. HSAG conducted an annual validation of the first remeasurement year reflective of CY 2022 (January 1, 2022, through December 31, 2022) using AHCCCS-calculated and validated indicator rates. HSAG evaluated DES/DDD's performance indicator rates based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in the Validation of Performance Improvement Projects section, How Conclusions Were Drawn subsection of Appendix A. Methodology.

## Validation Results

Table 11-7 displays the overall confidence levels for the DES/DDD *Back to Basics* PIP.

**Table 11-7—DES/DDD *Back to Basics* PIP Overall Confidence Levels**

| Contractor | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
|---|---|---|---|---|---|---|
| | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met | Confidence Level | Percentage Score of Evaluation Elements Met | Percentage Score of Critical Elements Met |
| DES/DDD | *High Confidence* | 100% | 100% | *High Confidence* | 100% | 100% |

## Measure Results

Table 11-8 provides the *Back to Basics* PIP baseline, intervention, and Remeasurement 1 rates for DES/DDD.

**Table 11-8—DES/DDD *Back to Basics* PIP Rates**

| Contractor | PIP Indicator 2: *Child and Adolescent Well-Care Visits* (*WCV*) | |
|---|---|---|
| | Baseline Year | Remeasurement 1 |
| | CYE 2019 | CY 2022 |
| DES/DDD | 50.7% | 54.4% |

## Interventions

Table 11-9 presents PIP interventions for DES/DDD. Language in the PIP interventions section is minimally edited and generally reflective of the language provided by the Contractor.

**Table 11-9—DES/DDD Program *Back to Basics* PIP Interventions**

| Contractor | Intervention |
|---|---|
| DES/DDD | • HPV educational mailing to members turning 11 years of age.<br>• Multi-modal member outreach to members who have gaps in care with well-child visits and/or immunizations. Outreach includes motivational messaging distributed through the Healthmine member portal, text messaging, emails, and incentives.<br>• Incentive offer to members 7–11 years of age to encourage receipt of a well-child visit.<br>• During postpartum calls, the outreach staff reviews the baby's PCP information on file and assistance is offered if the parent has not made the baby's first appointment.<br>• Proactive reminder calls to parents/guardians of 6-, 9-, and 11-month-olds to remind them that their child is due for a well-child visit and immunizations (if appropriate) during the month. If the parent has not already made an appointment, a three-way call is placed to the provider's office to schedule an appointment.<br>• Mailing to parents/guardians of 1-month-olds that includes a well-child magnet listing the ages that children need well visits and a booklet on immunizations and debunking immunization myths.<br>• Immunization magnet mailing to parents of 6-month-olds listing the immunization schedule.<br>• EPSDT Reminder cards, including information consistent with the AHCCCS periodicity schedule.<br>• EPSDT second reminder cards.<br>• Written reminders: member handbook, member newsletters, and newborn booklets to promote well-child visits; EPSDT reminder cards; and well-child reminder letters.<br>• Written provider outreach process which includes mailings to PCPs for members in need of an EPSDT visit; members 0–24 months of age in need of immunizations; adolescents in need of immunizations; a reminder on the requirement to conduct developmental screenings at the 9-, 18-, and 24-month visits; information pertaining to the member's historical dental care and whether or not the member is due for dental care. |

| Contractor | Intervention |
|---|---|
| | • Face-to-face or virtual contacts between the Mercy Care coordinators and providers encouraging outreach efforts on members lacking childhood immunizations and/or well-child visits.<br>• Provider pay-for-performance to PCMH/ACO groups for improving performance in the measure.<br>• Telephone outreach to members turning 3–6 years of age during the measurement year. For members in need of an appointment, a three-way call with their provider to schedule the visit will be conducted.<br>• Outreach telephone calls to the member or the parent or guardian of members in need of a well exam to assist them in scheduling a visit with their PCP.<br>• Missed dental appointment outreach calls to EPSDT members who appear on the weekly dental vendor missed appointment report.<br>• Adolescent immunization reminder card is mailed to the parents/guardians of members during the month of the member's 12th birthday, reminding them of the importance of obtaining immunizations.<br>• 18–21-year-old members diagnosed with diabetes: written reminders to obtain diabetes-related services.<br>• Mailing a cover letter and CDC brochure to the Native American members in need of a well visit specific to the health of Native Americans.<br>• Follow-up calls to members who were referred for dental screening or services via an EPSDT visit.<br>• Dental mailing to members who were referred for dental screening or services via an EPSDT visit.<br>• Self-mailer is sent to members 6–9 years of age and includes information on the importance of dental sealants.<br>• Educate PCPs on the application of fluoride varnish, including the required training and the process for submission of the certificate of completion.<br>• The dental vendor to send dental "gaps in care" letter to contracted dental providers who have members assigned to them through the dental home program who are in need of a preventive dental care and/or dental sealant application.<br>• Missed dental appointment outreach calls to EPSDT members who appear on weekly dental vendor missed appointment report.<br>• MCH/EPSDT, Network Management, and Care Management staff will develop a collaborative outreach and engagement strategy to improve surveillance of adolescent well visits. |

| Contractor | Intervention |
|---|---|
| | • Care Management monitors gaps in care for all youth enrolled in Peds Care Management<br>• Collaborate with Native Health and the Phoenix Indian Medical Center.<br>• Partnership and collaboration with PCCN and EHN to promote EPSDT awareness.<br>• Distribution of the latest AHCCCS Periodicity schedule to MC care managers to remind caregivers of the required visit intervals.<br>• Refer new members to PCCN providers for comprehensive EPSDT services and care.<br>• Provider Tip Sheet: Well-Care Visits with Sick Visits (WCV).<br>• Myth versus Fact Member Letter and Flyer.<br>• Wellness Visit Reimbursement Increase Campaign (WCV).<br>• Quality Management Member Mailings: Well Visit and Immunizations Self Mailer 4–6 years: WCV.<br>• Quality Management Member Mailings: First Well-Child and Dental Notification Self Mailer 0–17 years: WCV ADV.<br>• Quality Management Member Mailings: First Well-Child and Dental Notification Self Mailer 18–20 years: WCV ADV.<br>• Quality Management Member Mailings: Second Well-Child Reminder Non-Comp Self Mailer 18–20 years: WCV.<br>• Quality Management Member Mailings: Second Well-Child Reminder Non-Comp Self Mailer 0–17 years: WCV.<br>• PCOR: Providers with WCV.<br>• Quality Management Live Calls: WCV.<br>• Quality Management Live Calls: Dental.<br>• TTECH Live Calls and Member Letters (WCV).<br>• Mpulse OmniChannel IVR Call: wcv_3_11_total.<br>• Mpulse OmniChannel IVR Call: wcv_12_17_total.<br>• Mpulse OmniChannel IVR Call: wcv_18_21_total.<br>• Mpulse OmniChannel Email: wcv_3_11_total.<br>• Mpulse OmniChannel Email: wcv_12_17_total.<br>• Mpulse OmniChannel Email: wcv_18_21_total.<br>• Mpulse OmniChannel SMS: wcv_3_11_total.<br>• Mpulse OmniChannel SMS: wcv_12_17_total.<br>• Mpulse OmniChannel SMS: wcv_18_21_total. |

| Contractor | Intervention |
|---|---|
| | • Member Incentive Rewards (WCV).<br>• Well-Child and Dental Notification (Postcard).<br>• QM Member Mailings Second and Third Dental Notification Reminder Non-Comp Self Mailer 0–17 years: WCV ADV.<br>• Quality Management Member Mailings: Second and Third Dental Notification Reminder Non-Comp Self Mailer 18–20 years: ADV.<br>• Virgin Pulse IVR Call: Dental IVR Call: ADV.<br>• Dental Special Needs Flyer: ADV.<br>• Quality Management Member Mailings: Dental Adolescent Benefits Flyer ACC 16–20 years: ADV.<br>• Quality Management Member Mailings: Dental Sealants 6–9 years: Sealant Receipt On Permanent First Molars (SFM)<br>• Annual Dental Home New Member Letter.<br>• Annual Dental Home Reminder Letter.<br>• Dental Department Fluoride Varnish Letter.<br>• Dental Healthy Hound Flyer DD and LTC—16–20 years; All programs—1–5 years and 10–15 years: ADV.<br>• Quality Management Provider Mailings: Dental Home Gaps in Care.<br>• Dental Care Opportunity Report (DCOR) to Targeted Dental Providers.<br>• Dedicated Dental CPC meets with dental providers.<br>• Pfizer Campaign IVR and postcard.<br>• Email Campaigns: Virtual Visit.<br>• CPC Monthly Talking Points/Provider Education.<br>• Provider EPSDT Toolkit.<br>• CP-PCPi Program (WCV). |

## Strengths, Opportunities for Improvement, and Recommendations

Table 11-10 presents strengths, opportunities for improvement, and recommendations for DES/DDD, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

**Table 11-10—DES/DDD Strengths, Opportunities for Improvement, and Recommendations Related to the *Back to Basics* PIP**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG noted that DES/DDD performed accurate statistical testing between the baseline and Remeasurement 1 results and that the indicator had a statistically significant improvement of 3.7 percentage points from the baseline year at Remeasurement 1. **[Quality, Access]**<br><br>DES/DDD developed and implemented measurement systems for interventions that may lead to improvement in indicator outcomes at Remeasurement 2. **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| HSAG did not identify any opportunities for improvement for DES/DDD.<br><br>Recommendations: Although HSAG did not identify any opportunities for improvement, as the PIP progresses, to sustain the improvement achieved, HSAG recommends that DES/DDD:<br>• Revisit the causal/barrier analysis used to develop interventions and adjust the interventions as necessary to sustain improvement.<br>• Continue to implement identified interventions with clearly defined intervention effectiveness measures to assess the effectiveness of each intervention.<br>• Develop interventions that affect a large enough percentage of the eligible population to drive improvement in the overall indicator rates. |

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

Table 11-11 presents PIP recommendations made to DES/DDD in the CYE 2022 Annual Technical Report[11-10] and DES/DDD's follow-up to the recommendations, as well as an assessment of the degree to which DES/DDD has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

[11-10] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for Arizona Long Term Care System. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportEPDandDDD.pdf. Accessed on: Feb 8, 2024.

