Demonstration Title:	Arizona Health Care Cost Containments System –AHCCCS, A Statewide Approach of Cost Effective Health Care Financing
Demonstration Start Date:	October 22, 2011
Demonstration End Date:	September 30, 2016

I. INTRODUCTION

Since the inception of its Medicaid program in 1982, the Arizona Health Care Containment System (AHCCCS), the State of Arizona has the unique distinction of operating under a statewide, managed care 1115 Research and Demonstration Waiver. During its 30 years of operation, the program has proven to be an effective model for the delivery of high quality and cost effective health care services to low income populations.

Under the new five-year waiver demonstration, the State will continue to operate the AHCCCS program efficiently while further enhancing the program. The State will test how mandatory copay requirements for the adults without dependent children population affects utilization of needed preventive, primary care, and treatment services. The State will also measure how a pharmacy copayment affects appropriate utilization of cost and clinically effective generic and brand name drugs. The State will also measure how the application of mandatory copays related to non-emergent use of emergency rooms will ensure appropriate use of emergency room services. The State will evaluate whether there is an impact on physician participation, or physician willingness to accept appointments from the adults without dependent children population because of the mandatory copay requirement.

AHCCCS will continue to provide medical assistance for adults without children who were enrolled in AHCCCS under the Demonstration waiver through the Employer Sponsored Insurance (ESI) Program. The State will measure the number of individuals approved for ESI premium subsidies annually.

Under the new Demonstration, the State will test how providing family planning and family planning-related services for up to 24 months to women losing Medicaid pregnancy coverage at the conclusion of their 60-day postpartum period effects utilization of family planning services. The rate of utilization of family planning services in the Family Planning Extension Program should increase as members are enrolled in the program.

AHCCCS will also test the effect of mandatory copays for non-emergency medical transportation to medically necessary services for Childless Adults counties in Maricopa and Pima Counties. The State will evaluate whether imposing copays for transportation results in lower utilization of health care services. The goal is to assist members to take personal responsibility for their own healthcare and to offer a tool to providers to better manage their Medicaid clientele.

In an effort to increase member accountability and provider satisfaction during a period of decreased funding for the program, many providers have asked for the ability to seek relief from those individuals who miss their scheduled appointments. This is permitted for those who are uninsured and commercially insured as a matter of personal responsibility and respect for the health care provider's time. Accordingly, the State will test the effectiveness of penalties for missed appointments by permitting providers to charge a fee for adults outside of Maricopa and Pima counties who miss appointments. The goal of this waiver

authority is to assist members to take personal responsibility for their own healthcare and to offer a tool to providers to better manage their Medicaid clientele.

The State recognizes it will not benefit from any monetary savings. By allowing the same flexibilities providers have for beneficiaries enrolled in Medicare and with private insurance carriers, addressing the high rate of missed appointments promotes continued provider participation, especially during a time when provider rates are being reduced. Providers will be required to obtain express written acknowledgement from Medicaid enrollees prior to enforcing standard no-show charges for members who miss scheduled appointments or do not abide by provider cancellation policies. Also, as part of this effort, the State will explore opportunities to partner with the provider community and share best practices for reducing no shows among the Medicaid population. Already there are many community health centers that have reduced the rate of no-shows by changing the structure of appointment scheduling. AHCCCS will post "best practices" on its website to share these types of success stories.

The State, through its demonstration waiver, will limit the effects of State budget issues on Indian tribes and Indian Health Services (IHS). Through several consultation sessions with Tribes, it was determined that this fragile healthcare delivery system must be protected from State budget cuts so that Medicaid payments can be preserved and members retain an adequate health care infrastructure in their community. The objective of this waver authority is to ensure the viability of the IHS and 638 systems for the provision of care to American Indians. Avoiding this cost shift is particularly important since it is of no savings to the State because services provided to these facilities is 100 percent federally funded.

The demonstration will continue to preserve the core of the AHCCCS program as measured through various performance measures. Utilizing final reported rates for selected measures from the 2006 waiver evaluation as a baseline, AHCCCS will report the results of these measures at the end of the 2011 demonstration. Results will demonstrate the sustainability of high quality, cost effective care through a managed care Medicaid program. In order to evaluate the effectiveness and success of the demonstration and to identify future opportunities for improvement, the AHCCCS Administration will conduct an evaluation of the AHCCCS program. This evaluation will be designed to meet the waiver demonstration special terms and conditions, including testing specific hypotheses that evaluate the demonstration's impact on the following components:

1. The target populations within the Acute care, Arizona Long Term Care System (ALTCS), Children's Medical and Dental Program (CMDP), Children's Rehabilitative Services (CRS) and the behavioral health system.
2. The Family Planning Extension Program with a focus on utilization of family planning services.
3. The Employer Sponsored Insurance Program with a focus on the effects of providing premium assistance and maintaining enrollment in employer sponsored insurance programs.
4. The Childless Adult population with a specific focus on the effects of mandatory copayments on receipt of access to care, urgent and emergency room utilization and use of generic and brand name medications.
5. The Childless Adult population with a focus on differences in utilization patterns for routine care and emergency room services related to imposition of mandatory copays for transportation in Maricopa and Pima counties.
6. The experience of providers who implement missed appointment charges related to provider and member satisfaction, patient panel retention, and best practices for reducing the no show rate.
7. The viability of I.H.S. and 638 facilities with a focus on staff to facility ratios.

The purpose of this document is to present AHCCCS' proposed waiver evaluation plan design for the components listed above. In designing this evaluation plan, AHCCCS relied heavily on the guidance contained in the September 2006 - *CMS Evaluating Demonstrations: A Technical Assistance Guide for*

States. AHCCCS has also ensured that the draft evaluation plan addresses all of the specific evaluation design requirements contained in the special terms and conditions - *Section VII. Evaluation*, e.g. discussion of specific hypotheses, outcome measures and detailed analysis plan.

II. BACKGROUND INFORMATION ON DEMONSTRATION

Brief History

Arizona, which was the last state to have a Medicaid program, implemented AHCCCS as a Medicaid Section 1115 demonstration program in 1982. The demonstration program initially focused only on the delivery of acute care services to Medicaid eligibles. Over time the demonstration has been expanded to cover other population groups such as the CHIP population, as well as other Medicaid covered services including long term care and behavioral health services. Throughout all the expansions, the AHCCCS core service delivery model has remained the same – the utilization of a managed care model to deliver high quality health care to Arizonans. A brief history of this demonstration is provided below.

The initial demonstration waiver allowed Arizona to operate a statewide managed care system that covered only acute care services and 90 days post-hospital skilled nursing facility coverage. This program continues to operate under the demonstration today and is referred to as the AHCCCS acute care program. All eligible Medicaid and CHIP members (the two exceptions being American Indians and later individuals who receive services through federal emergency services program) are required to enroll in an AHCCCS-contracted health plan for acute care services. AHCCCS makes prospective capitation payments to acute health plans for each enrolled member. As part of the AHCCCS acute care program, AHCCCS established two special programs to serve children with special needs. The first is the Comprehensive Medical and Dental Program (CMDP) that provides health care services to Arizona's children in foster care under a capitation arrangement with AHCCCS. The second is the Children's Rehabilitative Services (CRS) program that provides specified services to children with certain medical, handicapping or potentially handicapping conditions. The CRS program provides a multi-specialty interdisciplinary team approach to care focused on the special health care needs of children with special health care needs.

Six years after the initial program implementation, the original demonstration waiver was substantially amended to allow Arizona to implement a capitated long term care program for the elderly and physically disabled and the developmentally disabled population – the Arizona Long Term Care System (ALTCS). The ALTCS program, administered as a distinct program from the AHCCCS acute care program, provides acute, long term care and behavioral health services to Medicaid eligible that are at risk of institutionalization. The program strives to maintain its members in the community by covering the delivery of a wide array of home and community based services.

In October 1990, AHCCCS began to cover comprehensive behavioral health services. These services were phased in over a five year period, beginning with children who had seriously emotionally disabling conditions. While behavioral health services are integrated as part of the benefit package for the ALTCS program, the services are carved out for members in the AHCCCS acute care program and are managed by the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (DBHS). ADHS/DBHS has capitated managed care contracts with behavioral health organizations, referred to as Regional Behavioral Health Authorities or RBHAs that are responsible for delivering behavioral health services to AHCCCS acute care members.

Subsequent to the program service expansions, two major population groups were added to the program, including:

- Title XXI CHIP (referred to as KidsCare in Arizona) members in 1998. The KidsCare program has been implemented as a stand-alone CHIP program and includes children under the age of 19 whose family income is below 200 percent of the federal poverty level (FPL).

- Arizona voter approved Proposition 204 in 2001. This expansion group was approved by CMS as part of the AHCCCS 1115 waiver demonstration, and covers individuals whose income is below 100 percent of FPL, including adults without dependent children and traditional Temporary Assistance for Needy Families and the Social Security Income populations.

These additional population groups receive services through the AHCCCS acute health plans and ADHS/DBHS behavioral health organizations (i.e., RBHAs).

Since the 2006 waiver demonstration approval by CMS, and particularly beginning in 2008, the country has experienced a significant recession. The recession has had far reaching and lasting effects on Arizona's economy. According the Arizona Office of Employment and Population's reporting of statewide unemployment statistics, Arizona's unemployment rate was 9.7 percent in February 2011. Prior to the beginning of the recession, Arizona's unemployment rate was at 3.6 percent. Although it is expected that Arizona will have a slow and steady increase in employment, even the most optimistic forecast for job growth in 2012 predicts the number of people working in Arizona by the end of the year (2012) will be about 250,000 below when the economy peaked in 2007. Another factor influencing the unemployment rate is population mobility, the ease with which residents can move to new opportunities. Population mobility in Arizona is the lowest it has been since 1948. These employment conditions have resulted in an increased number of members being served by the AHCCCS program.

Also during this time, AHCCCS reached a high of over 1.37 million members, including over 700,000 children. During the recession, Arizona added more than 300,000 new members to the AHCCCS program, a growth of nearly 30 percent. The rapid growth, coupled with revenue declines, placed a tremendous strain on Arizona's General Fund. All of these factors combined resulted in significant impacts to the AHCCCS program. First, AHCCCS found it necessary to make reductions in benefits and freezes in reimbursement rates to contracted health plans, hospitals, and other providers. Second, Agency resources were reduced to the lowest level in years. Thus, resources to be innovative and to be able to develop and implement new strategies focused on quality and system improvement and efficiencies were limited and focused on maintaining the core business requirements of the AHCCCS program.

The Arizona legislature made cuts of 21.7 percent to the AHCCCS budget for SFY 2012. This was the largest Medicaid reduction nationally, and was more than twice that of the next highest cut. To handle the reduction, AHCCCS has made the following large changes:

- Enrollment was reduced by eliminating or freezing membership for certain populations.
- Benefits were reduced or eliminated, including capping covered inpatient bed days for adults at 25 days annually.
- Rates for all providers were reduced by up to 15 percent.

Elimination of HIFA

AHCCCS eliminated the Health Insurance for Parents (HIFA) program on October 1, 2009. This program typically covered parents of KidsCare children who had income between 100 percent and 200 percent of the Federal Poverty Level (FPL). The state did not have enough funds to keep paying its portion of the program. This program was funded jointly by the state and federal government under Title XXI of the Social Security Act. Arizona notified CMS of this change as required by the Special Terms and Conditions of Arizona's 1115 Waiver, and the change was approved by CMS. AHCCCS also sent letters

to members to inform them of the program ending and provided information about other community health care resources.

KidsCare Wait List

Due to insufficient state funds available for the state match, and after obtaining approval from CMS, an enrollment freeze was placed on the CHIP (KidsCare) program effective January 1, 2010. The program began placing individuals on a waiting list at that time. New applications would not be processed until such time that AHCCCS would be able to verify that funding was sufficient to meet the requirements of the CHIP program. There is a limited enrollment of children onto the KidsCare II program through the Safety Net Care Pool program, which is part of the State's new 2011 demonstration.

Benefit Changes

In response to significant fiscal challenges facing the State and substantial recent growth in the Medicaid population, AHCCCS partnered with its acute care Contractors to review and provide preliminary recommendations to modify the acute care adult benefit package. As required by law, AHCCCS consulted with and received input from Arizona's tribes, Indian Health Service Area Offices, and tribal health programs.

The workgroup, which included physicians, medical economists, data experts, coders, policy staff, and an independent consultant from the Lewin Group, spent a significant amount of hours compiling, reviewing and validating utilization data and trends. Consideration was given to multiple options, and potential savings were calculated including offsets due to costs of avoidable alternative treatments and adverse outcomes. The process resulted in AHCCCS implementing several changes to the adult benefit package in fiscal year 2009.