**Table 11-11—DES/DDD Follow-Up to CYE 2022 PIP Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| HSAG recommended that DES/DDD:<br>• Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary.<br>• Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available.<br>• Develop and document a plan for sustaining the improvement for any demonstrated improvement in indicator rates. |
| **DES/DDD's Response:**<br>As a part of the Performance Improvement Program development, a desktop procedure and standard process is being developed in conjunction with the PMMR and WPE evaluation process standardization (see the response in the first performance measure recommendation), which includes an in-depth assessment and review of DES/DDD and subcontracted health plan-submitted PIPs to ensure robustness and effectiveness of the project PDSA cycles and alignment with AHCCCS Medical Policy Manual (AMPM) 980/980A requirements. Incorporating feedback from the 2022 EQR report, this new process will also include providing feedback to health plans on their PIP submissions and improved oversight of health plan-submitted PIPs and ensuring DES/DDD's PIP quality prior to submitting to AHCCCS.<br><br>The PDSA cycles will be managed through A3 documents to help ensure sufficient, well monitored, and effective PDSA cycles, ensuring each phase passes requirements in relation to AMPM 980 requirements, the project scope, goals, and each project phase's tools and processes. The data analysis will be supported by DES/DDD's Performance Improvement team and use of the PIP Intervention & Analysis worksheet to study rates, and Business Intelligence (BI) dashboards to aid visual management of the projects.<br><br>The first draft of the PIP desktop procedure is anticipated to be completed by December 31, 2023.<br><br>As a part of its key functions, the PIM Committee (re-launched Feb. 2023) has oversight of DES/DDD's PIPs and progress toward meeting PIP goals. PIP progress, data analysis, root causes, barriers, and other critical details are provided to committee members for additional insight and recommendations to help the projects reach their goals. The PIM (sub)Committee reports up to the QMPI Committee where DES/DDD's performance improvement manager submits the PIM recommendations and key information on PIP progress to DES/DDD leadership and key stakeholders including DES/DDD subcontracted health plan and vendor representatives. Both committees have DES/DDD PIPs as a standard agenda topic in the quarterly meetings.<br><br><u>Mercy Care</u> |

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| Mercy Care continues to review the PIP rates at least quarterly, with an annual final measurement year evaluation once the data are finalized. When the health plan identifies declines in performance, or that the rates are not on track to reach the defined goal, Mercy Care will initiate or continue to the next step in the PDSA cycle. Best practices are identified, documented, and incorporated into the health plan's standard operating procedures.<br><br>The COVID-19 PHE continued to impact the rates of member receipt of well-child visits through 2022; however, Mercy Care data for MY 2023 demonstrate significant year-over-year improvements in the *Child and Adolescent Well-Care Visit (WCV)* and *Well Child Visits in the First 30 Months of Life* (Rate 1) rates.<br><br>The *WCV* rate with claims through 09/30/2023: 47.01% (a 16.4 percent improvement over the 2022 rates for the same time period)<br><br>The *W30* (Rate 1) is not applicable to DES/DDD.<br><br>AHCCCS notified the health plans that the *Annual Dental Visit (ADV)* measure is being removed as an indicator for this PIP due to retirement by NCQA.<br><br><u>UHCCP</u><br>UHCCP used the DES/DDD Back to Basics PIP baseline rate of 50.7% as the *WCV* (indicator 2) B2B PIP baseline rate for its DD Program, which was calculated by AHCCCS for DES/DDD. UHCCP's rate in MY 2020 (intervention year 1) dropped by 4.5 points but then increased by 2.2 points in MY 2021 (intervention year 2). UHCCP's MY 2022 rate exceeded the goal rate of 51.7% by one point. The declines noted in the intervention years demonstrate the impact the COVID-19 PHE had on compliance with well visits.<br>• The UHCCP quality manager monitors the B2B PIP performance measure rates monthly and reviews them with the B2B PIP workgroup quarterly (at a minimum). The B2B PIP workgroup is composed of various stakeholders and subject matter experts from within the plan. The workgroup meets regularly to review PIP performance measure rates, evaluate the effectiveness of current PIP interventions, and identify root causes of performance deficiencies as well as new opportunities for improvement.<br>• The B2B PIP workgroup collaborates on adjusting interventions for continued improvement as needed, based on root cause analysis intervention success. The workgroup utilizes the PDSA method to evaluate interventions and determine next steps: adopt, adapt, or complete. Many interventions have been revamped/improved to meet the changing needs for member health outcomes and rate improvement. Some interventions undergo an effectiveness analysis to evaluate the before and after effects by comparing members with open gaps in care to those with closed gaps in care after the completion of the interventions. The PIP workgroup continues the PDSA |

| Prior Year's Recommendation from the EQR Technical Report for PIPs |
|---|
| process and collaborating to improve the B2B measure rates. A few examples of UHCCP MY 2022 (Remeasurement Year 1) and MY 2023 (Remeasurement Year 2) interventions are provided below:<br>– MY 2022: Myth versus Fact letter and flyer were distributed to 897 parents/guardians and members, which provide education on the importance of well visits, even during sick visits. By the end of MY 2022, 50.3% had obtained a well visit.<br>– MY 2022: A Wellness Visit Reimbursement Campaign was conducted in Q3 and Q4 2022 to help increase well visits and improve *WCV* and *W30* performance measure rates. The campaign encouraged providers to perform well visits by increasing the allowed amount on well visit claims by 50%.<br>– MY 2023: UHCCP added/incorporated outreach phone calls to over 2,000 members assigned to provider groups actively engaged with UHCCP to promote the AHCCCS Back to School gift card incentive campaign.<br><br>UHCCP's plans for sustaining improvement are documented in the B2B PIP workgroup's meeting minutes, the intervention analysis template, and the annual PIP report. |
| **HSAG's Assessment:** HSAG has determined that the Contractor has satisfactorily addressed these prior year's recommendations. |

## *Compliance Reviews*

### Results

AHCCCS conducts a full compliance review for DES/DDD every three years. This current three-year review cycle spans from CYE 2021 to CYE 2023. AHCCCS conducted a compliance review of DES/DDD from August 23, 2021, through August 27, 2021. AHCCCS finalized the DES/DDD compliance report, provided DES/DDD with a CAP submission matrix, and required a CAP for any standard with a total score of less than 95 percent. On April 13, 2022, AHCCCS accepted DES/DDD's proposed CAPs and required the Contractor to submit updated policies, manuals, desktop procedures, and other vital documents to provide evidence of CAP completion. On September 29, 2023, AHCCCS approved and closed all of DES/DDD's CAPs. Table 11-12 presents the compliance review results for DES/DDD.

**Table 11-12—DES/DDD Compliance Review Results**

| Focus Areas | CYE 2021 DES/DDD Scores | CYE 2022 CAP Update | CYE 2023 CAP Update |
|---|---|---|---|
| CC | 87% | M | M |
| CIS | 88% | M | M |
| CM | 82% | M | M |

| Focus Areas | CYE 2021 DES/DDD Scores | CYE 2022 CAP Update | CYE 2023 CAP Update |
|---|---|---|---|
| DS | 75% | PM | M |
| GA | 76% | PM | M |
| GS | 100% | NA | NA |
| MCH | 28% | PM | M |
| MM | 64% | PM | M |
| MI | 83% | M | M |
| QM | 85% | PM | M |
| QI | 65% | M | M |
| RI | 100% | NA | NA |
| TPL | 100% | NA | NA |
| ISOC | NR+ | NA | NA |

+ NR = "not reviewed." This Focus Area was not reviewed separately during the compliance review; however, elements of this Focus Area were included in other Focus Areas (e.g., QI standards included in QM and ISOC standards included in MM).
NA = "not applicable." A CAP was not required as the CYE 2022 score was 95% or above.
PM = "partially met." AHCCCS approved the Contractor's proposed CAP. The Contractor must submit evidence of compliance.
M = "met." AHCCCS accepted and closed the Contractor's CAP.

## Strengths, Opportunities for Improvement, and Recommendations

Table 11-13 presents strengths, opportunities for improvement, and recommendations for DES/DDD related to compliance.

**Table 11-13—DES/DDD Strengths, Opportunities for Improvement, and Recommendations Related to Compliance**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| DES/DDD successfully closed CAPs in the following Focus Areas:<br>• Case Management (CM) **[Quality, Access]**<br>• Corporate Compliance (CC) **[Quality, Access]**<br>• Claims and Information Standards (CIS) **[Access]**<br>• Delivery Systems (DS) **[Timeliness, Access]**<br>• General Administration (GA) **[Timeliness, Access]** |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| • Adult, EPSDT, and Maternal Child Health (MCH) **[Quality, Timeliness, Access]**<br>• Medical Management (MM) **[Timeliness, Access]**<br>• Member Information (MI) **[Quality]**<br>• Quality Management (QM) **[Quality]**<br>• Quality Improvement (QI) **[Quality, Access]** |
| **Opportunities for Improvement and Recommendations** |
| DES/DDD successfully closed all CAPs; therefore, HSAG did not identify any opportunities for improvement.<br><br>Recommendation: HSAG recommends that DES/DDD review all Focus Area requirements in preparation for its next full compliance review. |

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

Table 11-14 presents compliance recommendations made to DES/DDD in the CYE 2022 Annual Technical Report[11-11] and DES/DDD's follow-up to the recommendations, as well as an assessment of the degree to which DES/DDD has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 11-14—DES/DDD Follow-Up to CYE 2022 Compliance Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for Compliance |
|---|
| HSAG recommended that DES/DDD leadership conduct a high-level assessment of the CM, CC, CIS, DS, GA, MCH, MM, MI, QM, and QI requirements to ensure ongoing oversight of compliance for these areas. |
| **DES/DDD's Response:**<br>DES/DDD conducted an OR of Mercy Care and UHCCP's DD Programs in 2022. In preparation for the 2024 OR by AHCCCS, in 2023 DES/DDD's compliance team also began conducting internal OR audits in each OR domain to identify any current gaps, and each area lead is currently implementing their CAPs to close any gaps. CAP and OR preparation progress is monitored by DES/DDD's compliance team and documented in a standard tool created to prepare DES/DDD for the OR and close gaps for overall quality improvement. DES/DDD's domain leads meet with the compliance team at least once a month to review current progress. |

[11-11] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for Arizona Long Term Care System. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportEPDandDDD.pdf. Accessed on: Feb 8, 2024.

| Prior Year's Recommendation from the EQR Technical Report for Compliance |
|---|
| Mercy Care<br>DES/DDD performed an OR of Mercy Care's DD Program in 2022 and determined that Mercy Care did not meet compliance in the following areas: CC, DS, GS, MM, MI, QM, RI, and QI. This resulted in 27 CAPs. On March 14, 2023, DES/DDD identified that all steps identified in the 27 CAPs met the requirements for the standards and considered the CAPs closed.<br><br>UHCCP<br>DES/DDD performed an OR of UHCCP's DD Program in February 2022. DES/DDD determined that UHCCP did not meet compliance in the following areas: CC, CIS, DS, GA, GS, MCH, MM, MI, RI, TPL, and QI. This resulted in 36 CAPs. UHCCP implemented CAPs for areas of noncompliance and provided progress updates to DES/DDD over the next six months. On December 12, 2022, DES/DDD identified that all steps identified in the 36 CAPs met the requirements for the standards and considered the CAPs closed. This concluded the DES/DDD OR process for UHCCP. Following the OR with DES/DDD in February 2022, UHCCP participated in two additional Operational Reviews (ORs) with AHCCCS in August 2022 and February 2023 for its other programs (ACC and LTC). These ORs provided UHCCP the opportunity to conduct additional detailed assessments to ensure compliance requirements and to address and correct any areas of deficiency identified during the ORs. DES/DDD will be conducting another UHCCP OR in February 2024. |
| **HSAG's Assessment:**<br>Based on the results of the CYE 2023 compliance review activity and the response provided, HSAG determined that DES/DDD has satisfactorily addressed this prior year's recommendation. |

## *Network Adequacy Validation*

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

Table 11-15 summarizes HSAG's assessment of each DES/DDD subcontracted health plan's compliance with AHCCCS' minimum time/distance network standards. A check mark indicates that the DES/DDD subcontracted health plan met the minimum network standard for each Arizona county during each of the three quarterly assessments, and an "X" indicates that the DES/DDD subcontracted health plan failed to meet one or more minimum network standards in any county or quarter.

**Table 11-15—Summary of CYE 2023 Compliance with Minimum Time/Distance Network Requirements for DES/DDD Subcontracted Health Plans**

| Minimum Network Requirement | Mercy Care DD | UHCCP DD |
|---|---|---|
| Behavioral Health Outpatient and Integrated Clinic, Adult | X | X |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | ✓ | X |
| BHRF (Only Maricopa and Pima Counties) | ✓ | ✓ |
| Cardiologist, Adult | X | X |
| Cardiologist, Pediatric | ✓ | X |
| Dentist, Pediatric | X | X |
| Hospital | X | X |
| OB/GYN | ✓ | ✓ |
| Pharmacy | X | X |
| PCP, Adult | ✓ | ✓ |
| PCP, Pediatric | ✓ | ✓ |

DES/DDD consistently met the BHRF; OB/GYN; and PCP, Adult and Pediatric standards while not consistently meeting the standards for Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult; Dentist, Pediatric; Hospital; and Pharmacy standards.

As part of the NAV, AHCCCS maintained its feedback process for DES/DDD to review and improve the accuracy of its data submissions. Specifically, AHCCCS supplied DES/DDD with a copy of HSAG's quarterly network adequacy analysis, a copy of the PAT file that HSAG used to conduct the analysis, and a copy of HSAG's saturation analysis results. When issues were identified, DES/DDD was expected to research the instances and make corrections for future PAT data and/or ACOM 436 submissions.

Overall, DES/DDD met all minimum time/distance network standards during both quarters in Cochise, Coconino, Graham, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. Based on the semiannual NAV results, DES/DDD did not meet all requirements for all standards and quarters in the applicable counties.

DES/DD should continue to monitor and maintain its existing provider network as of CYE 2023 Q4, with specific attention to ensuring the availability of the following provider types:

- Behavioral Health Outpatient and Integrated Clinic, Adult in Apache County
- Behavioral Health Outpatient and Integrated Clinic, Pediatric in Apache County
- Cardiologist, Adult in Apache County

- Dentist, Pediatric in Apache, Greenlee, Gila, and La Paz counties
- Hospital in Apache and Greenlee County
- Pharmacy in Apache County

## Results

HSAG evaluated DES/DDD's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents semiannual validation findings specific to the DES/DDD Program, with one results table for each of the following GSAs:

- Central GSA: Gila, Maricopa,[11-12] and Pinal counties
- North GSA: Apache, Coconino, Mohave, Navajo, and Yavapai counties
- South GSA: Cochise, Graham,[11-13] Greenlee, La Paz, Pima, Santa Cruz,[11-14] and Yuma counties

Each Contractor-specific table summarizes semiannual validation results containing the percentage of members meeting each time/distance standard by quarter and county, with color-coding to identify whether the time/distance standard was "*Met*" or "*Not Met*."

The value "NA" is shown for time/distance standards that do not apply to the county or program.

The value "NR" is shown for time/distance standards in which no members met the network requirement denominator for the program and county; therefore, HSAG calculated no corresponding time/distance result.

Yellow color-coding identifies instances in which HSAG's time/distance results met the minimum network requirement but differed from the ACOM 436 results.

Red color-coding identifies instances in which HSAG's time/distance results did not meet the compliance standard, regardless of the ACOM 436 results.

An asterisk (*) indicates that fewer than 10 members were included in the denominator of HSAG's results.

A carat (^) indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.

[11-12] Maricopa County includes the 85342, 85358, and 85390 ZIP Codes; these ZIP Codes are physically located in both Maricopa and Yavapai counties.
[11-13] Graham County includes the 85542, 85192, and 85550 ZIP Codes representing the San Carlos Tribal area; these ZIP Codes are physically located in Gila or Pinal County.
[11-14] Santa Cruz County includes the 85645 ZIP Code; this ZIP Code is physically located in both Pima and Santa Cruz counties.

**Table 11-16—Mercy Care DD Time/Distance Validation Results for Central GSA—Percentage of Members Meeting Minimum Network Requirements**

| Minimum Network Requirement | Gila | | Maricopa | | Pinal | |
|---|---|---|---|---|---|---|
| | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0^ | 100.0^ | 97.8^ | 97.9^ | 100.0^ | 100.0^ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 100.0^ | 100.0^ | 97.6^ | 97.7^ | 100.0^ | 100.0^ |
| BHRF | NA | NA | 99.2 | 99.1 | NA | NA |
| Cardiologist, Adult | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| Cardiologist, Pediatric | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| Dentist, Pediatric | 100.0 | 97.7 | 99.6 | 99.5 | 100.0 | 100.0 |
| Hospital | 100.0 | 100.0 | 99.9 | 99.9 | 100.0 | 100.0 |
| OB/GYN | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 100.0 | 100.0 | 99.2 | 99.1 | 99.9 | 99.9 |
| PCP, Adult | 100.0^ | 100.0^ | 99.7^ | 99.7^ | 100.0^ | 100.0^ |
| PCP, Pediatric | 100.0^ | 100.0^ | 99.8^ | 99.8^ | 100.0^ | 100.0^ |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
^indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.

**Table 11-17—Mercy Care DD Time/Distance Validation Results for North GSA—Percentage of Members Meeting Minimum Network Requirements**

| Minimum Network Requirement | Apache | | Coconino | | Mohave | | Navajo | | Yavapai | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 62.5*^ | 55.6*^ | 88.2^ | 88.2^ | 100.0^ | 100.0^ | 100.0*^ | 100.0*^ | 100.0^ | 100.0^ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | NR*^ | NR*^ | 100.0^ | 100.0^ | 97.6^ | 98.2^ | 88.9*^ | 91.7^ | 100.0^ | 100.0^ |
| BHRF | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Cardiologist, Adult | 57.1*^ | 37.5*^ | 92.9^ | 100.0^ | 100.0^ | 100.0^ | 100.0*^ | 100.0*^ | 100.0^ | 100.0^ |
| Cardiologist, Pediatric | 100.0*^ | 100.0*^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0*^ | 100.0^ | 100.0^ | 100.0^ |
| Dentist, Pediatric | 100.0* | 100.0* | 100.0 | 100.0 | 95.5 | 96.4 | 100.0* | 100.0 | 100.0 | 100.0 |
| Hospital | 100.0* | 55.6* | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

| Minimum Network Requirement | Apache | | Coconino | | Mohave | | Navajo | | Yavapai | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| OB/GYN | 100.0* | 100.0* | 100.0* | 100.0* | 100.0* | 100.0* | 100.0* | 100.0* | 100.0* | 100.0* |
| Pharmacy | 100.0* | 100.0* | 100.0 | 100.0 | 98.1 | 98.5 | 94.1 | 94.7 | 98.5 | 100.0 |
| PCP, Adult | 85.7*^ | 87.5*^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0*^ | 100.0*^ | 100.0^ | 100.0^ |
| PCP, Pediatric | 100.0*^ | 100.0*^ | 100.0^ | 100.0^ | 97.7^ | 98.2^ | 100.0*^ | 100.0^ | 100.0^ | 100.0^ |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
represents time/distance standard results that do not meet the compliance standard based on HSAG's results.
NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.
* indicates that fewer than 10 members were included in the denominator of HSAG's results.
^ indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.

**Table 11-18—Mercy Care DD Time/Distance Validation Results for South GSA—Percentage of Members Meeting Minimum Network Requirements**

| Minimum Network Requirement | Cochise | | Graham | | Greenlee | | La Paz | | Pima | | Santa Cruz | | Yuma | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0*^ | 100.0*^ | 95.4^ | 95.8^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0*^ | 100.0*^ | 100.0*^ | 100.0*^ | 93.3^ | 93.3^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| BHRF | NA | NA | NA | NA | NA | NA | NA | NA | 94.9 | 94.0 | NA | NA | NA | NA |
| Cardiologist, Adult | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0*^ | 100.0*^ | 99.2^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| Cardiologist, Pediatric | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0*^ | 100.0*^ | 100.0*^ | 100.0*^ | 99.6^ | 99.9^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| Dentist, Pediatric | 100.0 | 100.0 | 97.8 | 95.6 | 100.0* | 100.0* | 20.0* | 25.0* | 98.5 | 98.7 | 100.0 | 100.0 | 100.0 | 100.0 |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0* | 100.0* | 99.4 | 99.5 | 100.0 | 100.0 | 100.0 | 100.0 |
| OB/GYN | 100.0 | 100.0 | 100.0 | 100.0 | 100.0* | 100.0* | NR* | 100.0* | 99.6 | 99.6 | 100.0* | 100.0* | 100.0 | 100.0 |
| Pharmacy | 100.0 | 100.0 | 98.0 | 99.0 | 96.2 | 100.0 | 85.7* | 100.0* | 98.9 | 98.9 | 100.0 | 100.0 | 100.0 | 100.0 |
| PCP, Adult | 100.0^ | 100.0^ | 98.1^ | 98.1^ | 100.0^ | 100.0^ | 100.0*^ | 100.0*^ | 99.7^ | 99.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| PCP, Pediatric | 100.0^ | 100.0^ | 97.8^ | 95.6^ | 100.0*^ | 100.0*^ | 100.0*^ | 100.0*^ | 99.6^ | 99.6^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
represents time/distance standard results that do not meet the compliance standard based on HSAG's results.
NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.
* indicates that fewer than 10 members were included in the denominator of HSAG's results.
^ indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county

**Table 11-19—UHCCP DD Time/Distance Validation Results for Central GSA—Percentage of Members Meeting Minimum Network Requirements**

| Minimum Network Requirement | Gila | | Maricopa | | Pinal | |
|---|---|---|---|---|---|---|
| | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0^ | 100.0^ | 98.4^ | 99.1^ | 100.0^ | 100.0^ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 100.0^ | 100.0^ | 98.7^ | 99.4^ | 100.0^ | 100.0^ |
| BHRF | NA | NA | 98.5 | 97.8 | NA | NA |
| Cardiologist, Adult | 100.0^ | 100.0^ | 99.9^ | 99.8^ | 100.0^ | 100.0^ |
| Cardiologist, Pediatric | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| Dentist, Pediatric | 100.0 | 55.9 | 99.5 | 99.3 | 100.0 | 100.0 |
| Hospital | 100.0 | 100.0 | 99.9 | 99.7 | 100.0 | 100.0 |
| OB/GYN | 100.0 | 100.0 | 99.8 | 99.9 | 100.0 | 100.0 |
| Pharmacy | 100.0 | 100.0 | 99.1 | 99.2 | 100.0 | 100.0 |
| PCP, Adult | 100.0^ | 100.0^ | 99.7^ | 99.7^ | 100.0^ | 100.0^ |
| PCP, Pediatric | 100.0^ | 100.0^ | 99.8^ | 99.8^ | 100.0^ | 100.0^ |

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

represents time/distance standard results that do not meet the compliance standard based on HSAG's results.

NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.

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

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

NA indicates results are not applicable to the county.

**Table 11-20—UHCCP DD Time/Distance Validation Results for North GSA—Percentage of Members Meeting Minimum Network Requirements**

| Minimum Network Requirement | Apache | | Coconino | | Mohave | | Navajo | | Yavapai | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 63.6^ | 64.5^ | 81.5^ | 81.4^ | 96.7^ | 96.2^ | 95.2^ | 94.4^ | 99.8^ | 99.9^ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 65.8^ | 70.3^ | 81.8^ | 82.8^ | 95.1^ | 95.3^ | 95.0^ | 95.0^ | 100.0^ | 100.0^ |
| BHRF | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Cardiologist, Adult | 61.3^ | 63.5^ | 99.3^ | 99.7^ | 100.0^ | 100.0^ | 97.7^ | 97.9^ | 100.0^ | 100.0^ |
| Cardiologist, Pediatric | 79.2^ | 88.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 99.3^ | 100.0^ | 100.0^ | 100.0^ |

| Minimum Network Requirement | Apache | | Coconino | | Mohave | | Navajo | | Yavapai | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Dentist, Pediatric | 90.6 | 86.0 | 92.8 | 92.1 | 98.7 | 99.0 | 96.0 | 95.9 | 98.3 | 98.3 |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| OB/GYN | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 87.0 | 89.4 | 95.8 | 95.6 | 99.6 | 99.7 | 97.6 | 97.3 | 99.1 | 99.3 |
| PCP, Adult | 88.7^ | 85.7^ | 99.3^ | 99.7^ | 99.2^ | 99.5^ | 100.0^ | 100.0^ | 99.8^ | 100.0^ |
| PCP, Pediatric | 88.7^ | 90.0^ | 94.1^ | 93.4^ | 99.7^ | 99.8^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
represents time/distance standard results that do not meet the compliance standard based on HSAG's results.
^ indicates that meeting the network requirement for the specified Contractor, program, county, and provider category was evaluated using a modified telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.