Adult Benefit Eliminations:

- Dental services
- Services by a Podiatrist
- Insulin pumps
- Percussive vests
- Bone-anchored hearing aids
- Cochlear implants
- Orthotics
- Gastric bypass surgery
- Selected durable medical equipment
- Specified transplants
- Well exams
- Non-emergency medical transportation for limited populations

Adult Benefit Limitations:

- Non-emergency medical transportation (not available for waiver groups in Maricopa and Pima counties)
- Negative pressure wound therapy
- Somnography (limit to 1 study/year)
- Physical therapy (limit to 6 visits/year)
- Durable medical equipment (limit to Medicare covered items only)
- Prosthetics (limit non-implantable items to $12,500/year)
- Transplants (selected limitations)

Rate Reductions

Upon completing the appropriate access to care analysis, AHCCCS also implemented provider rate reductions for claims with dates of service between April 1, 2011 and September 30, 2011. Payments for the services listed below were reduced by 5 percent of the payment that would otherwise have been made under the methodology in effect as of October 1, 2010,

- Laboratory services
- Behavioral health services
- Physician services
- Dental services
- Transportation services
- FQHCs- subject to reconciliation to costs
- Clinic services
- Rural health clinic services
- Family planning services
- Nurse-midwife services
- Pediatric and family nurse practitioner services
- Other licensed practitioners
- Vision services
- Diagnostic, screening and preventive services
- Respiratory care services
- Other practitioner's services
- Physical therapy, occupational therapy, and speech therapy services
- Prosthetic devises
- Home health services to the extent that they include medical supplies, equipment and appliances suitable for use in the home.

Claims with dates of service between April 1, 2011 and September 30, 2011 for the following services were reduced by 2.5 percent of the payment that would otherwise have been made under the methodology in effect as of October 1, 2010:

- Home health services other than those home health items and services that are subject to the 5 percent reduction above.
- Private duty nursing services

The following payments were not subject to the 5 percent rate reduction:

- Pharmacy services
- EPSDT services
- Hospice
- Services provided by a participating local education agency
- Payments for services provided by the Indian Health Service or Tribal 638 health facilities that are claimed at 100 percent FMAP.

Copay Implementation

AHCCCS through a State Plan Amendment (SPA), implemented cost sharing for certain populations as authorized under the Deficit Reduction Act (DRA) (§§ 1916 and 1916A of the Social Security Act) as of July 1, 2010. Women on Medicaid by virtue of the Breast and Cervical Cancer Treatment Program were exempt from the population in which alternative co-payments were allowed under the DRA.

Arizona's 2006 demonstration expired on September 30, 2011. This resulted in AHCCS submitting a new 1115 Waiver Demonstration Proposal on March 31, 2011 which received final approval from CMS

on October 21, 2011. The new AHCCCS waiver demonstration will be in place for five years and allows AHCCCS to: 1) operate its managed care model by providing authority related to Medicaid managed care requirements regarding choice of coverage, disenrollment and reenrollment policies; 2) implement mandatory copays for the Childless Adult population; 3) allow providers to charge copays for missed appointments; and 4) provides supplemental payments to I.H.S. and 638 facilities for uncompensated care related to restrictions made to the AHCCCS program.

Demonstration Goals

The primary goal of the AHCCCS demonstration waiver is to provide, through the employment of managed care models, quality health care services to all Medicaid and CHIP eligible members in Arizona while at the same time deliver care in a cost effective manner. Specific goals of this managed care demonstration as detailed in the Section 1115 waiver include:

- Providing quality health care to members in a mainstream environment
- Ensuring access to care for members
- Maintaining or improving member satisfaction with care and services
- Maintaining a cost effective program while at the same time providing fair reimbursement to providers

In addition, and as mentioned above, AHCCCS seeks to create additional efficiencies through the: 1) implementation of mandatory copays for the Childless Adult population aimed at encouraging appropriate utilization of service; 2) implementation of missed appointment fees in efforts to promote member self-responsibility and increase provider satisfaction and retention; and 3) limit the effects of State budget issues on Indian Health Services and tribally operated 638 facilities.

Hypotheses and Objectives on Outcomes of Demonstration

Over the past 30 years, the AHCCCS demonstration has been evaluated by federal agencies, including the United States Government Accountability Office (GAO), private firms, and contractors hired by CMS. Reports have been positive and have praised various components of the program, including the quality of care and the overall cost-effectiveness when compared with traditional fee-for-service (FFS) programs in other states.

In developing the evaluation plan for the State's new waiver demonstration, AHCCCS is proposing to test a series of hypotheses that will allow the state to: 1) evaluate its success in achieving its overall demonstration goals as well as those associated with the implementation of new programs; 2) identify opportunities for improvement to strengthen the demonstration; and 3) meet the requirements of the waiver special terms and conditions (STCs). In addition, the hypotheses have been developed around eight key areas of the demonstration program:

1. AHCCCS acute care program
2. ALTCS program
3. Family Planning Extension Program
4. Employer Sponsored Insurance (ESI)
5. Special plans for individuals with special needs (CMDP, DBHS and CRS)
6. Mandatory copays for Adults Without Dependent Children
7. Missed appointment fees for Childless Adults and TANF Parents
8. Payments to I.H.S. and 638 facilities

For the Acute care program the following hypothesis and associated objectives will be tested:

- Quality of care for AHCCCS Acute care program members enrolled in AHCCCS Acute health plans will improve over the waiver demonstration period as it relates to:
    - Receipt of medically necessary covered services;
        - Childhood immunization rates will increase
        - Adolescent immunization rates will increase
        - EPSDT participation rates will increase
        - Annual dental visit rates will increase
        - Well child visits during the first 15 months of life will increase
        - Well child visits for 3, 4, 5 and 6 year olds who have at least one visit will increase
        - Adolescent well care visits will increase
        - Children's access to PCPs will increase
        - Influenza vaccinations in older adults will increase
        - Timeliness of prenatal care will increase
    - Management of chronic conditions; and
        - HbA1d and LDL screenings will increase for members diagnosed with diabetes
        - Long-term asthma control medication use for members diagnosed with asthma will increase
    - Mitigation of health disparities among ethnic populations
        - Performance measure results will indicate a reduction in disparities among ethnic populations
- Member satisfaction in the Acute care program for members enrolled in AHCCCS Acute health plans will improve over the waiver demonstration period.
- Access to medical care for AHCCCS Acute care program members enrolled in both rural- and urban-based acute plans will improve over the waiver demonstration period as demonstrated by:
    - A reduction in readmissions
    - A reduction in inpatient stays
    - Emergency department (ED) utilization will decrease
    - PCP participation in the AHCCCS program will not be adversely affected as a result of rate cuts
    - The number of providers terminating due to rate cuts will not be significant
- The AHCCCS Acute care program will continue to operate as a cost-effective delivery model
    - The AHCCCS program will operate within predicted budgetary expectations

For the ALTCS program the following hypothesis and associated objectives will be tested:

- Quality of care for AHCCCS ALTCS program members enrolled in AHCCCS EPD and DDD health plans will improve over the waiver demonstration period as it relates to:
    - Receipt of covered services;
        - Immunization rates will increase
        - EPSDT participation rates will increase
        - Annual dental visit rates will increase

        - Children ages 3, 4, 5 and 6 years of age who have at least one well child visit will increase
        - Adolescents ages 12 through 21 years of age who have one well care visit will increase
        - Influenza vaccinations for older adults will increase
    - Management of chronic conditions.

- Access to care for AHCCCS ALTCS Program members enrolled in EPD and DDD health plans will improve over the demonstration period as evidenced by:
    - A reduction in readmissions
    - A reduction in inpatient stays
    - Stability of provider network
        - The number of providers participating in the AHCCCS program will not be adversely affected due to rate cuts
- The AHCCCS ALTCS program will continue to operate as a cost effective service delivery model during the waiver demonstration period as demonstrated by:
    - The AHCCCS program will operate within predicted budgetary expectations
- Quality of life for ALTCS members (EPD and DDD) who reside in a home and community based setting will improve over the waiver demonstration period as demonstrated by.
    - The percentage of ALTCS members residing in a home and community based setting will be maintained above 80 percent
    - An increase in the number of direct care workers with documentation of qualified training
    - Member satisfaction survey results will indicate a high degree of satisfaction with quality of life indicators
    - An increase in the number of ALTCS members that reside in a home and community based setting
    - An increase in the percentage of ALTCS members utilizing either Self-Directed Attendant Care or Agency with Choice

For the Special Plans for Individuals with Special Needs the following hypothesis and associated objectives will be tested:

- Quality of care for AHCCCS acute care program members enrolled in Special Plans for Individuals with Special Needs will improve over the waiver demonstration period as it relates to receipt of covered services:
    - Immunization rates will increase for children enrolled in the CMDP program
    - EPSDT participation rates will increase for children enrolled in the CMDP program
    - Annual dental visit rates will increase for children enrolled in the CMDP program
    - The rate at which children 3, 4, 5 and 6 years of age receive at least one well child visit will increase for children enrolled in the CMDP program
    - The rate of members ages 12 through 18 years of age who had at least one well-care visit will increase for children enrolled in the CMDP program
    - Children's access to PCPs will increase for children enrolled in the CMDP program

- Access to medical care for AHCCCS acute care program members enrolled in Special Plans for Individuals with Special Needs will improve over the waiver demonstration period as demonstrated by:
    - A reduction in readmissions within 30 days of discharge from a behavioral health inpatient stay
    - Emergency department (ED) utilization for the primary reason of a behavioral health condition will decrease
    - Timeliness of the first CRS appointment will improve
    - The rate at which members receiving behavioral health services have a routine appointment within 23 days of the initial assessment will increase

- Member satisfaction in Special Plans for Individuals with Special Needs will improve over the waiver demonstration period.
    - Member satisfaction survey results will indicate a high degree of satisfaction with the behavioral health program
    - Member satisfaction survey results will indicate a high degree of satisfaction with the CRS program

- The AHCCCS program Special Plans for Individuals with Special Needs will continue to operate as a cost effective service delivery model
    - The AHCCCS program will operate within predicted budgetary expectations for the CMDP program
    - The AHCCCS program will operate within predicted budgetary expectations for the Behavioral Health program
    - The AHCCCS program will operate within predicted budgetary expectations for the Children's Rehabilitative Services program

For the CHIP (KidsCare) Demonstration the following hypothesis and associated objectives will be tested:

- Quality of care for members enrolled in AHCCCS KidsCare program will improve over the waiver demonstration period as it relates to:
    - Receipt of medically necessary covered services;
        - Childhood immunization rates will increase
        - Adolescent immunization rates will increase
        - EPSDT participation rates will increase
        - Annual dental visit rates will increase
        - Well child visits during the first 15 months of life will increase
        - Well child visits for 3, 4, 5 and 6 year olds who have at least one visit will increase
        - Adolescent well care visits will increase
        - Children's access to PCPs will increase

- Member satisfaction in the KidsCare program will improve over the waiver demonstration period

- Access to medical care for KidsCare members enrolled in both rural- and urban-based acute plans will improve over the waiver demonstration period as demonstrated by:
    - A reduction in readmissions
    - A reduction in inpatient stays
    - Emergency department (ED) utilization will decrease

For the Family Planning Extension Program Demonstration the following hypothesis and associated objectives will be tested:

- Access to family planning services for members enrolled in the Family Planning Demonstration Program will be maintained over the waiver demonstration period as demonstrated by:
    - The utilization rate of family planning services for women enrolled in the Family Planning Extension Program will be maintained or increase

For the Cost Sharing, Mandatory Copays for Childless Adults the following hypothesis and associated objectives will be tested:

- Quality of Care: Implementing mandatory copays on the Childless Adult population will improve use of services related to chronic disease management and brand and generic medication selection
    - The relative use of office visits for ongoing asthma care for Adults Without Dependent Children will be similar to that of TANF Adults
    - The relative use of office visits for ongoing diabetes care for Adults Without Dependent Children will be similar to that of TANF Adults
    - The relative use of brand name medications by Adults Without Dependent Children will not change as a result of implementation of mandatory copayment

- Access to Care: The implementation of mandatory copays on the Childless Adult population will not result in an increase in the use of the emergency room.
    - The relative use of inpatient services provided to the Adults Without Dependent Children will not change as a result of implementation of mandatory copayments for office visits
    - The relative readmission rate of Adults Without Dependent Children will not change as a result of implementation of mandatory copayments

- Access to Care: The implementation of mandatory copays on the Childless Adult population for non-emergency transportation will not adversely affect access to care
    - The relative access to care for Adults Without Dependent Children in Maricopa and Pima counties who pay a transportation copayment will be similar to the relative access to care for Adults Without Dependent Children in all counties excluding Maricopa and Pima

- Access to Care: Implementing mandatory copays on non-emergency medical transportation for the Childless Adult population in Maricopa and Pima counties will not result in a decrease in the rate at which these members use provider office visits

For the Permissible Provider Fee for Missed appointments the following hypothesis and associated objectives will be tested:

- Access to Care: Charging a $3 fee to TANF parents and adults without children who miss a scheduled appointment without cancelling will not result in a decrease in the utilization rate of office visits
    - The rate of missed appointments will decrease for TANF Parents and Adults without Dependent Children that are charged a missed appointment fee
    - The number and percent of TANF Parents and Adults Without Dependent Children that have been assessed a missed appointment fee and denied an appointment because of the outstanding fee will not increase

- Access to Care: TANF parents and adults without children who are charged a $3 missed appointment fee will not increase their utilization of walk-in clinics, urgent care, or emergency rooms, resulting in no additional higher level of care costs to the AHCCCS program
    - The relative rate of utilization of urgent care centers, walk-in clinics and/or emergency departments by TANF Parents and Adults Without Dependent Children that have been assessed a missed appointment fee will not increase

- Health Care Disparities: There are no differences in the TANF parents or adults without children populations such as race, ethnicity, or age that result in an inability to pay the $3 missed appointment fee
    - Performance measures analysis will include age, gender and race/ethnicity

- Administrative Complexities: The complexities of meeting the requirements specified by CMS to be eligible to implement the missed appointment fee will result in a limited number of providers being able to take on the administrative workload
    - The administrative requirements to allow a primary care provider to implement a missed appointment fee will limit the number of providers that choose to assess missed appointment fees

For the Uncompensated Care Payments to I.H.S. and 638 Facilities the following hypothesis and associated objectives will be tested:

- Access to Care: Implementing uncompensated care payments to I.H.S. and 638 facilities will allow staffing levels to be maintained or increased.
    - The I.H.S. and 638 facilities will be able to maintain or increase their staffing levels

- Access to Care: Uncompensated care payments to I.H.S. and 638 facilities will increase capacity to provide care and services resulting in AHCCCS I.H.S. members receiving health care services.
    - Childhood immunization rates for children receiving services through an I.H.S or 638 facility will be maintained
    - Access to oral health care providers for members receiving services through an I.H.S. or 638 facility that are 0 to 21 years of age will be maintained
    - The relative rate of ideal glycemic control of members receiving services through an I.H.S or 638 facility that are diagnosed with diabetes will be maintained
    - The relative rate of members receiving services through an I.H.S or 638 facility that are diagnosed with diabetes that are assessed for dyslipidemia will be maintained

The specific hypotheses details as well as the accompanying performance measures to be used to evaluate the impact of the demonstration during the period of approval are described in Attachment A.