**Table 11-21—UHCCP DD Time/Distance Validation Results for South GSA—Percentage of Members Meeting Minimum Network Requirements**

| Minimum Network Requirement | Cochise | | Graham | | Greenlee | | La Paz | | Pima | | Santa Cruz | | Yuma | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 | Q2 | Q4 |
| Behavioral Health Outpatient and Integrated Clinic, Adult | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0*^ | 100.0^ | 100.0^ | 100.0^ | 97.6^ | 97.8^ | 99.0^ | 100.0^ | 100.0^ | 100.0^ |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 95.9^ | 95.6^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| BHRF | NA | NA | NA | NA | NA | NA | NA | NA | 91.4 | 90.7 | NA | NA | NA | NA |
| Cardiologist, Adult | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0*^ | 100.0*^ | 100.0^ | 100.0^ | 99.9^ | 99.9^ | 98.9^ | 100.0^ | 100.0^ | 100.0^ |
| Cardiologist, Pediatric | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 99.9^ | 99.9^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| Dentist, Pediatric | 98.1 | 98.3 | 94.4 | 96.2 | 100.0 | 41.2 | 100.0 | 95.5 | 98.7 | 98.4 | 100.0 | 100.0 | 99.8 | 99.8 |
| Hospital | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 58.3 | 100.0 | 100.0 | 99.9 | 99.8 | 100.0 | 100.0 | 100.0 | 100.0 |
| OB/GYN | 100.0 | 100.0 | 100.0 | 100.0 | 100.0* | 100.0* | 100.0 | 100.0* | 99.9 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Pharmacy | 99.7 | 99.8 | 94.4 | 98.9 | 100.0 | 100.0 | 100.0 | 100.0 | 99.1 | 99.4 | 99.5 | 100.0 | 99.9 | 99.8 |
| PCP, Adult | 100.0^ | 100.0^ | 100.0^ | 94.6^ | 100.0*^ | 100.0*^ | 100.0^ | 100.0^ | 99.9^ | 99.9^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ |
| PCP, Pediatric | 100.0^ | 100.0^ | 100.0^ | 98.1^ | 100.0^ | 100.0^ | 100.0^ | 100.0^ | 99.7^ | 99.7^ | 100.0^ | 100.0^ | 99.8^ | 99.8^ |

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

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

## Strengths, Opportunities for Improvement, and Recommendations

Table 11-22 presents strengths, opportunities for improvement, and recommendations for DES/DDD, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

**Table 11-22—DES/DDD Strengths, Opportunities for Improvement, and Recommendations Related to NAV**

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| **Strengths** |
| HSAG identified the following strengths:<br>• DES/DDD consistently met the BHRF; OB/GYN; and PCP, Adult and Pediatric standards**. [Access]**<br><br>Note: DES/DDD provide coverages in the following counties: Apache, Cochise, Coconino, Gila, Graham, Greenlee, La Paz, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma. |
| **Opportunities for Improvement and Recommendations** |
| HSAG identified the following opportunities for improvement:<br>• DES/DDD did not meet standards for at least one quarter and/or county for Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult; Dentist, Pediatric; Hospital; and Pharmacy standards in Apache, Greenlee, Gila, and La Paz counties. **[Access]**<br><br>Recommendations:<br>• HSAG recommends that AHCCCS support DES/DDD in continuing to monitor its processes for creating the PAT file and that DES/DDD review the PAT file for accuracy prior to submitting to AHCCCS.<br>• HSAG recommends that AHCCCS support the DES/DDD in continuing to monitor and maintain existing provider network coverage as of CYE 2023 Q4, with specific attention to ensuring the availability of the following provider types:<br>– Behavioral Health Outpatient and Integrated Clinic, Adult in Apache County.<br>– Behavioral Health Outpatient and Integrated Clinic, Pediatric in Apache County<br>– Cardiologist, Adult in Apache County<br>– Dentist, Pediatric in Apache, Greenlee, Gila, and La Paz counties<br>– Hospital in Apache County and Greenlee County |

| Strengths, Opportunities for Improvement, and Recommendations |
|---|
| – Pharmacy in Apache County<br>• DES/DDD should maintain current compliance with network standards but continue to address network gaps, as applicable. |

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

Table 11-23 presents NAV recommendations made to DES/DDD in the CYE 2022 Annual Technical Report[11-15] and DES/DDD's follow-up to the recommendations, as well as an assessment of the degree to which DES/DDD has effectively addressed the recommendations. Language in this section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

**Table 11-23—DES/DDD Program Follow-Up to CYE 2022 NAV Recommendations**

| Prior Year's Recommendation from the EQR Technical Report for NAV |
|---|
| HSAG recommended that:<br>• DES/DDD continue to seek support from AHCCCS in monitoring and maintaining existing provider network coverage for its subcontracted health plans, with specific attention to ensuring the availability of adult and pediatric behavioral health outpatient and integrated clinics and adult cardiologists in Apache County.<br>• Mercy Care DD should continue to monitor and maintain its existing provider network coverage as of CYE 2022 Q4, with specific attention to ensuring the availability of the following provider types:<br>– Behavioral health outpatient and integrated clinics for adults in Apache County<br>– Cardiologists for adults in Apache County<br>– Pediatric dentists in La Paz County<br>• UHCCP DD should continue to monitor and maintain its existing provider network coverage as of CYE 2022 Q4, with specific attention to ensuring the availability of the following provider types in Apache County:<br>– Behavioral Health Outpatient and Integrated Clinics, Adult and Pediatric<br>– Cardiologist, Adult and Pediatric<br>– Dentist, Pediatric<br>– Pharmacy |

[11-15] Health Services Advisory Group. Arizona Health Care Cost Containment System: Contract Year Ending 2022 External Quality Review Annual Technical Report for Arizona Long Term Care System. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2022/CYE2022ExternalQualityReviewAnnualReportEPDandDDD.pdf. Accessed on: Feb 8, 2024.

| Prior Year's Recommendation from the EQR Technical Report for NAV |
|---|
| **DES/DDD's Response:**<br>DES/DDD's performance improvement team shared the EQR feedback and recommendations regarding provider network coverage gaps in Apache County with DES/DDD's Performance Improvement Monitoring (PIM) and Health Equity Committees identifying the gaps as potential health disparities for DES/DDD members. DES/DDD will continue to monitor the network coverage in these areas and partner with the subcontracted health plans to ensure efforts are made and effective in addressing these gaps.<br><br><u>Mercy Care</u><br>Mercy Care continues existing processes to ensure that the plan maintains compliance with the AHCCCS-required network coverage requirements.<br><br><u>UHCCP</u><br>UHCCP will continue to monitor and review the PAT file quarterly. Although UHCCP only submits biannually to the State of Arizona UHCCP runs the PAT process quarterly to ensure we have addressed any data discrepancies, as well as internal/external errors, and root cause analyses. In addition, UHCCP performs monthly reviews and audits of our provider data to ensure the highest level of accuracy is maintained.<br><br>UHCCP will continue to evaluate the contracted network quarterly. This includes a comprehensive review of those providers actively registered with the State regulator and not contracted with UHCCP along with any new providers that enter the county.<br><br>UHCCP's annual review of the minimum network adequacy shows that while we are not meeting the 90% standard requirement in Apache County, our adequacy for CYE 23 has improved per our semi-annual Q4 submission. UHCCP added two pharmacies to our network in CYE 23 and have confirmed all general dental providers serve members under the age of 21 years; however, they are not considered in our reporting due to their 22 specialty code.<br><br>UHCCP is meeting the minimum network standard in Coconino County with the telehealth modification. |
| **HSAG's Assessment:**<br>HSAG has determined that the DES/DDD has satisfactorily addressed these prior year's recommendations. |

# Appendix A. Methodology

*Appendix A. Methodology* presents, for each EQR activity:

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

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

## Validation of Performance Measures

### *Objectives*

Conducted in alignment with CMS' publication, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023,[A-1] the primary objectives of the PMV process were to:

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

### *Technical Methods of Data Collection*

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

- **Information Systems Capabilities Assessment Tool (ISCAT):** Contractors completed and submitted an ISCAT to address data collection and reporting specifics of their performance

[A-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 19, 2024.

measures. HSAG used the responses from the ISCAT to complete the pre-on-site assessment of information systems.

- **Source code (programming language) for performance measures:** Contractors calculated, or contracted with vendors to calculate, the non-HEDIS performance measures using source code and were required to submit the source code used to generate non-HEDIS performance measures being validated. HSAG completed a line-by-line review of the supplied source code to ensure compliance with the measure specifications required by AHCCCS. If NCQA Certified Measures[SM, A-2] vendors were used, HSAG reviewed a copy of the certified measures reports to confirm each measure's certification status. HSAG identified any areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any).
- **Medical record documentation:** Contractors submitted the following documentation for review: medical record hybrid tools and instructions, training materials for MRR staff, and policies and procedures outlining the processes for monitoring the accuracy of the reviews performed by the review staff.
- **Supporting documentation:** HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

**Pre-Review Activities:**

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

- **Define the scope of the validation**: HSAG worked with AHCCCS to identify the performance measures to be validated for each Contractor and to confirm all standardized measure specifications (e.g., sampling guidelines, eligible population criteria, and numerator and denominator identification). HSAG submitted final validated performance measure results in an agreed-upon AHCCCS-approved Microsoft (MS) Excel workbook format. HSAG provided AHCCCS with each Contractor's program-specific rate reporting template and provided AHCCCS with a consolidated view of the final validated rates as well. HSAG used Contractor-to-Contractor comparisons; comparisons to CY 2021 rates, where applicable; and comparisons to national Medicaid benchmarks, as reasonability checks.
  - A rate was considered materially biased and received a Do Not Report (DNR) designation if any identified error or errors impacted the performance measure rate by more than 5 percentage points.
  - For hybrid measure reporting, each Contractor's sampling and oversampling methodology was required to align with the measure steward's hybrid reporting specifications. If the Contractor used an oversampling rate greater than 20 percent, HSAG required the Contractor to provide

[A-2] NCQA Measure Certification[SM] is a service mark of the National Committee for Quality Assurance (NCQA).

evidence of NCQA approval. HSAG did not accept an oversampling rate greater than the established NCQA standard without the Contractor providing its evidence of NCQA approval.

  - HSAG followed CMS Protocol 2 in reviewing hybrid measures by conducting MRR validation of 30 records for at least two performance measures, across programs as applicable per Contractor, as selected by each Contractor's lead auditor.

- **Audit preparation**: HSAG confirmed the final scope of the audit with AHCCCS to ensure all written communication to the Contractors contained accurate information on the measures being reported. Upon obtaining AHCCCS' approval of the document request packet templates, HSAG prepared customized document request packets for each Contractor. The memorandum accompanying the packet provided details of the audit process and requirements, including:
  - The audit timeline
  - Information about virtual review scheduling
  - A list of all measures under the scope of the audit
  - The ISCAT to complete and reference to appropriate use of the HEDIS MY 2022 Record of Administration, Data Management, and Processes (Roadmap)
  - Information on source code review, as well as medical record review validation (MRRV) and supplemental database review, as applicable
  - Information on where and how to submit performance measure rates and required documentation
  - Next steps and whom to contact for additional information
- **Assess the integrity of the Contractor's information systems (IS)**: As part of the ISCAT, HSAG received detailed information regarding all data systems that feed into collecting and reporting performance measures, including patient data, provider data, claims/encounter data, survey data, and data integration processes.