III. EVALUATION DESIGN

Management and Coordination of Evaluation

The AHCCCS Office of Intergovernmental Relations will coordinate the waiver evaluation process and will work in close collaboration with the Division of Health Care Management as well as other key areas within the agency, e.g., Office of the Director, Division of Member Services, Division of Business and Finance, and Information Services Division.

The Assistant Director of the Office of Intergovernmental Relations will serve as project lead and primary contact for CMS for the waiver evaluation project. The Assistant Director will be supported in this effort by the Executive Management Team. The Assistant Director will work closely with qualified staff in the Division of Health Care Management, including the Clinical Quality Management staff who have extensive experience in conducting program evaluations, performance improvement initiatives, and quality improvement processes, including developing the study design, data collection and analysis and the reporting of findings. Other Divisions and AHCCCS staff will also be involved in the waiver evaluation processes.

AHCCCS will continue to strengthen stakeholder input including that received from AHCCCS health plans, local advocacy groups, state agencies, federal programs, the CMS Quality Improvement Organization, and will also include reference information obtained from literature reviews in the waiver evaluation process. AHCCCS will utilize findings gained through the evaluation to develop recommendations to enhance and improve the program design.

AHCCCS will develop, implement, analyze, and report the activities and results of the work tasks associated with the waiver evaluation. AHCCCS will utilize a contracted External Quality Review Organization (EQRO) to conduct an independent validation of AHCCCS performance measures utilized for the waiver evaluation components including those required in the Managed Care Act that are not conducted by the State, and those required in the Special Terms and Conditions including Cost Sharing - Mandatory Copays for Childless Adults and the Uncompensated Care Payments to IHS and 638 Facilities. AHCCCS will use an EQRO to conduct a validation of performance measures for the cost sharing and the American Indian/Alaska Native evaluation components of the Waiver Evaluation as

specified in the STC 28 (c) (d) and (e). This will be accomplished in conjunction with the annual EQRO reporting requirements.

Once the evaluation plan has been approved by CMS, AHCCCS will develop a detailed project work plan that incorporates all the key components of the evaluation project design. Preliminary key project milestones and deliverables for the waiver demonstration are identified in Attachment B.

Performance Measures

AHCCCS will use a wide array of valid, reliable and quantifiable performance measures to test the specific hypotheses in each of the key areas of the demonstration. Performance measures have been selected from all three of the basic measure types CMS has recommended states consider using in their evaluations of their demonstration. This includes: 1) measures of outcomes related to health outcomes, satisfaction and program performance; 2) measures of input related to access to health care services, participation of providers, types of services provided, clinical measures of quality; and 3) financial measures related to costs incurred by the program. Attachment A identifies each of the specific performance measures chosen to test the evaluation hypotheses, and for each measure provides: a description of the measure, the target population, the sampling methodology and the measurement period. A list of the data sources to be used to calculate the performance measures can also be found in Attachment A.

In addition to choosing performance measures that would allow AHCCCS to effectively test each of the specific hypotheses, AHCCCS employed the following additional criteria for selecting the performance measures: 1) were nationally recognized and evidenced based measure; 2) allowed for comparisons with other states and benchmarking to national means and percentiles; 3) represented areas that were new enhancements to the current program or had been targeted for improvement; 4) would substantially impact members' health outcomes; 5) were an integral component of AHCCCS Quality Improvement Strategy (see discussion below); 6) were feasible to compile given the finite administrative resources and 7) were specified by CMS as waiver components that were to be included in the waiver evaluation.

There are a number of steps that AHCCCS will take to ensure the statistical validity and reliability of the performance measures utilized in the waiver evaluation. These include but are not limited to the following:

- Where ever possible, AHCCCS will follow the methodologies for the collection and reporting of performance results that have been established by nationally recognized organizations, such as NCQA (i.e., Health Plan Employer Data and Information Set - HEDIS® and Consumer Assessment of Healthcare Providers and Systems - CAHPS®), National Core Indicators (performance and outcome indicators for state developmental disabilities programs), Mental Health Statistical Improvement Project (adult and child consumer satisfaction survey), Meaningful Use methodologies, CMS Core Measure Sets and CMS Nursing Home Quality Measures.
- State specific performance measures such as access to behavioral health care, or timeliness of CRS initial assessments, will be validated by AHCCCS or in some cases by its EQRO. Validation may involve a medical chart, electronic medical records, claims or encounters, or hard copy documentation on a statistically significant random sample of members who meet the numerator criteria.
- Many of the performance measures are dependent on encounter data from AHCCCS' automated managed care data system – Prepaid Medical Management Information System. AHCCCS has and will continue to conduct annual data validation studies of its encounters. For example, based

on the most recent data validation study by AHCCCS, approximately 90 percent of all encounters for acute-care professional services are complete when compared with corresponding medical records. Approximately 85 percent are fully accurate, compared with services documented in members' medical records. AHCCCS may also utilize a qualified vendor with data and outcomes measurement systems that are certified by NCQA, ONC or other recognized entities to calculate quality and performance measure results.

Integration of State Quality Improvement Strategy

The AHCCCS Quality Assessment and Performance Improvement Strategy, established in 2003 by AHCCCS, is a coordinated, comprehensive, and pro-active approach to drive quality through creative initiatives, monitoring assessment and outcome-based performance improvement. The Strategy describes how AHCCCS will assess the quality of care delivered through the AHCCCS acute and ALTCS Contractors, and will improve the quality of care delivered through these plans. This evaluation of the quality of and access to care received by members enrolled in AHCCCS and ALTCS programs is also an integral component of the waiver evaluation demonstration. As such AHCCCS has incorporated into the waiver evaluation a number of the Strategy's goals and objectives (e.g., improve member's health status, use of partnerships to improve access to health care services) and assessment strategies/activities (e.g., use of nationally recognized protocols, standards of care and benchmarks, mechanisms for collection of information).

While AHCCCS will, as required by CMS, conduct the waiver evaluation independent of the evaluation of the AHCCCS Quality Assessment and Performance Improvement Strategy, AHCCCS will integrate the findings of these two separate evaluations on quality of care in assessing the program's effectiveness and identifying opportunities for improvement.

Plan for Analysis

AHCCCS' overall plan for analysis is based on the principles of continuous process and quality improvement in which AHCCCS will utilize the waiver demonstration performance measure results and outcomes to: 1) evaluate if the demonstration goals and hypotheses are being met; 2) identify best practices and opportunities for improvement, 3) change the demonstration design or operational process to improve performance, and 4) monitor the effectiveness of any changes implemented to improve performance, member satisfaction and program outcomes.

Data collection and analysis will follow generally accepted principles for qualitative and quantitative research as well as the specific methodologies used for nationally recognized performance measures such as HEDIS® and the CMS Core Measure sets. For each performance measure, AHCCCS will report results in the aggregate for the population being targeted by the performance measure. As appropriate AHCCCS will control for key independent variables that could impact the measure results, e.g., age, gender, eligibility category, length of program enrollment.

Depending on the performance measure, AHCCCS will also conduct three basic types of comparisons. Using a control group has a variety of benefits for establishing causation, but the evaluation plan does not indicate any measures where a control group will be used. If a control group is used, the state should ensure that the control and intervention groups are comparable.

- Within the state, comparing performance measure rates between members residing in rural vs. those residing in urban areas and among members from different ethnic groups (e.g., Hispanic, American Indian, or Non-Hispanic Black relative to non-Hispanic White members). AHCCCS

will also compare the target population results with those of an AHCCCS control group that are not subject to the program change for certain measures. For cost sharing programs, the State will include comparison across geographic or regional areas.

- With other states and national benchmarks, comparing waiver demonstration outcomes using the same measures in the same period of time in other states. In particular AHCCCS will conduct this type of comparison for measures related to quality of care. When possible, AHCCCS will compare waiver demonstration performance measures results with published fee for service results in other states.
- Across time, comparing changes in performance measure rates at different points in time during the five year waiver demonstration program. AHCCCS bio statisticians, certified professionals in health care quality and quality improvement specialists will conduct a temporal analysis through the collection of both baseline and remeasurement data for specified performance measures listed in Attachment A. Changes from the previous measurement will be described as increases or decreases only when analysis using the Pearson chi-square test yields a statistically significant value (p less than or equal to 0.05), that is the probability of obtaining such a difference by chance only is relatively low.

AHCCCS will use the data analysis findings to:

- Evaluate the effectiveness of the demonstration. Based on the performance measure results, AHCCCS will determine the extent to which its hypotheses were correct and that the demonstration was successful in meeting its specific demonstration goals: providing quality health care to members and maintaining a cost effective program.
- Identify opportunities for improvement. If opportunities for improvement are identified based on the waiver demonstration performance measure outcomes, AHCCCS will conduct more in-depth analyzes of the issues in order to better understand the occurrence and root causes. Based on this analysis a set of interventions will be developed. This could range from asking CMS to approve a change in the waiver, to requesting a corrective action be developed by a health plan.
- Identify demonstration successes. As successful elements of the demonstration are identified, AHCCCS will ensure transparency and disseminate these positive outcomes and successful strategies to stakeholders within the state (e.g., health plans, advocacy groups, government officials) as well as to other state and national entities. Methods used to communicate this information will include posting results to the AHCCCS website formal reports, fact sheets, and presentations at local and national meetings.

Finally, throughout the evaluation, AHCCCS will evaluate status and outcomes and modify the current evaluation design based on significant changes in programmatic, political or fiscal factors at the state and federal level. Examples of such changes could include population changes, benefit changes, rate changes, changes in health plans as a result of the AHCCCS Request for Proposal process, health home, integration initiatives, and program changes required under health care reform. Any proposed changes to the evaluation design will be presented to CMS for approval prior to making the change, such as through a state plan amendment.

IV. EVALATION REPORTS

AHCCCS will include status reports on the waiver demonstration evaluation in the following reports that are required to be submitted to CMS under the terms of the waiver demonstration:

- Quarterly progress reports designed to present AHCCCS' analysis and the status of the various operational areas.

- Annual reports documenting accomplishments, project status, quantitative and case study findings, utilization data, the status of the collection and verification of encounter data and policy and administrative difficulties in operation of any components of the demonstration.
- Website reporting of waiver demonstration performance measure results for certain measures.

AHCCCS will also prepare and submit a final evaluation report within 120 days after the expiration of the demonstration. This final report will present the principal findings, conclusions and recommendations of the evaluation and will be formatted to include the recommended components, as appropriate which are set forth in the September 2006 - *CMS Evaluating Demonstrations: A Technical Assistance Guide for States.*

The AHCCCS Office of Intergovernmental Relations will be responsible for submitting these reports, working collaboratively with other involved agency divisions such as the Division of Health Care Management. The Executive Management Team will review these reports prior to submission to CMS. The deliverable dates for these reports are contained in Attachment B – Waiver Evaluation Project Key Milestones and Deliverables.

AHCCCS will post findings from the evaluation including the final report on its website upon submission to CMS.