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

If a Contractor had a recent (i.e., July 2022 or sooner) comprehensive, independent assessment of its IS as conducted during an NCQA HEDIS Compliance Audit, HSAG reviewed and assessed the Contractor's responses to NCQA's Roadmap and its associated attachments. Additionally, if the Contractor had not yet received its NCQA Medicaid Health Plan Accreditation but was working through a certified HEDIS Compliance Auditor specific to its Arizona Medicaid rates, HSAG accepted and reviewed the HEDIS Roadmap responses as applicable to the Contractor's Medicaid product.

- **Conduct detailed review of measures**: HSAG obtained from each Contractor the detailed source code and programming logic used to calculate each measure when NCQA Certified Measures vendors were not used. HSAG programmers, assigned according to familiarity and expertise with the programming language each Contractor used, conducted a detailed review of each line of code to

ensure strict compliance with measure specifications, identifying and estimating any potential bias, and identifying any necessary corrections. As part of this step, HSAG provided each Contractor with feedback on each measure selected for source code review. HSAG's source code reviewers conducted a line-by-line review to meet the following three objectives:

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

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

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

    - **Non-critical error**: Any finding that did not change the overall compliance of the member and resulted in no change to the overall rate. e.g., data entry errors, lab result date collected versus read by MD).
  - If errors were identified, a Contractor could be required to provide additional records for review, based on the auditor's request. Samples with errors exceeding 10 percent were determined to be materially biased, and HSAG reported the results to AHCCCS to consider adjusting the Contractor's reporting from hybrid to administrative in such instances (although none occurred during the CY 2021 PMV). Error rates less than 10 percent were evaluated for overall rate impact, and hybrid data collection would be allowed if the rate was not materially biased, based on an impact analysis.
- **Prepare for the contractor virtual audit**: HSAG worked with each Contractor to identify a date for the virtual audit that allowed for all appropriate Contractor staff to be present. Once the audit schedule was finalized, HSAG sent it to AHCCCS and coordinated for AHCCCS staff to observe audits based on AHCCCS' request. HSAG produced a detailed agenda for the virtual audit and worked with each Contractor to ensure the agenda timeline included appropriate staff in the sessions for which they are responsible. Before the date of the virtual audit, HSAG sent the agenda to the Contractor and to AHCCCS, if applicable.
  - Before the virtual audit, HSAG scheduled and facilitated a kick-off call with each Contractor to:
    - Discuss the audit logistics, including virtual review hosting preferences (i.e., Contractor or HSAG), key Contractor attendees, and potential vendor and/or subcontractor attendance if applicable.
    - Review the draft agenda.
    - Discuss any changes in the Contractor's processes or systems since the previous year's PMV audit.
    - Discuss the MRR process and timeline.
    - Discuss the timelines for ISCAT submission, use of the HEDIS Roadmap, identification of supplemental data, administrative rate review, preliminary rate review, and performance measure rate submission.
    - Remind the Contractor of the scope of the audit, including measures and primary source verification (PSV) processes.
    - Discuss supplemental databases.
    - Confirm the Contractor's vendor for certified measures, if applicable.
    - Address any Contractor questions or concerns.

**Virtual Site Review Activities:**

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

- **Opening meeting:** The opening meeting included an introduction of the validation team and key Contractor staff involved in the PMV activities. The review purpose, the required documentation, basic meeting logistics, and queries to be performed were discussed.
- **Review of ISCAT and Roadmap (if applicable) documentation:** This session was designed to be interactive with key Contractor staff so that the validation team could obtain a complete picture of all steps taken to generate responses to the ISCAT and evaluate the degree of compliance with written documentation. Additionally, to reduce the administrative burden on the Contractors, HSAG allowed submission of the same Roadmap used for the NCQA HEDIS Compliance Audit conducted by the Contractors' NCQA-licensed organizations, where appropriate and applicable as part of their ISCAT submissions. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and ascertained that written policies and procedures were used and followed in daily practice.
- **Evaluation of enrollment, eligibility, and claims systems and processes:** This evaluation included a review of the IS focusing on claims processing, enrollment and disenrollment data processing, and change tracking. The evaluation also encompassed a review of the Contractor's claims processing steps through its encounter data submissions to AHCCCS, reviewing for a general reconciliation. Throughout the evaluation, HSAG conducted interviews with key staff familiar with processing, monitoring, reporting, and calculating the performance measures. Key Contractor staff included executive leadership, enrollment specialists, claims processors, business analysts, customer operations staff, data analytics staff, and other front-line staff familiar with processing, monitoring, and generating the enrollment, eligibility, and claims performance measure data.
- **Overview of data integration and control procedures:** The overview included discussion and observation of source code logic, a review of how all data sources were combined, and a review of how the analytic file was produced for reporting selected performance measure data. HSAG performed PSV to further validate the output files and reviewed backup documentation on data integration. HSAG also addressed data control and security procedures during this session.
- **Primary source verification:** HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Each Contractor provided a listing of the data that it had reported to HSAG from which HSAG selected a sample. These data included numerator positive records for HEDIS and Core Set measures. HSAG selected a random sample from the submitted data and requested that the Contractor provide proof of service documents or system screen shots that allowed for validation against the source data in the system. These data were also reviewed live in the Contractor's systems during the virtual on-site review for verification, which provided the Contractor with an opportunity to explain its processes as needed for any exception processing or unique, case-specific nuances that may not impact final measure reporting. There may be instances in which a sample case is acceptable based on virtual on-site clarification and follow-up documentation provided by the Contractor.

  Using this technique, HSAG assessed the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across measures to verify that the Contractor had system documentation which supported that it appropriately included records for measure reporting. This technique did not rely on a specific number of cases for review to determine

compliance; rather, it was used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected could result in the selection of additional cases to better examine the extent of the issue and its impact on reporting.

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

## Description of Data Obtained

As identified in the CMS EQR Protocol, HSAG obtained and reviewed the following key types of data for CY 2022 as part of the PMV:

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

## How Data Were Aggregated and Analyzed

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

HSAG analyzed the quantitative results obtained from the above PMV activity to identify strengths and opportunities for improvement in each domain of Quality, Timeliness, and Access as they relate to

services furnished by each Contractor. HSAG then identified common themes and the salient patterns that emerged across Contractors related to the PMV activity conducted.

## How Conclusions Were Drawn

### Information Systems Standards Review

Contractors were required to demonstrate compliance with IS standards. Contractors' compliance with IS standards is linked to the validity and reliability of reported performance measure data. HSAG reviewed and evaluated all data sources to determine Contractor compliance with *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*.[A-3] The IS standards are as follows:

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

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

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

Based on all validation activities, HSAG determined results for each performance measure. According to the CMS EQR PMV protocol, the validation designation for each performance measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be noncompliant based on the review findings. Consequently, an error for a single audit element may result in a designation of "DNR" because the impact of the error biased the reported

[A-3] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington D.C.

performance measure by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, leading to a designation of "R."

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

## Performance Measure Results

Each Contractor's performance measure results for CY 2022 were compared to program-level aggregate rates, prior year's Contractor-specific performance, and NCQA's Quality Compass national Medicaid HMO mean for CY 2022, where applicable.

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

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

| Performance Measure | Quality | Timeliness | Access |
|---|---|---|---|
| **Maternal and Perinatal Care** | | | |
| *Prenatal and Postpartum Care—Postpartum Care* | ✓ | ✓ | ✓ |
| **Behavioral Health** | | | |
| *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* | ✓ | | |
| *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* | ✓ | | |
| *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* | ✓ | ✓ | ✓ |
| *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* | ✓ | ✓ | ✓ |
| *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* | ✓ | ✓ | ✓ |
| *Use of Opioids at High Dosage* | ✓ | | |
| *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total* and *Engagement of SUD Treatment—Total—Total* | ✓ | ✓ | ✓ |
| **Care of Acute and Chronic Conditions** | | | |
| *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* and *HbA1c Poor Control (>9.0%)* | ✓ | | |
| *Controlling High Blood Pressure* | ✓ | | |

| Performance Measure | Quality | Timeliness | Access |
|---|---|---|---|
| *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication* | ✓ | | |
| ***Pediatric Health*** | | | |
| *Child and Adolescent Well-Care Visits* | ✓ | | ✓ |
| *Developmental Screening in the First Three Years of Life* | ✓ | ✓ | ✓ |
| *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months* and *Well-Child Visits for Age 15 Months–30 Months* | ✓ | | ✓ |
| *Oral Evaluation, Dental Services* | | | ✓ |
| *Childhood Immunization Status—*<br>*Combination 3: diphtheria, tetanus and acellular pertussis [DTaP]; polio [IPV]; measles, mumps and rubella [MMR]; haemophilus influenza type B [HiB]; hepatitis B [HepB]; chicken pox [VZV]; pneumococcal conjugate [PCV]*<br>*Combination 7: DTaP, IPV, MMR, HiB, HepB, VZV, PCV, hepatitis A [HepA], rotavirus [RV]*<br>*Combination 10: DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV, influenza [flu]* | ✓ | | ✓ |
| *Immunizations for Adolescents—Combinations 1 (tetanus; diphtheria toxoids and acellular pertussis [Tdap]) and 2 (tetanus, Tdap, human papillomavirus [HPV])* | ✓ | | |
| *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing*, *Cholesterol Testing*, and *Blood Glucose and Cholesterol Testing* | ✓ | | |
| *Prenatal and Postpartum Care—Timeliness of Prenatal Care* | ✓ | ✓ | ✓ |
| **Preventive Screening** | | | |
| *Breast Cancer Screening* | ✓ | | |
| *Cervical Cancer Screening* | ✓ | | |
| **Appropriate Utilization of Services** | | | |
| *Ambulatory Care—ED Utilization**** | NA | NA | NA |
| *Plan All-Cause Readmissions* | ✓ | | |

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

# Validation of Performance Improvement Projects

## Objectives

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

The primary objective of PIP validation is to determine the validity and reliability of a PIP through assessing a Contractor's compliance with the requirements. For CY 2023, AHCCCS required Contractors to conduct PIPs in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i–iv). In accordance with §438.330(d)(2)(i–iv), each PIP must include:

- Measuring performance using objective quality indicators.
- Implementing system interventions to achieve improvement in quality.
- Evaluating effectiveness of the interventions.
- Planning and initiating activities for increasing and sustaining improvement.

The goal of HSAG's PIP validation is to ensure that AHCCCS and key stakeholders can have confidence that the Contractor executed a methodologically sound improvement project, and any reported improvement is related to and can be reasonably linked to the QI strategies and activities conducted by the Contractor during the PIP.

## Technical Methods of Data Collection

In its PIP evaluation and validation, HSAG used the CMS publication, Protocol 1: Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity, February 2023.[A-4] HSAG's evaluation of the PIP includes two key components of the QI process:

- HSAG evaluates the technical structure of the PIP to ensure that the Contractor designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling methods, performance indicator, and data collection methodology) is based on sound methodological

[A-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 31, 2024.

principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

- HSAG evaluates the implementation of the PIP. Once designed, a Contractor's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the Contractor improves its rates through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results).

HSAG used the *AHCCCS Performance Improvement Project (PIP) Report* which each Contractor completed and submitted to HSAG for review and validation. The *AHCCCS Performance Improvement Project (PIP) Report* standardizes the process for submitting information regarding PIPs and ensures alignment with the CMS protocol requirements.

HSAG, with AHCCCS's input and approval, developed a PIP Validation Tool to ensure a uniformed validation of the PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS protocols. The HSAG PIP Team consisted of, at a minimum, an analyst with expertise in statistics, PIP design and expertise in performance improvement processes and a clinician with expertise in performance improvement processes. The CMS protocol identifies nine steps that should be validated for each PIP.