Demonstration Focus Area: AHCCCS Acute Care Program

Hypotheses:

- *Quality of care for AHCCCS Acute care program members enrolled in AHCCCS Acute health plans will improve over the waiver demonstration period as it relates to:*
    - *Receipt of medically necessary covered services;*
        - Childhood immunization rates will increase.
        - Adolescent immunization rates will increase.
        - EPSDT participation rates will increase.
        - Annual dental visit rates will increase.
        - Well child visits during the first 15 months of life will increase
        - Well child visits for 3, 4, 5 and 6 year olds who have at least one visit will increase
        - Adolescent well care visits will increase
        - Children's access to PCPs will increase
        - Influenza vaccinations in older adults will increase
        - Timeliness of prenatal care will increase
    - *Management of chronic conditions; and*
        - HbA1d and LDL screenings will increase for members diagnosed with diabetes
        - Long-term asthma control medication use for members diagnosed with asthma will increase
    - *Mitigation of health disparities among ethnic populations*
        - Performance measure results will indicate a reduction in disparities among ethnic populations

- *Member satisfaction in the Acute care program for members enrolled in AHCCCS Acute health plans will improve over the waiver demonstration period.*

- *Access to medical care for AHCCCS Acute care program members enrolled in both rural- and urban-based acute plans will improve over the waiver demonstration period as demonstrated by:*
    - A reduction in readmissions
    - A reduction in inpatient stays
    - Emergency department (ED) utilization will decrease
    - PCP participation in the AHCCCS program will not be adversely affected as a result of rate cuts
    - The number of providers terminating due to rate cuts will not be significant

- *The AHCCCS Acute care program will continue to operate as a cost-effective delivery model*
    - The AHCCCS program will operate within predicted budgetary expectations

HYPOTHESES	PERFORMANCE MEASURE	TARGET POPULATION	SAMPLING METHODOLOGY	DATA SOURCE	MEASUREMENT PERIOD
Childhood immunization rates will increase	**Childhood Immunizations** Percentage of children, two years of age during the measurement period who had: ▪ 4:3:1:3:3:1 combo series ▪ 4:3:1:3:3:1:4 combo series ▪ DTaP – 4 doses: ▪ IPV – 3 doses ▪ MMR – 1 dose ▪ Hib – 3 doses ▪ HBV – 3 doses ▪ VZV – 1 dose ▪ PCV – 4 doses	Children two years of age, continuously enrolled in AHCCCS acute health plans	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	• Claims • Encounters • Medical Record Review • ASIIS Immunization Registry • Electronic Health Records	CYE 2011: October 1, 2010 through September 30, 2011 • 4:3:1:3:3:1 combo series: **72.9%** • 4:3:1:3:3:1:4 combo series: **69.1%** • DTaP – 4 doses: **79.5%** • IPV – 3 doses: **91.4%** • MMR – 1 dose: **91.3%** • Hib – 3 doses: **91.5%** • HBV – 3 doses: **87.9%** • VZV – 1 dose: **90.5%** • PCV – 4 doses: **79.9%** *Remeasurement period*: CYE 2015: October 1, 2014 through September 30, 2015 • 4:3:1:3:3:1 combo series: • 4:3::1:3:3:1:4 combo series: • DTaP – 4 doses:: • IPV – 3 doses: • MMR – 1 dose: • Hib – 3 doses: • HBV – 3 doses: • VZV – 1 dose: • PCV – 4 doses:
Adolescent immunization rates will increase	**Adolescent Immunizations** Percentage of adolescents	Adolescents age 13 years of age during the measurement	The National Committee for Quality Assurance (NCQA)	• Claims • Encounters	*Baseline measurement period:* CYE 2011: October 1, 2010

	that are13 years of age during the measurement period who had: • MCV – 1 dose • Tdap/Td – 1 dose • Combo – 1 MCV and1 Tdap/Td	period	Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	• Medical Record Review • ASIIS Immunization Registry • Electronic Health Records	through September 30, 2011 • MCV – 1 dose: **83.9%** • Tdap/Td – 1 dose: **85.8%** • Combo – 1 MCV and 1 Tdap/Td: **81.3%** *Remeasurement period*: CYE 2015: October 1, 2014 through September 30, 2015 • MCV – 1 dose: • Tdap/Td – 1 dose: • Combo – 1 MCV and 1 Tdap/Td:
EPSDT participation rates will increase	**EPSDT Participation** Percentage of members, through 20 years of age, who received at least one initial or periodic EPSDT screen during the measurement period.	Members, through age 20 years, enrolled in AHCCCS acute health plans.	Calculated using the CMS 416 specifications (e.g., Report-416)	• Claims • Encounters • Electronic Health Records	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 EPSDT rate: **63%** *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 EPSDT rate:
Annual dental visit rates will increase	**Annual Dental Visits** Percentage of members, ages 2 through 21 years who had at least one dental visit during the measurement period.	Members, ages 2 through 21 years, continuously enrolled in AHCCCS acute health plans.	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if	• Claims • Encounters • Electronic Health Records	*Baseline measurement period:* CYE 2011, October 1, 2010 through September 30, 2011 Rate: *Remeasurement period*:

			different, including the sampling methodology will be utilized for this measure.		CYE 2016: October 1, 2015 through September 30, 2016 Rate:
Well child visits during the first 15 months of life will increase	**Well-Child Visits** Percentage of children, who had six or more well child visits during first 15 months of life.	Children, ages 15 months who were continuously enrolled in AHCCCS acute health plans.	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	• Claims • Encounters • Medical Record Review • Electronic Health Records	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 Rate: *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 Rate:
Well child visits for 3, 4, 5 and 6 year olds who have at least one visit will increase	**Well-Child Visits** Percentage of children who were 3, 4, 5, or 6 years and had at least one well child visit during the measurement period.	Children, ages 3 through 6 years, continuously enrolled in AHCCCS acute health plans.	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	• Claims • Encounters • Medical Record Review • Electronic Health Records	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 Rate: *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 Rate:
Emergency department (ED) utilization will	**Emergency Department (ED) Utilization**	AHCCCS Acute care members	ER visits per 1,000 Acute care member months.	• Claims • Encounters • Electronic	*Baseline measurement:* CYE 2011: October 1, 2010

decrease	ER visits per 1,000 member months		A sampling methodology will not be used for this measure.	Health Records • Arizona Health Query (state licensed provider data bank)	through September 30, 2011 ED visits per 1,000: *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 ED visits per 1,000:
Readmissions will decrease	**Readmissions** Within 30 days of discharge from an acute care stay	AHCCCS Acute care members	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, will be utilized for this measure. Behavioral health inpatient stays will be excluded in this calculation	• Claims • Encounters • Electronic Health Records	*Base line measurement:* CYE 2011: October 1, 2010 through September 30, 2011 Readmissions within 30 days of discharge: *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 Readmissions within 30 days of discharge:
Influenza vaccinations in older adults will increase	**Older Adults who receive an influenza vaccination who are:** • 50 – 64 years • 65+ years	AHCCCS Acute care members ages 50-64 years of age and 65 years or older	HEDIS-like measure. The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be	• Claims • Encounters • Electronic Health Record • Medical Record Review • ASIIS Immunization Registry	*Baseline measurement:* CYE 2011: October 1, 2010 through September 30, 2011 50-64 years: 65 + years: *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016

			utilized for this measure. AHCCCS will not include a member survey to collect data for this measure.		50-64 years: 65 + years:
Adolescent well care visits will increase	**<u>Adolescent Well Care Visits</u>** Percentage of members, ages 12 through 21 years who had at least 1 well-care visit during the measurement period.	Members, ages 12 through 21 years, continuously enrolled in AHCCCS acute health plans.	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	• Claims • Encounters • Electronic Health Record • Medical Record Review	*Baseline measurement period:* CYE 2005: October 11, 2010 through September 30, 2011 Rate: *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 Rate:
Children's access to PCPs will increase	**<u>Children's Access to Primary Care Providers (PCPs)</u>** Percentage of children/adolescents who had an annual visit with a PCP at: • 12 - 24 months • 25 months – 6 years • 7 – 11 years • 12 – 19 years	Members, 12 months to 19 years, continuously enrolled in AHCCCS acute health plans.	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	• Claims • Encounters • Electronic Health Record • Medical Record Review	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 • 12 - 24 months: • 25 months – 6 years: • 7 – 11 years: • 12 – 19 years: *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 • 12 - 24 months: • 25 months – 6 years: • 7 – 11 years:

					• 12 – 19 years:
Timeliness of prenatal care will increase	**Timeliness of Prenatal Care** Percentage of female members, who had a prenatal care visit during their first trimester of pregnancy or within 42 days of enrollment.	Female members enrolled in AHCCCS acute health plans, who had a live birth during the measurement period.	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	• Claims • Encounters • Electronic Health Records • Medical Record Review	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 Rate: *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 Rate:
HbA1d and LDL screenings will increase for members diagnosed with diabetes	**Diabetes Care** Percentage of members who: ▪ had one or more HbA1c test ▪ LDL screening	Members, ages 18 – 75 years, continuously enrolled in AHCCCS acute health plans and who had a diagnosis of type 1 or type 2 diabetes.	HEDIS-like measure. The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure. At this time AHCCCS is not able to collect the results of the lab tests. When EHRs and HIE are more complete within the system AHCCCS will move toward implementation of the	• Claims • Encounters • Electronic Health Records • Medical Record Review	CYE 2011: October 1, 2010 through September 30, 2011 HbA1c rate: LDL screening rate: *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 HbA1c rate: LDL screening rate:

			outcomes methodology utilized by NCQA.		
Long-term asthma control medication use for members diagnosed with asthma will increase	**Asthma Management** Percentage of members, ages 5 through 64 years, who had at least one dispensed prescription that is acceptable as primary therapy for long-term asthma control	Members, ages 5 - 64 years, continuously enrolled in AHCCCS Acute health plans and who have a diagnosis of asthma	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	• Claims • Encounters	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 Rate: *Remeasurement period*: CYE 2015: October 1, 2015 through September 30, 2016 Rate:
Member satisfaction survey results will indicate a high degree of satisfaction with quality of life indicators	**Member Satisfaction** Percentage of members (adults and children) who give the highest ratings (9 or 10) for: • Rating of health plan • Rating of personal doctor/nurse • Rating of receipt of health care • Rating of specialist seen most often • Getting needed care • Getting prescription medicine • Getting care quickly • How well doctors communicate	Medicaid eligible members (adults and children) enrolled in AHCCCS acute health plans (excluding CMDP).	National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology – CAHPS Survey Tool	Member Survey Sampling will occur utilizing the HEDIS methodology technical specifications.	*Measurement period*: TBD Reported for ages: • 0 through 20 years • 21 years and older • Rating of health plan: • Rating of personal doctor/nurse: • Rating of receipt of health care: • Rating of specialist seen most often: • Getting needed care: • Getting prescription medicine: • Getting care quickly:

					• How well doctors communicate:
PCP participation in the AHCCCS program will remain at the same level	**<u>PCP Participation</u>** Percentage of licensed, active MD's and DO's practicing in Arizona that are AHCCCS registered providers	Active providers (DO and MD) licensed to practice in Arizona.	This measure will be calculated using the AHCCCS Provider Registration database and data from the MD and DO Medical Board data bases. A sampling methodology will not be applied to this measure	• Arizona Medical Board Data Base • Osteopathic Medical Board Data Base • AHCCCS Provider Registration Data Base	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 Participation percent: *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 Participation percent:
The number of providers participating in the AHCCCS program will not be adversely affected due to rate cuts	**<u>Providers terminating as AHCCCS registered providers due to rates</u>** Percentage of AHCCCS providers that terminate participation with AHCCCS due to rate related reasons within each contract year. Note: Provider terminations are not program specific. Therefore, the rates reported will be for the AHCCCS program overall.	Providers registered to provide services to AHCCCS members.	A sampling methodology will not be applied to this measure. This measure is calculated by using the numbers of providers enrolled with AHCCCS on the contract year begin date versus the number of providers that terminated participation with AHCCCS during the contract year due to rate related reasons.	AHCCCS Contractor Dashboards	*Baseline measurement:* CYE 2011: October 1, 2010 through September 30, 2011 Rate: **0.142%** ***Remeasure annually:*** *2012* *Rate:* *2013* *Rate:* *2014* *Rate:* *2015* *Rate:* *2016* *Rate:*

					Discussion:
The AHCCCS program will operate within predicted budgetary expectations	**Program Costs** Average annual AHCCCS capitation rate changes compared to budgetary expectations	Members enrolled in the following AHCCCS programs: • Acute • CMDP • EPD • DDD	In analyzing this measure AHCCCS will use the average annual capitation rates paid to all programs. A sampling methodology will not be applied.	AHCCCS Capitation Rates	*Measurement Period* CYE 2012: AHCCCS rate change: Budgetary expectation: CYE 2013: AHCCCS rate change: Budgetary expectation: CYE 2014: AHCCCS rate change: Budgetary expectation: CYE 2015: AHCCCS rate change: Budgetary expectation: CYE 2016: AHCCCS rate change: Budgetary expectation:

Demonstration Focus Area: ALTCS Program

Hypotheses:

- *Quality of care for AHCCCS ALTCS program members enrolled in AHCCCS EPD and DDD health plans will improve over the waiver demonstration period as it relates to:*
  - *Receipt of covered services;*
    - Immunization rates will increase
    - EPSDT participation rates will increase
    - Annual dental visit rates will increase
    - Children ages 3, 4, 5 and 6 years of age who have at least one well child visit will increase
    - Adolescents ages 12 through 21 years of age who have one well care visit will increase
    - Influenza vaccinations for older adults will increase

- *Access to care for AHCCCS ALTCS Program members enrolled in EPD and DDD health plans will improve over the demonstration period as evidenced by:*
  - A reduction in readmissions
  - A reduction in inpatient stays
  - Stability of provider network
    - The number of providers participating in the AHCCCS program will not be adversely affected due to rate cuts

- *The AHCCCS ALTCS program will continue to operate as a cost effective service delivery model during the waiver demonstration period as demonstrated by:*
  - The AHCCCS program will operate within predicted budgetary expectations

- *Quality of life for ALTCS members (EPD and DDD) who reside in a home and community based setting will improve over the waiver demonstration period as demonstrated by.*
  - The percentage of ALTCS members residing in a home and community based setting will be maintained above 80 percent
  - The number of direct care workers with documentation of qualified training will increase
  - Member satisfaction survey results will indicate a high degree of satisfaction with quality of life indicators
  - The number of ALTCS members that reside in a home and community based setting will increase
  - The percentage of ALTCS members utilizing either Self-Directed Attendant Care or Agency with Choice will increase

HYPOTHESES	PERFORMANCE MEASURE	TARGET POPULATION	SAMPLING METHODOLOGY	DATA SOURCE	MEASUREMENT PERIOD
The percentage of ALTCS members residing in a home and community based setting will be maintained above 80 percent	**HCBS Placement** The percentage of ALTCS members (E/PD and DDD combined) residing in a home and community based setting.	Members enrolled in the ALTCS program (excluding tribal members enrolled in the ALTCS Fee-for-Service Program).	This measure will be calculated using member placement and ALTCS enrollment data. A sampling methodology will not be utilized	• PMMIS • ACE	*Baseline measurement period*: CYE 2012: October 1, 2011 through September 30, 2012 EPD: DDD: *Remeasurement period:* CYE 2016: October 1, 2015 through September 30, 2016 EPD: DDD:
Member satisfaction survey results will indicate a high degree of satisfaction with quality of life indicators	**Member satisfaction** Percentage of ALTCS members (ALTCS E/PD, DDD and ALTCS Contractors combined) that respond with above average ratings for the following: • Satisfaction with Contractor/Health Plan • Satisfaction with health care • Satisfaction with Case Manager • Satisfaction with Primary Care Provider • Satisfaction with specialty physician • How well doctors communicate • Access to services, supports and care needed • Getting care quickly	Members enrolled with an ALTCS Contractor.	Random selection of enrolled ALTCS members from each ALTCS Contractor. Survey data will be collected using an independent survey research firm.	Member Survey Sampling will occur utilizing the HEDIS methodology technical specifications.	*Measurement period:* TBD • Satisfaction with Contractor/Health Plan: • Satisfaction with health care: • Satisfaction with Case Manager: • Satisfaction with Primary Care Provider: • Satisfaction with specialty physician: • How well doctors communicate: • Access to services, supports and care needed: • Getting care quickly: • Degree to which the member feels that s/he has control over

	• Degree to which the member feels that s/he has control over his/her own care (only members using Self-Directed Attendant Care - E/PD members only, or Agency with Choice – E/PD and DDD members)				his/her own care: (only members using Self-Directed Attendant Care or Agency with Choice)
Immunization rates will increase	**<u>Childhood Immunizations</u>** Percentage of children, two years of age during the measurement period who had: ▪ 4:3:1:3:3:1 combo series ▪ 4:3:1:3:3:1:4 combo series ▪ DTaP – 4 doses ▪ IPV – 3 doses ▪ MMR – 1 dose ▪ Hib – 3 doses ▪ HBV – 3 doses ▪ VZV – 1 dose ▪ PCV – 4 doses	Children at two years of age continuously enrolled in the ALTCS DDD program.	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	• Claims • Encounters • Medical Record Extraction • ASIIS Immunization Registry • Electronic Health Records	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 • 4:3:1:3:3:1 combo series: **64.5%** • 4:3::1:3:3:1:4 combo series: **60.2%** • DTaP – 4 doses: **74.2%** • IPV – 3 doses: **79.6%** • MMR – 1 dose: **80.7%** • Hib – 3 doses: **87.1%** • HBV – 3 doses: **78.5%** • VZV – 1 dose: **82.8%** • PCV – 4 doses: **76.3%** *Remeasurement period*: CYE 2015: October 1, 2014 through September 30, 2015 • 4:3:1:3:3:1 combo series: • 4:3:1:3:3:1:4 combo series: • DTaP – 4 doses: • IPV – 3 doses: • MMR – 1 dose:

					• Hib – 3 doses: • HBV – 3 doses: • VZV – 1 dose: • PCV – 4 doses:
EPSDT participation rates will increase	**<u>EPSDT Participation</u>** Percentage of members, through age 20 years, who received at least one initial or periodic EPSDT screen during the measurement period.	Members, through age 20 years, enrolled in ALTCS – DDD.	Per CMS specification (e.g., Report-416)	• Claims • Encounters	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 Rate: **50.0%** *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 Rate:
Annual dental visit rates will increase	**<u>Annual Dental Visits</u>** Percentage of members, ages 2 through 21 years who had at least one dental visit during the measurement period.	Members, ages 2 through 21 years, continuously enrolled in ALTCS - DDD.	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	• Claims • Encounters • Medical Record Review • Electronic Health Records	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 Rate: *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 Rate:
Children ages 3, 4, 5 and 6 years of age who have at least one well child visit will increase	**<u>Well-Child Visits</u>** Percentage of children who were 3, 4, 5, or 6 years who had at least one well child visit during the measurement period.	Children, ages 3 through 6 years, continuously enrolled in ALTCS - DDD.	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)®	• Claims • Encounters • Medical Record Review • Electronic	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 Rate:

			methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	Health Records	*Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 Rate:
Adolescents ages 12 through 21 years of age who have one well care visit will increase	**Adolescent Well Care Visits** Percentage of members, ages 12 through 21 years who had at least one well-care visit during the measurement period.	Members, ages 12 through 21 years, continuously enrolled in ALTCS - DDD.	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	• Claims • Encounters • Medical Record Review • Electronic Health Records	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 Rate: *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 Rate:
Emergency Department (ED) utilization will decrease	**Emergency Department Utilization** ED visits per 1,000 member months	ALTCS E/PD and DDD members	ED visits per 1,000 ALTCS member months. A sampling methodology will not be used for this measure.	• Claims • Encounters • Medical Record Review • Electronic Health Records	*Baseline measurement:* CYE 2011: October 1, 2010 through September 30, 2011 • E/PD ED visits per 1,000: • DDD ED visits per 1,000: *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 • E/PD ED visits per 1,000:

					• DDD ED visits per 1,000:
The rate of readmissions within 30 days will decrease	**<u>Readmissions within</u>** Readmissions within 30 days of an inpatient stay	ALTCS EPD and DDD members	The CMS Core Measure Set methodology will be utilized for this measure.	• Claims • Encounters	*Baseline measurement:* CYE 2011: October 1, 2010 through September 30, 2011 • E/PD Readmissions within 30 days of discharge: • DDD Readmissions within 30 days of discharge: *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 • E/PD Readmissions within 30 days of discharge: • DDD Readmissions within 30 days of discharge:
Influenza vaccinations for older adults will increase	**Flu Shots for Older Adults who receive an influenza vaccination who were:** • 50 – 64 years • 65+ years	AHCCCS E/PD and DDD members ages 50-64 years of age and 65 years or older	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling	• Claims • Encounters • Medical Record Review • ASIIS Immunization Registry • Electronic Health Records	*Baseline measurement:* CYE 2011: October 1, 2010 through September 30, 2011 *E/PD* • 50-64 years: • 65+ years: *DDD* • 50-64 years:

			methodology will be utilized for this measure.		• 65+ years: *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 *E/PD* • 50-64 years: • 65+ years: *DDD* • 50-64 years: • 65+ years:
The number of providers participating in the AHCCCS program will not be adversely affected due to rate cuts	**<u>Providers Requesting Termination due to Rates</u>** Percentage of AHCCCS providers that terminate their participation with AHCCCS due to rate related reason Note: Same results as reported in the Acute section as providers serve more than one line of business/AHCCCS Program (i.e. Acute, ALTCS, etc.)	Providers registered to provide services to AHCCCS members.	This measure will be calculated using the numbers of providers enrolled with AHCCCS on the contract year begin date versus the number of providers that terminated their participation with AHCCCS during the contract year due to rate related reasons.	• Contractor dashboards	*Baseline measure:* CYE 2011: October 1, 2010 through September 30, 2011 Rate: *Remeasurement period:* CYE 2011: October 1, 2011 through September 30, 2012 Rate: CYE 2011: October 1, 2012 through September 30, 2013 Rate: CYE 2011: October 1, 2013 through September 30, 2014 Rate: CYE 2011: October 1, 2014

					through September 30, 2015 Rate:
The percent of ALTCS members receiving services from workers that have passed a direct care workers fundamentals test will increase	**Direct Care Worker Training and Testing** The percent of direct care workers providing services to ALTCS members that have passed the direct care worker fundamentals test.	ALTCS Contractor HCB providers.	The percentage of direct care workers identified in the database as having passed the fundamentals test. A sampling methodology will not be utilized for this measure.	DCW Database	*Baseline measurement period:* CYE 2013: October 1, 2012 through September 30, 2013 Number: *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 Number:
The percent of ALTCS members utilizing Self-Directed Attendant Care or Agency with Choice will increase	**Directed Care Option Utilization** Percentage of ALTCS members utilizing either Self-Directed Attendant Care (E/PD) or Agency with Choice (E/PD and DDD)	ALTCS-enrolled members who are residing in their own home.	The number/percent of ALTCS members residing in their own home and choosing Self Directed Attendant Care or Agency with Choice. A sampling methodology will not be utilized	PMMIS ACE	*Baseline measurement period:* CYE 2013: October 1, 2012 through September 30, 2013 Rate: *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 Rate:
The AHCCCS program will operate within predicted budgetary expectations	**Program Costs** Average annual statewide ALTCS-E/PD Contractor capitation rates with HCBS percentage built into the capitation rates compared to capitation rates with HCBS percentage fixed at level when	Members enrolled in the ALTCS – E/PD program, excluding those enrolled with Tribal Contractors.	In analyzing this measure AHCCCS will use the average annual capitation rates paid to ALTCS/EPD Contractors. A sampling methodology will not be utilized.	Encounters	*Measurement period:* CYE 2012: • EPD capitation rate at capitation mix: • EPD capitation rate at fix mix: CYE 2013: • EPD capitation rate at

	HCBS reconciliation/incentive was implemented (i.e. 40.2%, 1998) (Fix-Mix Model).				capitation mix: • EPD capitation rate at fix mix: CYE 2014: • EPD capitation rate at capitation mix: • EPD capitation rate at fix mix: CYE 2015: • EPD capitation rate at capitation mix: • EPD capitation rate at fix mix: CYE 2016: • EPD capitation rate at capitation mix: • EPD capitation rate at fix mix:

Demonstration Focus Area: Special Plans for Individuals with Special Needs

Hypotheses:

- *Quality of care for AHCCCS acute care program members enrolled in Special Plans for Individuals with Special Needs will improve over the waiver demonstration period as it relates to receipt of covered services:*
  - Immunization rates will increase for children enrolled in the CMDP program
  - EPSDT participation rates will increase for children enrolled in the CMDP program
  - Annual dental visit rates will increase for children enrolled in the CMDP program
  - The rate at which children 3, 4, 5 and 6 years of age receive at least one well child visit will increase for children enrolled in the CMDP program
  - The rate of members ages 12 through 18 years of age who had at least one well-care visit will increase for children enrolled in the CMDP program
  - Children's access to PCPs will increase for children enrolled in the CMDP program

- *Access to medical care for AHCCCS acute care program members enrolled in Special Plans for Individuals with Special Needs will improve over the waiver demonstration period as demonstrated by:*
  - A reduction in readmissions within 30 days of discharge from a behavioral health inpatient stay
  - Emergency department (ED) utilization for the primary reason of a behavioral health condition will decrease
  - Timeliness of the first CRS appointment will improve
  - The rate at which members receiving behavioral health services have a routine appointment within 23 days of the initial assessment will increase

- *Member satisfaction in Special Plans for Individuals with Special Needs will improve over the waiver demonstration period.*
  - Member satisfaction survey results will indicate a high degree of satisfaction with the behavioral health program
  - Member satisfaction survey results will indicate a high degree of satisfaction with the CRS program

- *The AHCCCS program Special Plans for Individuals with Special Needs will continue to operate as a cost effective service delivery model*
  - The AHCCCS program will operate within predicted budgetary expectations for the CMDP program
  - The AHCCCS program will operate within predicted budgetary expectations for the Behavioral Health program
  - The AHCCCS program will operate within predicted budgetary expectations for the Children's Rehabilitative Services program