The nine steps included in the PIP Validation Tool are listed below:

1. Review the Selected PIP Topic
2. Review the PIP Aim Statement
3. Review the Identified PIP Population
4. Review the Sampling Method
5. Review the Selected Performance Indicator(s)
6. Review the Data Collection Procedures
7. Review the Data Analysis and Interpretation of PIP Results
8. Assess the Improvement Strategies
9. Assess the Likelihood that Significant and Sustained Improvement Occurred

HSAG used the following methodology to evaluate PIPs conducted by the Contractors to determine PIP validity and to rate the compliance with CMS' protocol for conducting PIPs.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as "critical elements." For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall rating of *No Confidence* for the PIP. The Contractor is assigned two confidence levels, the overall confidence of adherence to acceptable methodology for all phases of the PIP and the overall confidence that the PIP achieved significant improvement.

In addition to the two overall confidence levels, HSAG assigns the PIP a percentage score for all evaluation elements (including critical elements) for each confidence level. HSAG calculates the percentage scores by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met* with *Not Assessed* and *Not Applicable* elements removed. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met* with *Not Assessed* and *Not Applicable* elements removed. HSAG assessed the PIP's results for the two confidence levels using the following methods.

**Confidence Levels for Acceptable PIP Methodology**

- *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
- *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
- *Low Confidence*: Low confidence in reported PIP results. There were 65 percent to 79 percent of all evaluation elements *Met* across all steps; or one or more critical evaluation elements were *Partially Met*.
- *No Confidence*: No confidence in reported PIP results. Less than 65 percent of all evaluation elements were *Met* across all steps; or one or more critical evaluation elements were *Not Met.*

**Confidence Levels for Significant Improvement**

- *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
- *Moderate Confidence*: To receive Moderate Confidence for significant improvement, one of the three scenarios below occurred:
  - All performance indicators demonstrated improvement over the baseline **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
  - All performance indicators demonstrated improvement over the baseline **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
  - Some but not all performance indicators demonstrated improvement over baseline **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
- *Low Confidence*: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
- *No Confidence*: The remeasurement methodology differed from the baseline methodology for all performance indicators **or** none of the performance indicators demonstrated improvement over the baseline.

The Contractors had the opportunity to receive initial PIP validation scores and detailed feedback, request technical assistance and guidance from HSAG, make any necessary corrections, and resubmit the PIP for final validation. HSAG forwarded the completed validation tools to AHCCCS and the Contractors.

## Description of Data Obtained

For the CY 2023 validation, the Contractors submitted baseline data for the *Prenatal and Postpartum Care* PIP and Remeasurement 1 data for the *Back to Basics*, *Breast Cancer Screening,* and *Preventive Screening* PIPs. Contractor-calculated indicator results, validated by the EQRO in alignment with CMS EQR Protocol 2, were utilized for PIP validation. The performance indicator measurement period dates for the PIPs are listed below.

Table A-2 presents the measurement periods for the *Back to Basics, Breast Cancer Screening,* and *Preventive Screening* PIPs.

**Table A-2—Measurement Periods for *Back to Basics, Breast Cancer Screening* and *Preventive Screening* PIPs**

| PIPs—*Back to Basics, Breast Cancer Screening,* and *Preventive Screening* | | | | |
|---|---|---|---|---|
| **CYE 2019** | **CY 2020** | **CY 2021** | **CY 2022** | **CY 2023** |
| Baseline Measurement (10/1/2018–09/30/2019) | Intervention Year 1 (01/01/2020–12/31/2020) | Intervention Year 2 (01/01/2021–12/31/2021) | Remeasurement Year 1 (01/01/2022–12/31/2022) | Remeasurement Year 2 (01/01/2023–12/31/2023) |

Table A-3 presents the measurement periods for the *Prenatal and Postpartum Care* PIP.

**Table A-3—Measurement Periods for *Prenatal and Postpartum Care* PIPs**

| PIP—*Prenatal and Postpartum Care* | | | |
|---|---|---|---|
| **CY 2022** | **CY 2023** | **CY 2024** | **CY 2025** |
| Baseline Measurement (01/01/2022-12/31/2022) | Intervention Year 1 (01/01/2023-12/31/2023) | Remeasurement Year 1 (01/01/2024-12/31/2024) | Remeasurement Year 2 (01/01/2025-12/31/2025) |

## How Data Were Aggregated and Analyzed

For PIPs, performance indicator data were aggregated and analyzed by AHCCCS. AHCCCS-mandated PIPs typically begin on a date that corresponds with a calendar year. Baseline data are collected and analyzed at the beginning of the PIP. During the Intervention Year, AHCCCS requires the Contractors to implement interventions to improve performance based on an evaluation of barriers to care/use of services and evidence-based approaches to improving performance. An intervention may consider any unique factors, such as a Contractor's membership, provider network, or geographic area(s) served.

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

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

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

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

## How Conclusions Were Drawn

HSAG validated the PIPs to ensure the Contractor used a sound methodology in its design, implementation, analysis, and reporting of the PIP's findings and outcomes. The process assesses the validation findings on the likely validity and reliability of the results by assigning two confidence ratings, one for overall methodological soundness of the PIP design and the second for significant improvement achieved. The confidence levels assigned to the two ratings were either *High Confidence, Moderate Confidence, Low Confidence,* or *No Confidence.*

To draw conclusions about the quality and timeliness of, and access to care and services provided by the Contractors, HSAG assigned each of the components reviewed for PIP validation to one or more of the three domains (i.e., Quality, Timeliness, and/or Access). While the focus of a Contractor's PIP may have been to improve performance related to healthcare Quality, Timeliness, or Access, PIP validation activities were designed to evaluate the validity and quality of the Contractor's process for conducting valid PIPs. Therefore, HSAG assigns all PIPs to the Quality domain. In addition, the PIP topic was also assigned to other domains as appropriate. This assignment to domains is shown in Table A-4.

**Table A-4—Assignment of PIPs to the Quality, Timeliness, and Access Domains**

| PIP | Quality | Timeliness | Access |
|---|---|---|---|
| *Back to Basics* | ✓ | ✓ | ✓ |
| *Breast Cancer Screening* | ✓ | | ✓ |

| PIP | Quality | Timeliness | Access |
|---|---|---|---|
| *Preventive Screening* | ✓ | | ✓ |
| *Prenatal and Postpartum Care* | ✓ | ✓ | ✓ |

# Compliance Review

## Objectives

AHCCCS' objectives for conducting compliance reviews are as follows:

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

## Technical Methods of Data Collection

AHCCCS conducts compliance reviews on a three-year cycle. During the first year of the compliance review cycle, AHCCCS conducts the compliance review of all standards. During the second and third year of the cycle, Contractors submit proposed CAPs and evidence of compliance to AHCCCS for approval.

To assess the Contractors' compliance with regulations, AHCCCS conducted the five activities described in CMS' EQR *Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care*

*Regulations,* February 2023.[A-5] Table A-5 describes the five protocol activities and the specific tasks that AHCCCS performed to complete each activity.

**Table A-5—Protocol Activities Performed for Assessment of Compliance with Regulations**

| For this protocol activity, | AHCCCS completed the following activities: |
|---|---|
| **Activity 1:** | **Establish Compliance Thresholds** |
| | • AHCCCS determined the timing and scope of the reviews, as well as scoring strategies.<br>• AHCCCS developed monitoring tools and templates, agendas, and set review dates.<br>• AHCCCS conducted training for all reviewers to ensure consistency in scoring across the Contractors. |
| **Activity 2:** | **Perform Preliminary Review** |
| | • AHCCCS notified the Contractors in writing of the request for desk review documents via email delivery of the compliance monitoring tool and an agenda. The desk review request included instructions for organizing and preparing the documents to be submitted.<br>• Prior to the review, the Contractors provided data files from which AHCCCS chose samples to be reviewed, including grievance, appeal, and denial cases. AHCCCS provided the final samples to the Contractors via AHCCCS' secure file transfer protocol (SFTP) site. Prior to the scheduled review, the Contractors provided documentation for the desk review, as requested.<br>• Examples of documents submitted for the desk review and compliance review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.<br>• The AHCCCS review team reviewed all documentation submitted prior to the scheduled webinar and prepared a request for further documentation, as needed, and an interview guide to use during the webinar. |
| **Activity 3:** | **Conduct the Review** |
| | • During the review, AHCCCS met with groups of the Contractors' key staff to obtain a complete picture of the Contractors' compliance with Medicaid and CHIP managed care regulations and contract requirements, explore any issues |

[A-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Jan 31, 2024.

| For this protocol activity, | AHCCCS completed the following activities: |
|---|---|
| | not fully addressed in the documents, and increase overall understanding of the Contractors' performance.<br>• AHCCCS requested, collected, and reviewed additional documents, as needed.<br>• At the close of the review, AHCCCS may provide the Contractors' staff with a high-level overview of how the overall review process went. |
| **Activity 4:** | **Compile and Analyze Findings** |
| | • AHCCCS used a compliance report template to compile the findings and incorporate information from the compliance review activities.<br>• AHCCCS analyzed the findings and calculated scores based on pre-determined scoring strategies.<br>• AHCCCS determined opportunities for improvement, recommendations, and corrective actions required based on the review findings. |
| **Activity 5:** | **Report Results** |
| | • AHCCCS populated the report template.<br>• AHCCCS submitted the draft report to the Contractors for review and comment.<br>• AHCCCS considered the Contractors' requests for reconsideration, as applicable, and finalized the report.<br>• AHCCCS included a CAP template with the final report for all requirements determined to be out of compliance with managed care regulations (i.e., received a score less than 95%).<br>• AHCCCS distributed the final report, scores, and CAP template to the Contractor. |

## *Description of Data Obtained*

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

- Committee meeting agendas, minutes, and reports
- Policies and procedures
- Management/monitoring reports
- Quarterly reports
- Provider manual and directory
- Member handbook and informational materials
- Staff training materials and documentation of training attendance
- Applicable correspondence or template communications

- Records or files related to administrative tasks (grievances and appeals)
- Interviews with the Contractors' key staff

## How Data Were Aggregated and Analyzed

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

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

AHCCCS included the following Focus Areas in its compliance review. Table A-6 includes a list of each Focus Area cross-walked with the related federal requirements found in 42 CFR Part 438.

**Table A-6—Crosswalk of AHCCCS Focus Areas and Federal Requirements**

| Focus Areas | Federal Requirements Included |
|---|---|
| CC | 438.242, 438.608, 438.610, 455.1, 455.17, 455.100–106, 455.436 |
| CIS | 433.135, 434.6, 438.242, 438.600 |
| CM* | 438.208, 438.240, 438.608, 440.70, 440.169, 440.180, 440.189, 441.18, 441.400, 441.468, 441.725, 441.730 |
| DS | 438.12, 438.102, 438.206, 438.207, 438.214, 438.242 |
| GA | 164.530, 438.3, 438.224 |
| GS | 438.10, 438.228^, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.420, 438.424 |
| MCH | 441.56, 441.58 |
| MM | 438.62, 438.114, 438.136, 438.208, 438.210, 438.228, 438.230, 438.236, 438.240, 438.330, 438.404, 456.125–133 |
| MI | 438.10, 438.100, 438.206, 438.207, 438.208, 438.406 |
| QM | 438.3, 438.66, 438.206, 438.214, 438.228, 438.230, 438.402, 438.406, 438.408, 438.416, 438.330, 479.98, 476.160 |
| QI | 438.330, 438.240, 438.242 |
| DGA** | This Focus Area reflects the Contractor's fulfillment of State requirements or regulations outside of CFR §438. |
| RI | This Focus Area reflects the Contractor's fulfillment of State requirements or regulations outside of CFR §438. |
| TPL | This Focus Area reflects the Contractor's fulfillment of State requirements or regulations outside of CFR §438. |

| Focus Areas | Federal Requirements Included |
|---|---|
| ISOC | This Focus Area reflects the Contractor's fulfillment of State requirements or regulations outside of CFR §438. |

*The CM Focus Area does not apply to ACC Program Contractors.
**The DGA Focus Area is only applicable to RBHA/ACC-RBHA Contractors.
^42 CFR §438.228: While not specifically cited in past compliance review tools, the State conducts random reviews of each Contractor, its providers, and subcontractors through its OR process to ensure that they are notifying members of adverse decisions and benefit implications when required in a timely manner. For additional clarity, this citation will be added to future review tools.

IS review is part of the PMV process for AHCCCS; therefore, there is no IS component in the compliance review. In addition to the PMV process, AHCCCS evaluates the Contractors' IS through ongoing monthly deliverables, encounter editing processes, and data validation processes. Further, as of CY 2020, AHCCCS transitioned to using Contractor-calculated performance measure rates that are validated by HSAG.

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

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

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

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

In years 2 and 3 of the compliance review cycle, AHCCCS reviews Contractors' proposed CAPs, and either approves or requests more information. Once approved, Contractors must provide AHCCCS with evidence of compliance. AHCCCS reviews the evidence of compliance, and if sufficient, accepts and closes the Contactor's CAP.

HSAG reviewed AHCCCS' assessment of CAPs and assigned a score of *Met, Partially Met, Not Met,* or *Not Applicable* for each Focus Area reviewed:

- *Not Applicable:* A CAP was not required as the score was 95% or greater.

- *Partially Met*: AHCCCS approved the Contractor's proposed CAP. The Contractor must submit evidence of compliance.
- *Met*: AHCCCS accepted and closed the Contractor's CAP.

## How Conclusions Were Drawn

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

Table A-7 depicts assignment of the standards to the domains of care.

**Table A-7—Assignment of Focus Areas to the Quality, Timeliness, and Access Domains**

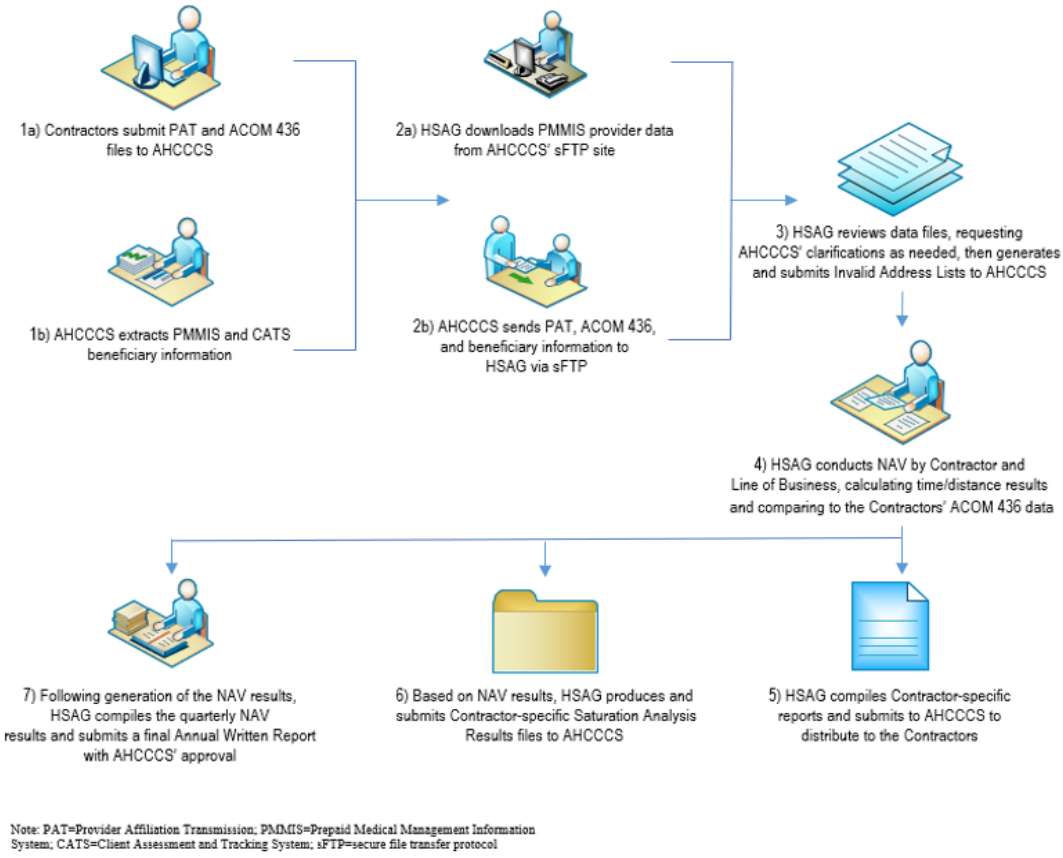
| Focus Areas | Quality | Timeliness | Access |
|---|---|---|---|
| CC | ✓ | | ✓ |
| CIS | | | ✓ |
| CM* | ✓ | | ✓ |
| DS | | ✓ | ✓ |
| GA | | ✓ | ✓ |
| GS | ✓ | ✓ | ✓ |
| MCH | | ✓ | ✓ |
| MM | ✓ | ✓ | ✓ |
| MI | ✓ | | |
| QM | ✓ | | |
| QI | ✓ | | ✓ |
| DGA** | ✓ | | |
| RI | ✓ | | |
| TPL | ✓ | ✓ | ✓ |
| ISOC | ✓ | | ✓ |

*The CM Focus Area does not apply to ACC Program Contractors.
**The DGA Focus Area is only applicable to RBHA/ACC-RBHA Contractors.

## Network Adequacy Validation

CYE 2023 is the fifth year in which AHCCCS contracted with HSAG to support semiannual analysis and validation of its Contractors' healthcare provider networks.[A-6] HSAG's semiannual NAV considered each Contractor's compliance with 11 AHCCCS-established time/distance standards and compliance with eight AHCCCS-established time/distance standards during the CYE 2023 measurement period.[A-7] Figure A-1 summarizes the semiannual network adequacy data process and reporting products.

**Figure A-1—CYE 2023 Semiannual Network Adequacy Validation Process**




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

[A-6] Validation of network adequacy is a mandatory EQR activity, and states must begin conducting this activity, described in CMS rule 438.358(b)(1)(iv), no later than one year from the issuance of the associated EQR protocol. CMS has published this protocol as of February 2023. The validation of the Contractors' time/distance results, as described in this methodology, aligns with current federal regulations and will help prepare AHCCCS to meet the NAV requirements once the provisions go into effect in CYE 2024.

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

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

## Objectives

The NAV activities were designed to align with the CMS protocol and helped prepare AHCCCS to meet the new NAV protocol requirements in CYE 2024. Table A-8 lists the Contractors that HSAG included in the CYE 2023 Validation of Managed Care Network Adequacy, as well as the programs and geographic region(s) associated with each Contractor. Each Contractor may serve members living in Arizona's Central, North, and/or South Geographic Service Areas (GSAs).[A-8]

**Table A-8—AHCCCS Contractors by Program and GSA, as of October 1, 2022**

| Contractor Name | Program and GSA | | | | |
|---|---|---|---|---|---|
| | ACC | ACC-RBHA | DCS CHP | ALTCS-EPD | ALTCS-DD |
| Arizona Complete Health–Complete Care Plan | Central<br>South | South | | | |
| Banner–University Family Care | Central<br>South | | | Central<br>South | |
| Care 1st Health Plan | North | North | | | |
| Health Choice Arizona | Central<br>North | | | | |
| Mercy Care | Central | Central | Statewide | Central<br>South (Pima Only) | Statewide |
| Molina Healthcare | Central | | | | |
| UnitedHealthcare Community Plan | Central<br>South (Pima Only) | | | Central<br>North | Statewide |

HSAG used data supplied by AHCCCS to calculate the percentage of members within a defined time or distance for all applicable AHCCCS-defined provider categories. As Table A-9 describes, these

[A-8] Maps showing the Arizona counties associated with the Central, North, and South GSA for the ACC, ACC-RBHA, and ALTCS Programs are available from AHCCCS at the following Internet locations:
- ACC regions: https://www.azahcccs.gov/AHCCCS/Downloads/Initiatives/ACC_Map_Web.pdf.
- ACC-RBHA regions: https://www.azahcccs.gov/img/BehavioralHealth/TribalWebMap.png.
- ALTCS regions: https://www.azahcccs.gov/Members/Downloads/ALTCS/ALTCSMap.pdf.

time/distance standards vary by provider type and county, and some standards may not apply to every Contractor or subcontracted health plan.

**Table A-9—Time/Distance Network Standards for AHCCCS Contractors by Provider Type and Geography**

| Provider Category | Member Population | Network Standard Maricopa and Pima Counties | Network Standard All Other Arizona Counties |
|---|---|---|---|
| Behavioral Health Outpatient and Integrated Clinic, Adult[5-6] | Members ages 18 years and older | 90 percent of members within 15 minutes or 10 miles | 90 percent of members within 60 miles |
| Behavioral Health Outpatient and Integrated Clinic, Pediatric[4-6] | Members younger than 18 years | 90 percent of members within 15 minutes or 10 miles | 90 percent of members within 60 miles |
| BHRF[1] | All members | 90 percent of members within 15 minutes or 10 miles | Not Applicable |
| Cardiologist, Adult[5-6] | Members ages 21 years and older | 90 percent of members within 30 minutes or 20 miles | 90 percent of members within 75 minutes or 60 miles |
| Cardiologist, Pediatric[6] | Members younger than 21 years | 90 percent of members within 60 minutes or 45 miles | 90 percent of members within 110 minutes or 100 miles |
| Crisis Stabilization Facility[2] | All members | 90 percent of members within 15 minutes or 10 miles | 90 percent of members within 45 miles |
| Dentist, Pediatric | Members younger than 21 years | 90 percent of members within 15 minutes or 10 miles | 90 percent of members within 40 minutes or 30 miles |
| Hospital | All members | 90 percent of members within 45 minutes or 30 miles | 90 percent of members within 95 minutes or 85 miles |
| Nursing Facility[3] | All members currently residing in their own home | 90 percent of members within 45 minutes or 30 miles | 90 percent of members within 95 minutes or 85 miles |
| OB/GYN | Female members ages 15 to 45 years | 90 percent of members within 45 minutes or 30 miles | 90 percent of members within 90 minutes or 75 miles |
| Pharmacy | All members | 90 percent of members within 12 minutes or 8 miles | 90 percent of members within 40 minutes or 30 miles |
| PCP, Adult[5-6] | Members ages 21 years and older | 90 percent of members within 15 minutes or 10 miles | 90 percent of members within 40 minutes or 30 miles |
| PCP, Pediatric[6] | Members younger than 21 years | 90 percent of members within 15 minutes or 10 miles | 90 percent of members within 40 minutes or 30 miles |

1. Applies only to Maricopa and Pima counties.
2. Applies only to ACC-RBHA Contractors.
3. Applies only to ALTCS-EPD Contractors.
4. Applies to all contractors except ACC-RBHA Contractors.
5. Calculations for DCS CHP will not include standards applicable only to adults (i.e., Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult; or PCP, Adult).
6. Services identified as eligible for a telehealth standard modification only require 80 percent of a county's membership to meet the time and distance standards where telehealth services are available for that provider category

## Technical Methods of Data Collection

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

1. **Time/Distance Calculation**: HSAG's calculation of results for all applicable AHCCCS-established time/distance standards by Contractor, program, and county, using member and PAT data.
   - Study indicators show the percentage of members assigned by AHCCCS to the specified county, with access to any provider location serving the program within the time/distance standard.
2. **Time/Distance Validation**: Validation of each Contractor's compliance with the time/distance standards, based on HSAG's time/distance calculation results from #1 above.
   - Study indicators validate each Contractor's reported compliance with each time/distance standard applicable to the program and county. Scoring is as follows:
     - A score of *Met* indicates that HSAG's time/distance results show a percentage of members at or above the time/distance standard.
     - A score of *Not Met* indicates that HSAG's time/distance results show a percentage of members below the time/distance standard.
     - An asterisk (*) identifies standards with fewer than 10 members included in HSAG's time/distance calculation results.
     - The value "NA" identifies standards not applicable to the program and/or geography.
     - The value "NR" identifies standards for which no members met the network requirement denominator for the program and geography; therefore, HSAG calculated no corresponding time/distance result.
   - Study indicators also consider the degree to which HSAG's time/distance results align with the time/distance values reported in each Contractor's ACOM 436 submission.
     - Shaded cells in the Findings tables identify notable differences between each Contractor's ACOM 436 time/distance calculation results and HSAG's results.
3. **Provider Saturation Analysis**: HSAG's assessment of the degree to which each Contractor's provider network reflects available AHCCCS-contracted providers.
   - Study indicators include the number of AHCCCS-contracted provider locations not reflected in each Contractor's semiannual PAT file for each applicable time/distance standard scored as *Not Met.*

## Description of Data Obtained

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

- Prepaid Medical Management Information System (PMMIS) provider data—Data files maintained by AHCCCS that list all AHCCCS-contracted providers and their corresponding addresses.

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

Table A-10 shows the effective dates for the data files supplied to HSAG in each measurement period.

**Table A-10—Effective Dates for AHCCCS-Supplied Network Adequacy Data by Quarter and Data Type**

| Data Source | CYE 2023 Q2 | CYE 2023 Q4 |
|---|---|---|
| Measurement Period | May 2023 | November 2023 |
| PMMIS Providers | May 2023 | November 2023 |
| AHCCCS Members | May 2023 | November 2023 |
| Contractor-Specific PAT Providers | May 2023 | November 2023 |
| Contractor-Specific ACOM 436 Submissions | May 2023 | November 2023 |

## *How Data Were Aggregated and Analyzed*

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

HSAG assembled the geocoded member (PMMIS) and provider (PAT) addresses into datasets that were used with Quest to calculate the percentage of members meeting the time/distance standards described in Table A-9. Semiannual county-specific time/distance calculations were conducted separately for each program and excluded less than 1 percent of members and providers with addresses that could not be geocoded or were geocoded to non-neighboring states. HSAG's time/distance calculations considered the driving time/distance between a member and the nearest provider location (i.e., the time or distance for the member to reach the provider using established roadways). Driving time calculations assumed 30 miles per hour (MPH) for Maricopa and Pima counties and 55 MPH for all other counties.

## How Conclusions Were Drawn

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

Semiannual analyses reflect the following measurement periods:

- CYE 2023 Q2: January 1–March 31, 2023
- CYE 2023 Q4: July 1–September 30, 2023

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

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

HSAG deemed that all NAV activities were related to the Access domain of care.

## Analytic Considerations

AHCCCS does not define the software or process by which each Contractor calculates the semiannual ACOM 436 time/distance results. HSAG uses Quest to calculate time/distance results based on driving distances, and additional discrepancies may result if Contractors use different versions of Quest during each of the different data network validations.[A-9] As of June 2023, each Contractor's self-reported method for calculating the ACOM 436 results was based on driving distances using Quest version 2022.4.

AHCCCS members may seek care from network providers practicing outside of the member's county of residence. As such, HSAG considered all applicable provider locations within a program when calculating time/distance results. This section presents, by program, the semiannual validation results for

[A-9] AHCCCS' member address data may not always reflect a member's place of residence (e.g., use of post office boxes) or be identifiable with mapping software (e.g., addresses reflecting local place designations, rather than street addresses). While mapping software may assign members to geographic coordinates, these coordinates may not align with the member's exact residential location for records that do not use a standard street address.

Contractors' county-specific time/distance network standards. However, HSAG's time/distance calculations included all available provider locations noted in Contractors' PAT data files, without considering potential barriers to new patient acceptance or appointment availability at individual provider locations.

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

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

## Consumer Assessment of Healthcare Providers and Systems Results

### *Objectives*

The overarching objective of the KidsCare and Statewide CAHPS surveys was to effectively and efficiently obtain information and gain understanding about adult members and parents'/caretakers' of child patients experience with healthcare. These surveys cover topics important to members, such as communication skills of providers and accessibility of services.

### *Technical Methods of Data Collection*

To support the reliability and validity of the findings, standardized sampling and data collection procedures were followed for member selection and survey distribution. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data.

The technical method of data collection for the KidsCare Program and DCS CHP was through the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set (with the children with chronic conditions [CCC] measurement set). Child members included as eligible for the surveys were 18 years of age or younger (less than 19 years of age) as of December 31, 2022, for the KidsCare Program, and child members included as eligible for surveys were 17 years of age or younger (less than 18 years of age) as of December 31, 2022, for DCS CHP. Parents/caretakers of child members

as part of the KidsCare Program completed the surveys from April to June 2023. Parents/caretakers of child members as part of DCS CHP completed the surveys from May to August 2023. The technical method of data collection for the adult population as part of the ACC Program was the CAHPS 5.1 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set. Adult members included as eligible for surveys were 18 years of age or older as of December 31, 2022. Adult members completed surveys from May to August 2023.

An English or Spanish version of the cover letter was mailed to adult members and parents/caretakers of all sampled child members that provided two options by which they could complete the survey: (1) complete the paper-based survey and return it using the pre-addressed, postage-paid return envelope, or (2) complete the web-based survey through the survey website with a designated login. The cover letters included a toll-free number that adult members and parents/caretakers could call to request a survey in another language (i.e., English or Spanish). A reminder postcard was sent to all non-respondents, followed by a second survey mailing and a second reminder postcard. Finally, a third survey mailing was sent to all non-respondents.

The surveys included a set of standardized items (76 items for the CAHPS 5.1 Child Medicaid Health Plan Survey that yield 14 measures of member experience and 40 items for the CAHPS 5.1 Adult Medicaid Health Plan Survey with the HEDIS supplemental item that yield 12 measures of member experience) that assess respondents' perspectives on care. These measures included four global ratings, four composite scores, one individual item measure, three Medical Assistance With Smoking and Tobacco Use Cessation items (adult population only), and five CCC composites/items (CCC population only). The global ratings reflected respondents' overall experience with their/their child's health plan, health care, personal doctors, and specialists. The composite scores were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *Getting Care Quickly*). The individual item measure is an individual question that looked at coordination of care. The Medical Assistance With Smoking and Tobacco Use Cessation items assess the various aspects of providing medical assistance with smoking and tobacco use cessation for the adult population. The CCC composites and items are sets of questions and individual questions that looked at different aspects of care for the CCC population (e.g., *Access to Prescription Medicines* or *Access to Specialized Services*). If a minimum of 100 respondents for a measure was not achieved, the result of the measure was denoted with a cross (+).

## Description of Data Obtained

HSAG aggregated data from survey respondents into a database for analysis. Results of the CAHPS surveys are found in Section 4. ACC (Non-SMI-Designated Population) Program-Level Comparative Results and Section 8. DCS CHP Program Results.

For each of the four composite measures, individual item measure, and CCC composites/items, the percentage of respondents who chose a positive or top-box response was calculated. Response choices for the CAHPS composite questions, individual item, and CCC composites/items in the child Medicaid surveys were: (1) "Never," "Sometimes," "Usually," and "Always" and (2) "Yes" and "No." A positive

or top-box response for these measures was defined as a response of (1) "Usually" or "Always" and (2) "Yes." For the three Medical Assistance With Smoking and Tobacco Use Cessation items, the percentages of smokers or tobacco users who were advised to quit, were recommended cessation medications, and were provided cessation methods or strategies were calculated. Response choices of the CAHPS Medical Assistance With Smoking and Tobacco Use Cessation items in the adult Medicaid survey were "Sometimes," "Usually," and "Always," which were used to determine if the member qualified for inclusion in the numerator. The scores presented deviate from NCQA's methodology of calculating a rolling average using the current and prior years' results since only the current year's results were available.

## How Data Were Aggregated and Analyzed

HSAG performed comparisons of the results to NCQA's Quality Compass Benchmark and Compare Quality Data to derive the overall member experience ratings.[A-10] Ratings of one (★) to five (★★★★★) stars were determined for each measure using the percentile distributions shown in Table A-11.

**Table A-11—Percentile Distributions**

| Stars | Percentiles |
|---|---|
| ★★★★★ Excellent | At or above the 90th percentile |
| ★★★★ Very Good | At or between the 75th and 89th percentiles |
| ★★★ Good | At or between the 50th and 74th percentiles |
| ★★ Fair | At or between the 25th and 49th percentiles |
| ★ Poor | Below the 25th percentile |

Also, HSAG performed a trend analysis that compared the 2023 general child and CCC scores to their corresponding 2022 scores to determine whether there were statistically significant differences for the KidsCare Program. A *t*-test was performed to determine whether results in 2023 were statistically significantly different from results in 2022. A difference was considered statistically significant if the two-sided *p* value of the *t* test was less than or equal to 0.05. The two-sided *p* value of the *t* test is the probability of observing a test statistic as extreme as or more extreme than the one actually observed by chance. Scores that were statistically significantly higher in 2023 than in 2022 are noted with black upward (▲) triangles. Scores that were statistically significantly lower in 2023 than in 2022 are noted

[A-10] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2022.* Washington, DC: NCQA, September 2022.

with black downward (▼) triangles. Scores in 2023 that were not statistically significantly different from scores in 2022 are noted with a dash (—). A trend analysis was not performed for DCS CHP and the ACC Program since this was the first year these populations were surveyed.

### How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to services provided by the KidsCare Program, ACC Program, and DCS CHP, HSAG assigned each of the measures to one or more of the three domains (i.e., Quality, Timeliness, and/or Access). The assignment to domains is depicted in Table A-12.

**Table A-12—Assignment of CAHPS Measures to the Quality, Timeliness, and Access to Care Domains**

| CAHPS Topic | Quality | Timeliness | Access |
|---|---|---|---|
| *Rating of Health Plan* | ✓ | | |
| *Rating of All Health Care* | ✓ | | |
| *Rating of Specialist Seen Most Often* | ✓ | | |
| *Rating of Personal Doctor* | ✓ | | |
| *Getting Needed Care* | ✓ | | ✓ |
| *Getting Care Quickly* | ✓ | ✓ | |
| *How Well Doctors Communicate* | ✓ | | |
| *Customer Service* | ✓ | | |
| *Coordination of Care* | ✓ | | |
| *Advising Smokers and Tobacco Users to Quit* | ✓ | | |
| *Discussing Cessation Medications* | ✓ | | |
| *Discussing Cessation Strategies* | ✓ | | |
| *Access to Specialized Services* | ✓ | | ✓ |
| *FCC: Personal Doctor Who Knows Child* | ✓ | | |
| *Coordination of Care for Children with Chronic Conditions* | ✓ | | |
| *Access to Prescription Medicines* | ✓ | | ✓ |
| *FCC: Getting Needed Information* | ✓ | | |

## Aggregating and Analyzing Program-Level Data

HSAG follows a four-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the quality and timeliness of, and access to care furnished by each Contractor, as well as the program overall. To produce AHCCCS' Annual Technical Reports, HSAG performed the

following steps to analyze the data obtained and draw program-level conclusions about the quality and timeliness of, and access to care and services provided by the Contractors:

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

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

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

**Step 4:** HSAG identified any patterns and commonalities that exist across the program to draw conclusions about the quality and timeliness of, and access to care for the program.

# Appendix B. Acknowledgements and Copyrights

CAHPS® refers to the Consumer Assessment of Healthcare Providers and Systems and is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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