HYPOTHESES	PERFORMANCE MEASURE	TARGET POPULATION	SAMPLING METHODOLOGY	DATA SOURCE	MEASUREMENT PERIOD
CMDP					
Immunization rates will increase	**Childhood Immunizations**: Percentage of children, two years of age who had: • 4:3:1:3:3:1 combo series: • 4:3:1:3:3:1:4 combo series: • DTaP – 4 doses: • IPV – 3 doses: • MMR – 1 dose: • Hib – 3 doses: • HBV – 3 doses: • VZV – 1 dose: • PCV – 4 doses:	Children at two years of age continuously enrolled in CMDP.	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	• Claims • Encounters • Medical Record Review • ASIIS Immunization Registry • Electronic Health Records	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 • 4:3:1:3:3:1 combo series: • 4:3:1:3:3:1:4 combo series: • DTaP – 4 doses: • IPV – 3 doses: • MMR – 1 dose: • Hib – 3 doses: • HBV – 3 doses: • VZV – 1 dose: • PCV – 4 doses: *Remeasurement period*: CYE 2015, October 1, 2014 through September 30, 2015 • 4:3:1:3:3:1 combo series: • 4:3:1:3:3:1:4 combo series: • DTaP – 4 doses: • IPV – 3 doses: • MMR – 1 dose: • Hib – 3 doses: • HBV – 3 doses: • VZV – 1 dose: • PCV – 4 doses
EPSDT participation rates will increase	**EPSDT Participation** Percentage of members,	Members, through 18 years of age, enrolled in	Per CMS specification (e.g., Report-416)	• Claims • Encounters • Medical	*Baseline measurement period:* CYE 2011: October 1, 2010 through

	through age 20 years, who received at least one initial or periodic EPSDT screen during the measurement period.	CMDP.		Record Review • Electronic Health Records	September 30, 2011 Rate: *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 Rate:
Annual dental visit rates will increase	**<u>Annual Dental Visits</u>** Percentage of members, ages 2 through 18 years who had at least one dental visit during the measurement period.	Members, ages 2 through 18 years, continuously enrolled in CMDP.	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	• Claims • Encounters • Medical Record Review • Electronic Health Records	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 Rate: *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 Rate:
The rate at which children 3, 4, 5 and 6 years of age receive at least one well child visit will increase	**<u>Well-Child Visits</u>** Percentage of children 3, 4, 5, or 6 years who had at least one well child visit during the measurement period.	Members, ages 3 through 6 years, continuously enrolled in CMDP.	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this	• Claims • Encounters • Medical Record Reviews • Electronic Health Records	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 Rate: *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 Rate:

			measure.		
The rate of members ages 12 through 18 years of age who had at least one well-care visit will increase	**Adolescent Well Care Visits** Percentage of members, ages 12 through 18 years who had at least one well-care visit during the measurement period.	Members, ages 12 through 18 years, continuously enrolled in CMDP.	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	• Claims • Encounters • Medical Record Reviews • Electronic Health Records	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 Rate: *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 Rate:
Children's access to PCPs will increase	**Children's Access to PCPs** Percentage of children/ adolescents who had an annual visit with a PCP at: ▪ 12 - 24 months ▪ 25 months – 6 years ▪ 7 – 11 years ▪ 12 – 19 years	Members, 12 months to 19 years, continuously enrolled in CMDP.	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	• Claims • Encounters • Medical Record Reviews • Electronic Health Records	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 Rate: *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 Rate:
The AHCCCS program will operate within predicted budgetary expectations	**Program Costs**: Average annual AHCCCS capitation rate changes compared to budgetary expectations	Members enrolled in: • Acute • CMDP • EPD • DDD • CRS • BHS	In analyzing this measure AHCCCS will use the average annual capitation rates paid to all programs. A sampling methodology will not be applied to		*Measurement Period* CYE 2012: • AHCCCS rate change: • Budgetary expectation: CYE 2013: • AHCCCS rate change: • Budgetary expectation:

			this measure.		CYE 2014: • AHCCCS rate change: • Budgetary expectation: CYE 2015: • AHCCCS rate change: • Budgetary expectation: CYE 2016: • AHCCCS rate change: • Budgetary expectation:
ADHS/DBHS					
The rate at which members receiving behavioral health services have a routine appointment within 23 days of the initial assessment will increase	**Access to Care/Appointment Availability** A behavioral health provider routine appointment within 23 days of initial assessment for ongoing services	All Acute care members in active behavioral health care	Statistically significant random sample size selected from Acute and DDD members identified as in active behavioral health care HEDIS sampling methodology will be utilized.	• Claims • Encounters	*Baseline measurement period:* CYE 2012: October 1, 2012 through September 30, 2013 *Acute care* 23 days: *DDD* 23 days *Remeasurement period*: CYE 2016, October 1, 2015 through September 30, 2016 *Acute care* 23 days: *DDD* 23 days
Emergency department (ED) utilization for the primary reason of a	**Emergency Department Utilization**	Acute care, CMDP and DDD members	ED visits per 1,000 member months stratified by the	• Claims • Encounters	*Baseline measurement period:* CYE 2011: October 1, 2010 through

behavioral health condition will decrease	ED visits per 1,000 member months for a principle or primary behavioral health condition		Acute care and DDD populations. A sampling methodology will not be used for this measure.		September 30, 2011 • Acute care ED visits per 1,000 • DDD ED visits per 1,000 • CMDP visits per 1,000 *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 • Acute care ED visits per 1,000 • DDD ED visits per 1,000 • CMDP visits per 1,000
Readmissions from a behavioral health inpatient stay will decrease	**Readmissions for a principle or primary behavioral health condition within 30 days** Readmissions with 30 days of an inpatient stay	Acute-care and DDD members	The CMS Core Measure Set methodology will be utilized for this measure.	• Claims • Encounters	*Baseline measurement:* CYE 2011: October 1, 2010 through September 30, 2011 • Acute care Readmissions within 30 days of discharge: • DDD Readmissions within 30 days of discharge: *Remeasurement period*: CYE 2016: October 1, 2015 through September 30, 2016 • Acute care Readmissions within 30 days of discharge: • DDD Readmissions within 30 days of discharge:

Member satisfaction in the Behavioral Health program will improve over the waiver demonstration period	**<u>Member Satisfaction</u>** For MHSIP Adult Consumer Survey, percentage reporting positively about: ▪ General satisfaction ▪ Service access ▪ Service Quality and appropriateness ▪ Participation in treatment planning ▪ Outcomes For Youth Services Survey for Families, percentage reporting positively about: ▪ General satisfaction ▪ Access to services ▪ Participation in treatment ▪ Cultural sensitivity ▪ Outcomes	Children under 18 years, and adults, who are enrolled with a RBHA and have receives a community based behavioral health services within the past six months and do not reside in an inpatient setting at the time of the survey.	A separate adult and child/adolescent sample is drawn. The state sample is stratified at the RBHA level and is statistically valid using a 95 percent confidence level and a confidence interval of 5 percent. The determined sample size is adjusted by 50 percent to allow for over-sampling of cases for purposes of addressing the rate of non-participation as a result of consumer no-show for scheduled appointments or non-response.	MHSIP survey	*Baseline measurement period:* CYE 2011 Adult Consumer Survey, percentage reporting positively about: • General satisfaction • Service access • Service Quality and appropriateness • Participation in treatment planning • Outcomes Youth Services Survey for Families, percentage reporting positively about: • General satisfaction • Access to services • Participation in treatment • Cultural sensitivity • Outcomes *Remeasurement period:* CYE 2016 Adult Consumer Survey, percentage reporting positively about: • General satisfaction • Service access • Service Quality and appropriateness • Participation in treatment planning • Outcomes Youth Services Survey for Families, percentage reporting positively

					about: • General satisfaction • Access to services • Participation in treatment • Cultural sensitivity • Outcomes
The AHCCCS program will operate within predicted budgetary expectations	**Program Costs:** Average annual AHCCCS capitation rate changes compared to budgetary expectations	Members enrolled in: • Acute • CMDP • EPD • DDD • CRS • BHS	In analyzing this measure AHCCCS will use the average annual capitation rates paid to all programs. A sampling methodology will not be applied to this measure		*Measurement Period* CYE 2012: • AHCCCS rate change: • Budgetary expectation: CYE 2013: • AHCCCS rate change: • Budgetary expectation: CYE 2014: • AHCCCS rate change: • Budgetary expectation: CYE 2015: • AHCCCS rate change: • Budgetary expectation: CYE 2016: • AHCCCS rate change: • Budgetary expectation:
CRS					
Timeliness of the first CRS appointment will improve	**Timeliness of First CRS Appointment** Percentage of members who were seen for an initial clinic appointment within 30 calendar days of being determined eligible for CRS.	AHCCCS members, 0 to 21 years of age, who were determined eligible for and enrolled in CRS during the measurement period.	Statistically significant sample of CRS members	Claims Encounters	*Baseline measurement period:* CYE 2014: July 1, 2013 through June 30, 2014 Visit within 30 days: *Remeasurement period:*

					CYE 2016: October 1, 2015 through September 30, 2016 Visit within 30 days:
Member satisfaction in the CRS program will improve over the waiver demonstration period	**Member Satisfaction** Percentage of members (children) • Rating of health plan • Rating of personal doctor/nurse • Rating of receipt of health care • Rating of specialist seen most often • Getting needed care • Getting prescription medicine • Getting care quickly • How well doctors communicate	Medicaid eligible members enrolled in CRS.	Random selection of members enrolled in the CRS program. The survey tool is based on CAHPS® 3 or another recognized survey tool.	Member Survey Sampling will occur utilizing the HEDIS methodology technical specifications.	*Measurement period* TBD • Rating of health plan: • Rating of personal doctor/nurse: • Rating of receipt of health care: • Rating of specialist seen most often: • Getting needed care: • Getting prescription medicine: • Getting care quickly: • How well doctors communicate:
The AHCCCS program will operate within predicted budgetary expectations	**Program Costs:** Average annual AHCCCS capitation rate changes compared to budgetary expectations	Members enrolled in: • Acute • CMDP • EPD • DDD • CRS • BHS	In analyzing this measure AHCCCS will use the average annual capitation rates paid to all programs. A sampling methodology will not be applied to this measure		*Measurement Period* CYE 2012: • AHCCCS rate change: • Budgetary expectation: CYE 2013: • AHCCCS rate change: • Budgetary expectation: CYE 2014: • AHCCCS rate change: • Budgetary expectation: CYE 2015:

					• AHCCCS rate change: • Budgetary expectation: CYE 2016: • AHCCCS rate change: • Budgetary expectation:

Demonstration Focus Area: CHIP (KidsCare) Demonstration

- *Quality of care for members enrolled in AHCCCS KidsCare program will improve over the waiver demonstration period as it relates to:*
  - *Receipt of covered services;*
    - Childhood immunization rates will increase.
    - Adolescent immunization rates will increase.
    - EPSDT participation rates will increase.
    - Annual dental visit rates will increase.
    - Well child visits during the first 15 months of life will increase
    - Well child visits for 3, 4, 5 and 6 year olds who have at least one visit will increase
    - Adolescent well care visits will increase
    - Children's access to PCPs will increase

- *Member satisfaction in the KidsCare program will improve over the waiver demonstration period*

- *Access to medical care for KidsCare members enrolled in both rural- and urban-based acute plans will improve over the waiver demonstration period as demonstrated by:*
  - A reduction in readmissions
  - A reduction in inpatient stays
  - Emergency department (ED) utilization will decrease

HYPOTHESES	PERFORMANCE MEASURE	TARGET POPULATION	SAMPLING METHODOLOGY	DATA SOURCE	MEASUREMENT PERIOD
Childhood immunization rates will increase	**Childhood Immunizations** Percentage of children, two years of age who had: • 4:3:1:3:3:1 combo series: • 4:3: 1:3:3:1:4 combo series: • DTaP – 4 doses: • IPV – 3 doses: • MMR – 1 dose: • Hib – 3 doses: • HBV – 3 doses: • VZV – 1 dose: • PCV – 4 doses:	KidsCare members who turn two years of age and are continuously enrolled in an AHCCCS acute health plan.	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	• Claims • Encounters • Medical Record Reviews • ASIIS Immunization Registry • Electronic Health Records	*Baseline measurement period:* CYE 2011:October 1, 2010 through September 30, 2011 • 4:3:1:3:3:1 combo series: • 4:3:1:3:3:1:4 combo series: • DTaP – 4 doses: • IPV – 3 doses: • MMR – 1 dose: • Hib – 3 doses: • HBV – 3 doses: • VZV – 1 dose: • PCV – 4 doses: *Remeasurement period*: CYE 2013: October 1,2012 through September 30, 2013 • 4:3:1:3:3:1 combo series: • 4:3:1:3:3:1:4 combo series: • DtaP – 4 doses: • IPV – 3 doses: • MMR – 1 dose: • Hib – 3 doses: • HBV – 3 doses: • VZV – 1 dose: • PCV – 4 doses:
EPSDT participation rates will increase	**EPSDT Participation** Percentage of members, through age 18 years, who received at least one initial	KidsCare members, through age 18 years, enrolled in	Per CMS specification (e.g., Report-416)	• Claims • Encounters	*Baseline measurement period:* CYE 211: October 1, 2010 through September 30, 2011

	or periodic EPSDT screen during the measurement period.	an AHCCCS acute health plan.			Rate: *Remeasurement period*: CYE 2013: October 1, 2012 through September 30, 2013 Rate:
Annual dental visit rates will increase	**<u>Annual Dental Visits</u>** Percentage of members, ages 2 through 18 years who had at least one dental visit during the measurement period.	KidsCare members, ages 2 through 18 years, continuously enrolled in an AHCCCS acute health plan.	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	• Claims • Encounters • Medical Record Reviews • ASIIS Immunization Registry • Electronic Health Records	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 Rate: *Remeasurement period*: CYE 2013: October 1, 2012 through September 30, 2013 Rate:
The rate at which children receive six or more well child visits during the first 15 months of life will increase	**<u>Well-Child Visits</u>** Percentage of children15 months who had six or more well child visits during first 15 months of life	KidsCare members, ages 15 months continuously enrolled in an AHCCCS acute health plan.	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	• Claims • Encounters • Medical Record Reviews • Electronic Health Records	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 Rate: *Remeasurement period*: CYE 2013: October 1, 2012 through September 30, 2013 Rate:

The rate at which children, 3, 4, 5 and 6 years of age who had at least one well child visit will increase	**Well-Child Visits** Percentage of children 3, 4, 5, or 6 years of age who had at least one well child visit during the measurement period.	KidsCare members 3 through 6 years of age continuously enrolled in an AHCCCS acute health plan.	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	• Claims • Encounters • Medical Record Reviews • Electronic Health Records	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 Rate: *Remeasurement period*: CYE 2013: October 1, 2012 through September 30, 2013 Rate:
The rate at which adolescents ages 12 through 18 years receive one well visit will increase	**Adolescent Well Care Visits** Percentage of members, ages 12 through 18 years who had at least one well-care visit during the measurement period.	KidsCare members ages 12 through 18 years, continuously enrolled in an AHCCCS acute health plan.	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	• Claims • Encounters • Medical Record Reviews • Electronic Health Records	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 Rate: *Remeasurement period*: CYE 2013: October 1, 2012 through September 30, 2013 Rate:
Children's access to PCPs will increase	**Children's Access to PCPs** Percentage of children/adolescents who had an annual visit with a PCP at: • 12 - 24 months • 25 months – 6 years • 7 – 11 years • 12 – 18 years	KidsCare members, 12 months to 18 years, continuously enrolled in an AHCCCS acute health plan.	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if	• Claims • Encounters • Medical Record Reviews • Electronic Health Records	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 Rate: *Remeasurement period*: CYE 2013: October 1, 2012

			different, including the sampling methodology will be utilized for this measure.		through September 30, 2013 Rate:
Emergency department (ED) utilization will decrease	**Emergency Department Utilization** ED visits per 1,000 member months	KidsCare members, 12 months to 18 years, continuously enrolled in an AHCCCS acute health plan.	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	• Claims • Encounters	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 Rate: *Remeasurement period*: CYE 2013: October 1, 2012 through September 30, 2013 Rate:
Adolescent immunizations will increase	**Adolescent Immunizations** Percentage of adolescents that are13 years of age during the measurement period who had: • MCV – 1 dose • Tdap/Td – 1 dose • Combo – 1 MCV and1 Tdap/Td	KidsCare members	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	• Claims • Encounters • Medical Record Reviews • ASIIS Immunization Registry • Electronic Health Records	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 • MCV – 1 dose: • Tdap/Td – 1 dose: • Combo – 1 MCV and 1 Tdap/Td: *Remeasurement period*: CYE 2015: October 1, 2014 through September 30, 2015 • MCV – 1 dose: • Tdap/Td – 1 dose: • Combo – 1 MCV and 1 Tdap/Td:

Member satisfaction in the KidsCare program will improve over the waiver demonstration period	**<u>Member Satisfaction</u>** Percentage of members (adults and children) who give the highest ratings (9 or 10) for: • Rating of health plan • Rating of personal doctor/nurse • Rating of receipt of health care • Rating of specialist seen most often • Getting needed care • Getting prescription medicine • Getting care quickly • How well doctors communicate	KidsCare members enrolled in an AHCCCS acute health plan	Random selection of enrolled KidsCare members from each Acute care Contractor. Survey data will be collected using an independent survey research firm.	Member Survey Sampling will occur utilizing the HEDIS methodology technical specifications	*Measurement period*: TBD • Rating of health plan: • Rating of personal doctor/nurse: • Rating of receipt of health care: • Rating of specialist seen most often: • Getting needed care: • Getting prescription medicine: • Getting care quickly: • How well doctors communicate:

Demonstration Focus Area: Family Planning Extension Program

Hypotheses:

- *Access to family planning services for members enrolled in the Family Planning Demonstration Program will be maintained over the waiver demonstration period as demonstrated by:*
  - The utilization rate of family planning services for women enrolled in the Family Planning Extension Program will be maintained or increase

HYPOTHESES	PERFORMANCE MEASURE	TARGET POPULATION	SAMPLING METHODOLOGY	DATA SOURCE	MEASUREMENT PERIOD
The utilization rate of family planning services for women enrolled in the Family Planning Extension Program will be maintained or increase	The rate women in enrolled in the Family Planning Extension Program use family planning services	Family Planning Extension Program members	A sampling methodology will not be utilized for this measure.	Claims Encounters Electronic health records	*Baseline measurement period:* CYE 2011: November 1, 2010 through September 30, 2011 Family Planning Service Utilization rate: *Remeasurement period:* CYE 2016: October 1, 2015 through September 30, 2016 Family Planning Service Utilization rate:

Demonstration Focus Area: Employer Sponsored Insurance (ESI) Program

Hypotheses:

- *Participation in Employer Sponsored Insurance will be maintained for individuals employed by a small business with a family income below 200 percent of the FPL as a result of receiving premium assistance:*
  - The number of requests for premium subsidies for employer sponsored insurance will not increase

HYPOTHESES	PERFORMANCE MEASURE	TARGET POPULATION	SAMPLING METHODOLOGY	DATA SOURCE	MEASUREMENT PERIOD
The number of requests for premium subsidies for employer sponsored insurance will not increase	The number of individuals approved annually for ESI premium subsidies compared annually.	ESI eligible individuals	Sampling will not be utilized for this measure	ESI applications	*Baseline measurement period:* CYE 2012: October 1, 2011 through September 30, 2012 Number of subsidies approved: *Remeasurement period:* CYE 2013: October 1, 2012 through September 30, 2013 Number of subsidies approved: CYE 2014: October 1, 2013 through September 30, 2014 Number of subsidies approved: CYE 2015: October 1, 2014 through September 30, 2015 Number of subsidies approved: CYE 2016: October 1, 2015 through September 30, 2016 Number of subsidies approved:

Demonstration Focus Area: Cost Sharing, Mandatory Copays for Childless Adults

Hypotheses:

- *Quality of Care: Implementing mandatory copays on the Childless Adult population will improve appropriate use of services related to chronic disease management and brand and generic medication selection*
  - The relative use of office visits for ongoing asthma care for Adults Without Dependent Children will be similar to that of TANF Adults
  - The relative use of office visits for ongoing diabetes care for Adults Without Dependent Children will be similar to that of TANF Adults
  - The relative use of brand name medications by Adults Without Dependent Children will not change as a result of implementation of mandatory copayment

- *Access to Care: The implementation of mandatory copays on the Childless Adult population will not result in an increase in the use of the emergency room.*
  - The relative use of inpatient services provided to the Adults Without Dependent Children will not change as a result of implementation of mandatory copayments for office visits
  - The relative readmission rate of Adults Without Dependent Children will not change as a result of implementation of mandatory copayments

- *Access to Care: The implementation of mandatory copays on the Childless Adult population for non-emergency transportation will not adversely affect access to care*
  - The relative access to care for Adults Without Dependent Children in Maricopa and Pima counties who pay a transportation copayment will be similar to the relative access to care for Adults Without Dependent Children in all counties excluding Maricopa and Pima.

- *Access to Care: Implementing mandatory copays on non-emergency medical transportation for the Childless Adult population in Maricopa and Pima counties will not result in a decrease in the rate at which these members use provider office visits.*

HYPOTHESES	PERFORMANCE MEASURE	TARGET POPULATION	SAMPLING METHODOLOGY	DATA SOURCE	MEASUREMENT PERIOD
The relative use of office visits for the Adults Without Dependent Children will be consistent with office visit rates for TANF Adults that are not charged a copayment for office visits.	Effect of charging Adults Without Dependent Children mandatory copayments for office visits on access to care in a primary or specialty provider's office • Office visits	Target population: Childless Adults without dependent children Control Group population: TANF Adults	The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure. Adults Access to Preventive and Ambulatory Care Measure	Claims Encounters Electronic health records	*Baseline measurement period:* CYE 2011: November 1, 2010 through September 30, 2011 Pre copay implementation: Target Group Adults Without Dependent Children Inpatient rate: Control Group, TANF Adults: Inpatient rate: *Remeasurement period:* CYE 2013: October 1, 2012 through September 30, 2013 Post copay implementation Target Group Adults Without Dependent Children Inpatient rate: Control Group, TANF Adults: Inpatient rate:
The relative use of inpatient services	Effect of Adults Without Dependent Children mandatory copayments for	Target population:	Members will be identified using the	Claims	*Baseline measurement period:*

provided to the Adults Without Dependent Children will not change as a result of implementation of mandatory copayments for office visits	office visits on utilization of the following service category: • Inpatient services	Childless Adults without dependent children • Pre copayment implementation • Post copayment implementation Control Group population: • TANF Adults	NCQA HEDIS methodology to identify individuals diagnosed with asthma. The NCQA HEDIS Access to Care Measure will be utilized to measure access to care.	Encounters Electronic health records	CYE 2011: November 1, 2010 through September 30, 2011 Pre copay implementation: Target Group Adults Without Dependent Children Inpatient rate: Control Group, TANF Adults: Inpatient rate: *Remeasurement period:* CYE 2013: October 1, 2012 through September 30, 2013 Post copay implementation Target Group Adults Without Dependent Children Inpatient rate: Control Group, TANF Adults: Inpatient rate:
The implementation of mandatory copays on the Childless Adult population for non-emergency use of the emergency room will decrease	Effect of Adults Without Dependent Children mandatory copayments non-emergency use of the emergency room: • ED visits per 1,000 members in the target population	Target population: Childless Adults without dependent children • Pre	A sampling methodology will not be utilized for the this measure.	Claims Encounters Electronic health records	*Baseline measurement period:* CYE 2011: November 1, 2010 through September 30, 2011 Pre copay implementation: Target Group Adults Without

utilization of non-emergency visits		copayment implementation • Post copayment implementation Control Group population: • TANF Adults			Dependent Children ED visits per 1,000: Control Group, TANF Adults: ED visits per 1,000: *Remeasurement period:* CYE 2013: October 1, 2012 through September 30, 20 Post copay implementation Target Group Adults Without Dependent Children ED visits per 1,000: Control Group, TANF Adults: ED visits per 1,000:
The relative readmission rate of Adults Without Dependent Children will not change as a result of implementation of mandatory copayments	Effect of Adults Without Dependent Children mandatory copayments on utilization of the following service category: • Inpatient readmissions within 30 days	Target population: Adults Without Dependent Children • Pre copayment implementation	A sampling methodology will not be utilized for this measure	Claims Encounters Electronic health records	*Baseline measurement period:* CYE 2011: November 1, 2010 through September 30, 2011 Pre copay implementation: Target Group Adults Without Dependent Children Readmission rate:

		• Post copayment implementation Control Group population: • TANF Adults			Control Group, TANF Adults: Readmission rate: *Remeasurement period:* CYE 2013: October 1, 2012 through September 30, 20 Post copay implementation Target Group Adults Without Dependent Children Readmission rate: Control Group, TANF Adults: Readmission rate:
The relative use of brand name medications by Adults Without Dependent Children will not change as a result of implementation of mandatory copayments	Effect of Adults Without Dependent Children mandatory copayments on utilization of the following service categories: • Pharmacy utilization o Brand name o Generic	Target population: Adults Without Dependent Children • Pre copayment implementation • Post copayment implem	A sampling methodology will not be utilized for this measure.	Claims Encounters Electronic health records	*Baseline measurement period:* CYE 2011: November 1, 2010 through September 30, 2011 Pre copay implementation: Target Group Adults Without Dependent Children Brand Name rate: Generic rate: Control Group, TANF Adults: Brand name rate:

		entation Control Group population: • TANF Adults			Generic rate: *Remeasurement period:* CYE 2013: October 1, 2012 through September 30, 20 Post copay implementation Target Group Adults Without Dependent Children Brand name rate: Generic rate: Control Group, TANF Adults: Brand name rate: Generic rate: Inpatient:
The relative use of office visits for ongoing asthma care for Adults Without Dependent Children will be similar to that of TANF Adults	**<u>Asthma</u>** Effect of Adults Without Dependent Children mandatory copayments on utilization of the following service category: • Routine and ongoing health care for childless adult members without children diagnosed with asthma	Target population: Adults Without Dependent Children who meet enrollment criteria and are diagnosed with asthma Control population: TANF Adults who meet enrollment	Members will be identified using the NCQA HEDIS methodology to identify individuals diagnosed with asthma. The NCQA HEDIS Access to Care Measure will be utilized to measure access to care.	Claims Encounters Electronic health records Chart review	*Baseline measurement period:* CYE 2011: November 1, 2010 through September 30, 2011 Pre copay implementation: Target Group Adults Without Dependent Children Access to care rate: Control Group, TANF Adults: Access to care rate:

		criteria and are diagnosed with asthma			*Remeasurement period:* CYE 2013: October 1, 2012 through September 30, 20 Post copay implementation Target Group Adults Without Dependent Children Access to care rate: Control Group, TANF Adults: Access to care rate:
The relative use of office visits for ongoing diabetes care for Adults Without Dependent Children will be similar to that of TANF Adults	**<u>Diabetes</u>** Effect of Adults Without Dependent Children mandatory copayments on utilization of the following service categories: • Routine and ongoing health care for Adults Without Dependent Children diagnosed with diabetes	Target population: Adults Without Dependent Children who are diagnosed with diabetes Control population: TANF Adults who meet enrollment criteria and are diagnosed with diabetes	Members will be identified using the NCQA HEDIS methodology to identify individuals diagnosed with diabetes. The NCQA HEDIS Access to Care Measure will be utilized to measure access to care.	Claims Encounters Electronic health records Chart review	*Baseline measurement period:* CYE 2011: November 1, 2010 through September 30, 2011 Pre copay implementation: Target Group Adults Without Dependent Children Access to care rate: Control Group, TANF Adults: Access to care rate: *Remeasurement period:* CYE 2013: October 1, 2012 through September 30, 20 Post copay implementation

					Target Group Adults Without Dependent Children Access to care rate: Control Group, TANF Adults: Access to care rate:
The relative access to care for Adults Without Dependent Children in Maricopa and Pima counties who pay a transportation copayment will be similar to the relative access to care for Adults Without Dependent Children in all counties excluding Maricopa and Pima.	Effect of Adults Without Dependent Children mandatory non-emergency transportation copayments on access to care in Maricopa and Pima counties compared to the same population in all other counties.	Target population: Adults Without Dependent Children in Maricopa and Pima Counties Control Group 1: TANF Adults in Maricopa and Pima Counties Control Group 2: Adults Without Dependent Children in all counties excluding Maricopa and Pima counties	Access to Care Measure. The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	Claims Encounters	*Baseline measurement period:* CYE 2011: April 1, 2012 through September 30, 2012 Pre copay implementation: Target Group Adults Without Dependent Children Access to care rate: Control Group 1, TANF Adults: Access to care rate: Control Group 2, Adults Without Dependent Children in all counties except Maricopa and Pima counties: Access to care rate: *Remeasurement period:* CYE 2013: October 1, 2012 through September 30, 2013

					Post copay implementation Target Group Adults Without Dependent Children Access to care rate: Control Group, TANF Adults: Control Group 2, Adults Without Dependent Children in all counties except Maricopa and Pima counties: Access to care rate:

Demonstration Focus Area: Permissible Provider Fee for Missed Appointments Evaluation

As specified in paragraph 17(e), the authority to impose this copayment is time limited, and will expire on January 1, 2013

Hypothesis:

- *Access to Care: Charging a $3 fee to TANF parents and adults without children who miss a scheduled appointment without cancelling will not result in a decrease in the utilization rate of office visits.*
  - The rate of missed appointments will decrease for TANF Parents and Adults without Dependent Children that are charged a missed appointment fee
  - The number and percent of TANF Parents and Adults Without Dependent Children that have been assessed a missed appointment fee and denied an appointment because of the outstanding fee will not increase

- *Access to Care: TANF parents and adults without children who are charged a $3 missed appointment fee will not increase their utilization of walk-in clinics, urgent care, or emergency rooms, resulting in no additional higher level of care costs to the AHCCCS program*
  - The relative rate of utilization of urgent care centers, walk-in clinics and/or emergency departments by TANF Parents and Adults Without Dependent Children that have been assessed a missed appointment fee will not increase

- *Health Care Disparities: There are no differences in the TANF parents or adults without children populations such as race, ethnicity, or age that result in an inability to pay the $3 missed appointment fee.*
  - Performance measures analysis will include age, gender and race/ethnicity

- *Administrative Complexities: The complexities of meeting the requirements specified by CMS to be eligible to implement the missed appointment fee will result in a limited number of providers being able to take on the administrative workload.*
  - The administrative requirements to allow a primary care provider to implement a missed appointment fee will limit the number of providers that choose to assess missed appointment fees

HYPOTHESES	PERFORMANCE MEASURE	TARGET POPULATION	SAMPLING METHODOLOGY	DATA SOURCE	MEASUREMENT PERIOD
The rate of missed appointments will decrease for TANF Parents and Adults without Dependent Children that are charged a missed appointment fee	The relative rate of utilization of office visits (access to care) pre- and post-missed appointment fee implementation for the following populations excluding Maricopa and Pima counties: • TANF Parents • Adults Without Dependent Children Additional analysis will include: • Age • Gender • Race/Ethnicity	TANF Parents and Adults Without Dependent Children	TANF Parents and Adults without Dependent Children excluding Maricopa and Pima counties. The National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS)® methodology, or the CMS Core Measure Set methodology if different, including the sampling methodology will be utilized for this measure.	Reports and data submitted by providers that choose to implement the missed appointment fee	*Baseline measurement period:* CYE 2011, October 1, 2010 through September 30, 2011 TANF Parents Pre-Implementation Missed Appointment Fee:: Access to Care: Childless Adults Pre-Implementation Missed Appointment Fee:: Access to Care: *Remeasurement period* ***Will be measured the contract year in which a provider submits a request to charge members missed appointment fees.*** CYE 2011, February 1, 2012 through January 1, 2013 TANF Parents Pre-Implementation Missed Appointment Fee:: Access to Care: Childless Adults Pre-Implementation Missed Appointment Fee::

					Access to Care:
The relative rate of utilization of urgent care centers, walk-in clinics and/or emergency departments by TANF Parents and Adults Without Dependent Children that have been assessed a missed appointment fee will not increase	The relative rate of utilization of urgent care, walk-in clinics and emergency departments pre- and post-missed appointment fee implementation for the following populations excluding Maricopa and Pima counties: • TANF Parents • Adults Without Dependent Children Additional analysis will include: • Age • Gender • Race/Ethnicity • ED/1,000	TANF Parents and Adults Without Dependent Children	TANF Parents and Adults without Dependent Children excluding Maricopa and Pima counties.	Reports and data submitted by providers that choose to implement the missed appointment fee Claims Encounters	*Baseline measurement period:* CYE 2011, October 1, 2010 through September 30, 2011 TANF Parents Pre-Implementation Missed Appointment Fee: ED rate per 1,000: UC rate per 1,000: Childless Adults Pre-Implementation Missed Appointment Fee:: ED rate per 1,000: UC rate per 1,000: *Remeasurement period* ***Will be measured the contract year in which a provider submits a request to charge members missed appointment fees.*** CYE 2011, February 1, 2012 through January 1, 2013 TANF Parents Pre-Implementation Missed Appointment Fee::

					ED rate per 1,000: UC rate per 1,000: Childless Adults Pre-Implementation Missed Appointment Fee:: ED rate per 1,000: UC rate per 1,000
The number and percent of TANF Parents and Adults Without Dependent Children that have been assessed a missed appointment fee and denied an appointment because of the outstanding fee will not increase	The number and percent of appointments denied due to unpaid missed appointment fees for the following populations excluding Maricopa and Pima counties: • TANF Parents • Adults Without Dependent Children Additional analysis will include: • Age • Gender • Race/Ethnicity	TANF Parents and Adults Without Dependent Children Assigned to a PCP outside of Maricopa or Pima County that participates in assessing missed appointment fees	TANF Parents and Adults without Dependent Children excluding Maricopa and Pima counties.	Reports and data submitted by providers that choose to implement the missed appointment fee Claims Encounters	*One time measurement:* CYE 2011, October 1, 2010 through September 30, 2011 TANF Parents: • Number of denied appointments • Percent of denied appointments
The administrative requirements to allow a primary care provider to implement a missed appointment fee will limit the number of providers that	The percent of primary care providers that are assigned TANF Parents and Adults Without Dependent Children that implement a missed appointment fee: Analysis will include: • Overall percentage • Provider type	Providers outside of Maricopa and Pima Counties that are assigned TANF Parents and Adults Without Dependent Children and of	No sampling. Based on requests received from providers to implement the missed appointment fee.	Reports and data submitted by providers that choose to implement the missed	*One time measurement:* CYE 2011, October 1, 2010 through September 30, 2011 • Overall percent of primary care providers assigned TANF Parents and Adults

choose to assess missed appointment fees	• Region of the State	those, the primary care providers that implement the missed appointment fee requirements.		appointment fee	Without Dependent Children that implement a missed appointment fee o Provider Type o Region of the State

Demonstration Focus Area: Uncompensated Care Payments to IHS and 638 Facilities

Hypotheses:

- *Access to Care: Implementing uncompensated care payments to I.H.S. and 638 facilities will allow staffing levels to be maintained or increased.*
  - The I.H.S. and 638 facilities will be able to maintain or increase their staffing levels

- *Access to Care: Uncompensated care payments to I.H.S. and 638 facilities will increase capacity to provide care and services resulting in AHCCCS I.H.S. members receiving health care services.*
  - Childhood immunization rates for children receiving services through an I.H.S or 638 facility will be maintained
  - Access to oral health care providers for members receiving services through an I.H.S. or 638 facility that are 0 to 21 years of age will be maintained
  - The relative rate of ideal glycemic control of members receiving services through an I.H.S or 638 facility that are diagnosed with diabetes will be maintained
  - The relative rate of members receiving services through an I.H.S or 638 facility that are diagnosed with diabetes that are assessed for dyslipidemia will be maintained

HYPOTHESES	PERFORMANCE MEASURE	TARGET POPULATION	SAMPLING METHODOLOGY	DATA SOURCE	MEASUREMENT PERIOD
The I.H.S. and 638 facilities will be able to maintain or increase their staffing levels	**Staffing levels** The number of providers per I.H.S. and 638 facility.	I.H.S. and 638 facilities	No sampling.		*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 Pre-implementation: Average staffing ratio: *Remeasurement period* CYE 2013: October 1, 2012 through September 30, 2013 Post-implementation: Average staffing ratio:
Childhood immunization rates for children receiving services through an I.H.S or 638 facility will be maintained	**Childhood Immunization Rates:** GPRA Measure 24: Combined (4:3:1:3:3:1:4) immunization rates for AI/AN patients aged 19-35 months. [outcome]	I.H.S. and 638 facilities – AHCCCS Members receiving services at I.H.S. and 638 facilities.	Government Performance and Results Act (GPRA) Quality Measures published methodologies GPRA Measure 24: Combined (4:3:1:3:3:1:4) immunization rates for AI/AN patients aged 19-35 months. [outcome]	I.H.S. GPRA Reported Measures	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 Pre-implementation: GPRA Childhood Immunization Rate: *Remeasurement period* CYE 2013: October 1, 2012 through September 30, 2013 Post-implementation: GPRA Childhood Immunization Rate:
Access to oral health care providers for	**Oral health care for children ages 0 to 21 years of age**	I.H.S. and 638 facilities – AHCCCS	Government Performance and Results Act (GPRA)	I.H.S. GPRA Reported	*Baseline measurement period:* CYE 2011: October 1, 2010

members receiving services through an I.H.S. or 638 facility that are 0 to 21 years of age will be maintained	GPRA Measure 13. Dental Access: Percent of patients who receive dental services. GPRA Measure 14. Dental Sealants: Number of sealants placed per year in AI/AN patients. [outcome] GPRA Measure 12. Topical Fluorides: Number of AI/AN patients receiving one or more topical fluoride. [outcome]	Members receiving services at I.H.S. and 638 facilities	Quality Measures published methodologies	Measures	through September 30, 2011 Pre-implementation: *GPRA Dental Performance Measure Result:* • General Access : • Sealants: • Topical Fluoride: *Remeasurement period* CYE 2016: October 1, 2015 through September 30, 2016 Post-implementation: *GPRA Dental Performance Measure Result:* • General Access: • Sealants: • Topical Fluoride:
The relative rate of ideal glycemic control of members receiving services through an I.H.S or 638 facility that are diagnosed with diabetes will be maintained The relative rate of members receiving services through an I.H.S or 638	**Diabetes** GPRA Measure 3. Diabetes: Blood Pressure Control: Proportion of patients with diagnosed diabetes that have achieved blood pressure control (<130/80). [outcome] GPRA Measure 2. Diabetes: Ideal Glycemic Control: Proportion of patients with diagnosed diabetes with ideal glycemic control (A1c < 7.0). [outcome]	I.H.S. and 638 facilities – AHCCCS Members receiving services at I.H.S. and 638 facilities.	Government Performance and Results Act (GPRA) Quality Measures published methodologies.	I.H.S. GPRA Reported Measures	*Baseline measurement period:* CYE 2011: October 1, 2010 through September 30, 2011 Pre-implementation: *GPRA Diabetes Performance Measure Results:* • Ideal Blood Pressure Control: • Ideal Blood Sugar Control: • LDL Cholesterol

facility that are diagnosed with diabetes that are assessed for dyslipidemia will be maintained	GPRA Measure 4. Diabetes: LDL Assessment: Proportion of patients with diagnosed diabetes assessed for dyslipidemia (LDL cholesterol). [outcome]				Assessed: *Remeasurement period* CYE 2016: October 1, 2015 through September 30, 2016 Post-implementation: *GPRA diabetes Performance Measure Results:* • Ideal Blood Pressure Control: • Ideal Blood Sugar Control: • LDL Cholesterol Assessed: