Arizona Health Care Cost Containment System

AHCCCS
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Contract Year Ending 2018 External Quality Review Annual Report

for

Arizona Long Term Care System (ALTCS) Contractors

July 2019

HSAG HEALTH SERVICES ADVISORY GROUP

Contents

Overview of the Contract Year Ending (CYE) 2018 External Review

The Code of Federal Regulations (CFR) at 42 CFR §438.364[1-1] requires that states use an external quality review organization (EQRO) to prepare an annual technical report that describes how data from activities conducted for Medicaid managed care organizations (MCOs), in accordance with the CFR, were aggregated and analyzed. The annual technical report draws conclusions about the quality of, timeliness of, and access to healthcare services that MCOs provide.

According to 42 CFR, Part 438 Subpart E, External Quality Review, §438.358(b) and (c), the three mandatory activities for each MCO, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) are:

- Validation of performance improvement projects (PIPs).
- Validation of performance measures (PMs) required in accordance with §438.330(b)(2).
- A review conducted within the previous three-year period to determine the MCO's, PIHP's, or PAHP's compliance with the standards set forth in Subpart D of §438.

For contracts starting on or after July 1, 2018, and no later than one year from the issuance of the revised EQR protocol, according to requirements set forth in §438.68, the Centers for Medicare & Medicaid Services (CMS) will require validation of MCO, PIHP, or PAHP network adequacy. For the purposes of this report, network validation is not applicable.

In accordance with the 42 CFR §438.358(a), the state; its agent that is not an MCO PIHP, PAHP, or primary care case manager (PCCM) entity (described in §438.310[c][2]); or an EQRO may perform the mandatory and optional EQR-related activities.

As permitted by CMS and incorporated under federal regulation at 42 CFR Part 438, AHCCCS elected to retain responsibility for performing the three of the EQR mandatory activities described in 42 CFR §438.358 (b) (validation of network adequacy is not in effect for this annual report). AHCCCS prepared Contractor-specific reports of findings related to each of the activities, and, as applicable, required Contractors to prepare and submit their proposed corrective action plans (CAPs) to AHCCCS for review and approval.

AHCCCS contracted with Health Services Advisory Group, Inc. (HSAG) as its CMS-required EQRO to prepare this annual EQR technical report. This report presents AHCCCS' findings from conducting each activity as well as HSAG's analysis and assessment of the reported results for each Contractor's performance and, as applicable, recommendations to improve Contractors' performance.

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register* Vol. 81, No. 88/Friday, May 6, 2016, Rules and Regulations, p. 27886. 42 CFR §438.364 Medicaid Program; External Quality Review, Final Rule.

HSAG is an EQRO that meets the competence and independence requirements set forth in 42 CFR §438.354. HSAG has extensive experience and expertise in both conducting the mandatory activities and in analyzing information obtained from AHCCCS' reviews of the activities. Accordingly, HSAG uses the information and data to draw conclusions and make recommendations about the quality and timeliness of, and access to care and services that AHCCCS' Contractors provide.

To meet the requirements set forth in 42 CFR §438.364, as the EQRO, HSAG must use the information AHCCCS obtained to prepare and to provide to AHCCCS EQR results in an annual, detailed technical report that summarizes findings on the quality, timeliness, and access to healthcare services, to include:

- A description of the manner in which the data from all activities conducted were aggregated and analyzed.
- For each external quality review (EQR)-related activity conducted:
  - Objectives.
  - Technical method of data collection and analysis.
  - Description of the data obtained.
  - Conclusions drawn from the data.
- An assessment of each Contractor's strengths and weaknesses.
- Recommendations for improving the quality of care furnished by each Contractor including how the State can target goals and objectives in the quality strategy, under 42 CFR §438.340, to better support improvement in the quality, timeliness, and access to healthcare services furnished to Medicaid members.
- Methodologically appropriate comparative information about all Contractors (described in §438.310[c][2]), consistent with guidance included in the EQR protocols.
- An assessment of the degree to which each Contractor has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

HSAG has prepared the annual technical report for AHCCCS for 15 consecutive years. The report complies with all requirements set forth at 42 CFR §438.364.

This executive summary includes an overview of AHCCCS' EQR activities as provided to HSAG and a high-level summary of the results. The results include a description of HSAG's findings with respect to performance by the AHCCCS Contractors in complying with the AHCCCS contract requirements and the applicable federal 42 CFR §438 requirements for each activity. In addition, this executive summary includes an assessment of each Contractor's strengths and weaknesses related to the quality and timeliness of, and access to, healthcare services and HSAG's recommendations for improving the quality of services.

Additional sections of this annual EQR technical report include the following:

- Section 2—An introduction to the annual technical report, including a description of the EQR mandatory activities.

- Section 3—An overview of AHCCCS' background including the Medicaid managed care history, AHCCCS' strategic plan with key accomplishments for CYE 2018, and AHCCCS' quality strategy.
- Section 4—An overview of AHCCCS' statewide quality initiatives across its Medicaid managed care program and those that are specific to the ALTCS program for CYE 2018.
- Section 5—An overview of the Contractors' best and emerging practices for CYE 2018.
- Section 6 (Organizational Assessment and Structure Performance)—A presentation of the CYE 2016 Contractor-specific operational review (OR) CAPs for MCP-LTC and DES/DDD (those Contractors still had outstanding CAPs in CYE 2018) and HSAG's associated findings and recommendations.
- Section 7 (Performance Measure Results)—A presentation of results for AHCCCS-selected performance measures for each ALTCS Contractor and DES/DDD, as well as HSAG's associated findings and recommendations for CYE 2017.
- Section 8 (Performance Improvement Project Performance)—A presentation of Contractor-specific CYE 2017 PIP rates as well as qualitative analyses and interventions for the ALTCS Contractors.

Please see appendices A, B, and C for an overview of the AHCCCS methodology for the OR, PM, and PIP activities, including objectives, descriptions of data obtained, technical methods of data collection and analysis, scoring methodology, and corrective action statements.

Contractors Reviewed

During the CYE 2016 review cycle, AHCCCS contracted with the Contractors[1-2] listed below to provide services to members enrolled in the AHCCCS ALTCS Medicaid managed care program. Associated abbreviations are included.

- Bridgeway Health Solutions (BWY)
- Mercy Care Plan-Long Term Care (MCP-LTC)
- UnitedHealthcare Community Plan-Long Term Care (UHCCP-LTC)
- Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD)*

*Note: In March 2017, AHCCCS issued a Notice to Cure to DES/DDD citing violations to Contract YH06-0014 related to DES/DDD's process for identification of qualified vendors to provide timely authorized care and services to members, stating that DES/DDD's failure resulted in significant delays in obtaining necessary services for members. In addition, in April 2017, AHCCCS issued a Notice to Cure to DES/DDD citing violations to Contract YH06-0014 related to the failure of DES/DDD's care coordination processes to address delivery of medically necessary care and services to members. In each case, DES/DDD was required to submit a corrective action plan.

[1-2] Note: Title 42 CFR §438.2 defines "managed care organization (MCO)," in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." CMS designates all AHCCCS Contractors as MCOs. Unless citing Title 42 CFR, this report will refer to AHCCCS' MCOs as Contractors.

From June 28, 2018 to July 3, 2018, AHCCCS' Division of Health Care Management (DHCM) conducted an on-site audit of DES/DDD in response to identified patterns of noncompliance with quality management requirements. The audit findings identified significant noncompliance with AHCCCS contract and policy requirements, immediate concerns regarding members' health and safety, and fundamental concerns about DES/DDD's quality management structure and operations.

In October 2018, AHCCCS issued a Notice to Cure to DES/DDD citing violations to Contract YH06-0014 for critical and substantial failures identified by AHCCCS during the on-site audit by DHCM of DES/DDD's quality management activities. Specifically, DHCM identified quality incident reports, including medication errors that DES/DDD had not evaluated, triaged using a clinician, or investigated. DHCM found that not only had these incidents created a substantial backlog, DES/DDD's failure to timely and thoroughly review these incidents placed the health and safety of members at risk. DES/DDD was required to develop an action plan to address the failures and to hire a third-party agency/ consultants, with the appropriate clinical expertise and qualifications, to assist the Contractor in completing the identification and resolution of each incident report. In addition, DES/DDD was required to perform tracking and trending of all incident reports and develop a comprehensive tracking report. Finally, AHCCCS located its Quality Manager on-site at DES/DDD for 90 days to be directly responsible for the management and oversight of DES/DDD's quality management unit.

Findings, Conclusions, and Recommendations About the Quality of, Timeliness of, and Access to Care

The following section provides a high-level summary of HSAG's findings and conclusions about the quality of, timeliness of, and access to care provided to AHCCCS members.

Organizational Assessment and Structure Standards

AHCCCS conducted a comprehensive OR for each Contractor during CYE 2016. In CYE 2017 and CYE 2018, AHCCCS monitored the progress of all Contractors in implementing their CAPs from the CYE 2016 OR. CAPs for UHCCP-LTC and BWY were closed in CYE 2017. Contractor-specific CAP results for MCP-LTC and DES/DDD are presented following.

The CYE 2016 OR was organized into 12 standard areas. For the ALTCS Contractors, each standard area consisted of several elements designed to measure the Contractor's performance and compliance.

In accordance with the EQRO protocols and based on AHCCCS' review findings and assessment of the degree to which the Contractor complied with the standards, AHCCCS defined what constituted "compliance" and identified the evidence and details it required to satisfy compliance with the standards.

Each standard area contains elements designed to measure the Contractor's performance and compliance with the federal managed care rules and the AHCCCS ALTCS contract provisions. A Contractor may receive up to a maximum possible score of 100 percent for each standard measured during the CYE

2016 OR review cycle. Within each standard are specific scoring detail criteria worth a defined percentage of the total possible score.

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

Contractors are required to complete a CAP for any standard for which the total score is less than 95 percent. In addition, when AHCCCS evaluated performance for a standard as less than fully compliant or made a recommendation worded as "The Contractor must" or "The Contractor should," the Contractor was required to develop a CAP, submit it to AHCCCS for review and approval, and implement the corrective actions once approved.

Overall Compliance Scores for the CYE 2016 OR Review Cycle

AHCCCS conducted the comprehensive OR for the ALTCS Contractors in CYE 2016. Table 1-1 details the percentage score for each Contractor for each of the 12 standards.

Table 1-1—ALTCS Contractors' Standard Area Scores for the CYE 2016 OR Review Cycle

Standard	BWY	MCP-LTC	UHCCP-LTC	DES/DDD
Case Management (CM)	98%	94%	97%	93%
Corporate Compliance (CC)	95%	93%	92%	87%
Claims and Information Systems (CIS)	92%	96%	88%	73%
Delivery Systems (DS)	100%	98%	92%	93%
General Administration (GA)	100%	100%	100%	100%
Grievance Systems (GS)	100%	96%	100%	100%
Adult, EPSDT, and Maternal Child Health (MCH)	100%	100%	100%	100%
Medical Management (MM)	99%	96%	97%	92%
Member Information (MI)	97%	100%	100%	100%
Quality Management (QM)	96%	97%	98%	97%
Reinsurance (RI)	100%	100%	100%	63%
Third-Party Liability (TPL)	100%	100%	100%	57%

As indicated in Table 1-1, BWY and UHCCP-LTC received standard area scores of 100 percent for most standards (six). BWY received only one standard area score below the 95 percent compliance threshold. For DES/DDD, seven standards received scores below the 95 percent compliance threshold and four standards received 100 percent compliance. MCP-LTC received 100 percent compliance for five standards and met the 95 percent compliance threshold on five standards.

Table 1-2 details the number of Contractors with standard area scores that met or exceeded the 95 percent compliance threshold, as well as the number that fell below the 95 percent compliance threshold for the ORs conducted in CYE 2016 for the CYE 2016 review cycle.

Table 1-2—Number of Contractors Meeting Compliance Thresholds

Standard Area	Number of Contractors that Received Full Compliance (100%)*	Number of Contractors at or Above the 95% Compliance Threshold	Number of Contractors Below the 95% Compliance Threshold
Case Management	0	2	2
Corporate Compliance	0	1	3
Claims and Information Systems	0	1	3
Delivery Systems	1	2	2
General Administration	4	4	0
Grievance Systems	3	4	0
Adult, EPSDT, and Maternal Child Health	4	4	0
Medical Management	0	3	1
Member Information	3	4	0
Quality Management	0	4	0
Reinsurance	3	3	1
Third-Party Liability	3	3	1

*This column is a subgroup of the "Number of Contractors at or Above the 95% Compliance Threshold" column.

Strongest performances were in the GA and MCH standards as all Contractors received full compliance (100 percent). With the exception of the CM, CC, CIS, and DS standards, most Contractors scored at or above the 95 percent threshold on eight standards. For the GA, GS, MCH, MI, and QM standards, all Contractors scored at or above the 95 percent compliance threshold. For the MM, RI, and TPL standards, only one Contractor scored below the 95 percent compliance threshold. The lowest performance occurred in two standards, CC and CIS, as most Contractors scored below the 95 percent compliance threshold. For five standards (CM, CC, CIS, MM, and QM) no Contractor received a full compliance (100 percent) standard area score.

Overall Strengths

All Contractors received full compliance (100 percent) standard area scores, in the GA and MCH standards. Most Contractors scored at or above the 95 percent threshold on the GA, GS, MCH, MM, MI, QM, RI, and TPL standards. All Contractors scored at or above the 95 percent compliance threshold for the GA, GS, MCH, MI, and QM standards. For the MM, RI, and TPL standards, only one Contractor scored below the 95 percent compliance threshold.

Overall Opportunities for Improvement and Recommendations

Contractors had the lowest performance in four standards (CM, CC, CIS, DS), as more than one Contractor scored below the 95 percent compliance threshold. The standards for which the most Contractors scored below the 95 percent compliance threshold were the CC and CIS standards (three Contractors). Notably, for five standards (CM, CC, CIS, MM, and QM) no Contractor received a full compliance (100 percent) standard area score. Although DES/DDD received 100 percent compliance for four standards, DES/DDD received standard area scores below the 95 percent compliance threshold for most standards (seven).

A comprehensive OR was completed in CYE 2016 for the ALTCS Contractors; therefore, AHCCCS only needed to review the CAPs in CYE 2017 and CYE 2018. Based on the results from the CYE 2016 OR and subsequent CAP updates, HSAG makes the following general recommendations to ALTCS Contractors regarding ORs:

- Contractors should continue to conduct internal reviews of operational systems to identify barriers that affect compliance with AHCCCS standards, State rules, and federal regulations. Specifically, Contractors should cross-reference existing policies, procedures, and information distributed to providers, subcontractors, and members with AHCCCS requirements and ensure, at a minimum, alignment with both the intent and content of AHCCCS standards, State rules, and federal regulations.
- Contractors should continue to regularly monitor and ensure that updates are made to contracts with providers and that policy manual updates from AHCCCS are also included when issued in Contractors' policies, procedures, and manuals (if impacted by the updates). Contractors should also continue to ensure that communications to all areas directly and indirectly impacted by these updates (including Contractor staff, providers, subcontractors, and members) are provided and documented. In addition, Contractors should continue to assess current monitoring processes and activities to identify strengths and opportunities for improvement within operational processes and implement periodic assessments of those elements reviewed by AHCCCS for which Contractors are found deficient.
- Contractors should continue to apply lessons learned from improving performance for one category of standards to other categories. Further, Contractors should continue to use opportunities to address and discuss issues identified during ORs.

Based on AHCCCS' review of the ALTCS Contractors' performance in the comprehensive OR in CYE 2016 and the subsequent CAP submissions, HSAG recommends the following:

- AHCCCS should consider distributing technical assistance documents to all Contractors and holding in-person meetings with Contractors that scored lowest in the ALTCS OR standards, including guidance on how to complete a CAP.
- AHCCCS should consider using the quarterly meetings with Contractors as forums in which to share lessons learned from both the State and Contractor perspectives. AHCCCS should present identified best practices on the predominant issues for ALTCS Contractors' issues and facilitate a group discussion on Contractors' policies and procedures. In addition, AHCCCS should consider

conducting a root cause analysis with the Contractors to determine why Contractors continue to have difficulty complying with specific standards.

Performance Measures

Aggregate Results for CYE 2017

AHCCCS collected data and reported Contractor performance for a set of performance measures for the CYE 2017 measurement period. For CYE 2017, AHCCCS selected four performance measures (five measure indicator rates) for the ALTCS Contractors and 12 performance measures (15 measure indicator rates) for DES/DDD to be reported in the annual report. The following tables display the performance measure rates with established minimum performance standards (MPS). An MPS had not yet been established for all reported performance measure rates. Contractor-specific results for performance measures with an MPS are included in Section 7, with additional performance measures (i.e., without an established MPS) included in Appendix B of this report.

Throughout the report, references to "significant" changes in performance indicate statistically significant differences between performance from CYE 2016 to CYE 2017. The threshold for a significant result is traditionally reached when the p value is ≤0.05.

Findings

Table 1-3 and Table 1-4 present the CYE 2016 and CYE 2017 aggregate performance measure results with an MPS for the ALTCS Contractors and DES/DDD. Of note, the ALTCS aggregate rates include all members who met the enrollment criteria based on enrollment for all three ALTCS Contractors. The tables display the following information: CYE 2016 performance, where available; CYE 2017 performance; the relative percentage change between CYE 2016 and CYE 2017 rates, where available; the significance of the relative percentage change, where available; and the AHCCCS MPS. Performance measure rate cells shaded green indicate that aggregate performance met or exceeded the CYE 2017 MPS established by AHCCCS. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the established MPS are shaded green.

Table 1-3—CYE 2016 and CYE 2017 Aggregate Performance Measure Results—ALTCS Contractors

Performance Measure	CYE 2016 Performance	CYE 2017 Performance	Relative Percentage Change	Significance Level (p value)[1]	MPS
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness[2]					
7-Day Follow-Up	—	30.3%	—	—	85.0%
30-Day Follow-Up	—	51.0%	—	—	95.0%
Utilization					

Performance Measure	CYE 2016 Performance	CYE 2017 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Ambulatory Care (per 1,000 Member Months)					
ED Visits—Total*	71.3	66.7	-6.4%	—	80.0
Plan All-Cause Readmissions					
Total*	11.7%	15.9%	35.9%	**P<0.001**	17.0%

* A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2016 and CYE 2017 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between CYE 2017 and prior years; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
— Indicates that the CYE 2016 rate was not displayed due to technical specification changes, or that a comparison of performance between CYE 2016 and CYE 2017 was not possible or appropriate.

    Cells shaded green indicate that the rate met or exceeded the CYE 2017 MPS established by AHCCCS.

Table 1-4—CYE 2016 and CYE 2017 Performance Measure Results—DES/DDD

Performance Measure	CYE 2016 Performance	CYE 2017 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Total	86.0%	85.8%	-0.2%	P=0.679	75.0%
Annual Dental Visits					
2–20 Years	51.9%	56.5%	8.9%	**P<0.001**	60.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	100.0%	96.2%	-3.8%	P=0.234	93.0%
25 Months–6 Years	89.6%	89.2%	-0.4%	P=0.645	84.0%
7–11 Years	92.0%	92.1%	0.1%	P=0.854	83.0%
12–19 Years	88.5%	89.6%	1.2%	**P=0.048**	82.0%
Pediatric Health					
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	43.5%	43.4%	-0.2%	P=0.923	41.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	51.2%	53.4%	4.3%	P=0.102	66.0%
Preventive Screening					
Breast Cancer Screening[2]					
Breast Cancer Screening	—	45.9%	—	—	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	17.4%	16.6%	-4.6%	P=0.296	64.0%

Performance Measure	CYE 2016 Performance	CYE 2017 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Chlamydia Screening in Women					
Total	9.7%	10.5%	8.2%	P=0.651	63.0%
Utilization					
Ambulatory Care (per 1,000 Member Months)					
ED Visits—Total*	43.0	39.1	-9.1%	—	43.0
Plan All-Cause Readmissions					
Total*	7.3%	11.3%	54.8%	**P=0.004**	11.0%

* *A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.*
[1] *Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2016 and CYE 2017 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.*
[2] *Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between CYE 2017 and prior years; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.*
— *Indicates that the CYE 2016 rate was not displayed due to technical specification changes, or that a comparison of performance between CYE 2016 and CYE 2017 was not possible or appropriate.*

⬛ *Cells shaded green indicate that the rate met or exceeded the CYE 2017 MPS established by AHCCCS.*

Conclusions

Compared to the CYE 2017 MPS, the ALTCS aggregate's performance in the **quality**, **access**, and **timeliness** areas indicated opportunities for improvement as both *Follow-Up After Hospitalization for Mental Illness* measure rates fell below the MPS.

Performance for DES/DDD within the **quality** area indicated opportunities for improvement, with five of six (83.3 percent) measure rates (*Breast Cancer Screening*; *Cervical Cancer Screening*; *Chlamydia Screening in Women*; *Plan All-Cause Readmissions*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) falling below the MPS. *Adolescent Well-Care Visits* was the only performance measure rate within the **quality** area that exceeded the MPS for DES/DDD.

DES/DDD demonstrated positive performance in the **access** area, exceeding the MPS for five of six (83.3 percent) performance measure rates (*Adults' Access to Preventive/Ambulatory Health Services* and *Children and Adolescents' Access to Primary Care Practitioners*). Despite falling below the MPS, the *Annual Dental Visits* performance measure rate demonstrated significant improvement from CYE 2016 to CYE 2017.

Additionally, the utilization performance measure rates (*Ambulatory Care*) for the ALTCS aggregate and DES/DDD should be monitored for informational purposes.

Recommendations

HSAG recommends that AHCCCS work with the ALTCS Contractors to increase rates for the behavioral health performance measure that failed to meet the CYE 2017 MPS. AHCCCS and the ALTCS Contractors should conduct root cause analyses for the low rates of follow-up visits after

hospitalization for mental illness to determine the nature and scope of the issue (e.g., barriers to care, lack of continuity of care, transportation issues, ineffective communication). Effective transition of care programs have been shown to reduce readmissions and exacerbation of symptoms related to mental illness by engaging the patient and family members (e.g., structured discharge checklist for accountability, awareness of red flags), establishing clear transition and care plans (e.g., follow-up appointments scheduled prior to discharge), utilizing transition coaches and providers (e.g., visits and phone calls to review illness management and questions), and ensuring effective provider communication (e.g., healthcare professionals understanding of transition and care plan).[1-3] After the key factors related to the low rates are identified, AHCCCS and the ALTCS Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase follow-up visits and improve member transitions of care.

Additionally, HSAG recommends that AHCCCS work with DES/DDD to increase preventive screenings for women. To understand the cause of the low rates, AHCCCS and DES/DDD should examine potential barriers (e.g., provider misconceptions, lack of education, member anxiety) to women receiving breast cancer, cervical cancer, and chlamydia screenings. Once the causes are identified, AHCCCS and DES/DDD should ensure that members receive screenings in accordance with the U.S. Preventive Services Task Force (USPSTF) screening recommendations for breast cancer, cervical cancer, and chlamydia in women.[1-4,1-5,1-6]

Performance Improvement Projects (PIPs)

In CYE 2015, AHCCCS implemented a new PIP, *E-Prescribing*, for all lines of business. The baseline year for this PIP was CYE 2014, which is reflective of October 1, 2013, through September 30, 2014. The subsequent year was an "Intervention" year in which each Contractor implemented strategies and interventions to improve performance. AHCCCS conducted annual measurements to evaluate Contractor performance, with the first remeasurement reflective of CYE 2016 and the second reflective of CYE 2017.

Electronic prescribing (e-prescribing) was meant to improve the quality of healthcare for members as well as to improve efficiency for providers. E-prescribing is a clinician's ability to electronically send an accurate, error-free, and understandable prescription directly to a pharmacy from the point of care. Thus, clinicians can safely and efficiently manage patients' medications, while reducing risk of error.

[1-3] Viggiano T, Pincus HA, and Crystal S. Care Transition Interventions in Mental Health. *Current Opinion in Psychiatry*. Vol. 25. No. 6. Nov. 2012.

[1-4] U.S. Preventive Services Task Force. *Breast Cancer: Screening*. Available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/breast-cancer-screening1?ds=1&s=breast. Accessed on: Apr. 12, 2019.

[1-5] U.S. Preventive Services Task Force. *Cervical Cancer: Screening*. Available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening2?ds=1&s=cervical cancer. Accessed on: Apr. 5, 2019.

[1-6] U.S. Preventive Services Task Force. *Chlamydia and Gonorrhea: Screening*. Available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/chlamydia-and-gonorrhea-screening?ds=1&s=chlamydia. Accessed on: Apr. 5, 2019.

Additional benefits include reducing phone calls between clinicians and pharmacies, and providing patients convenience by helping them to avoid additional trips to pharmacies to drop off prescriptions.

The purpose of the *E-Prescribing* PIP is to increase the number of providers ordering prescriptions electronically (Indicator 1) and to increase the percentage of prescriptions submitted electronically (Indicator 2) in order to improve patient safety. AHCCCS' goal is to demonstrate a statistically significant increase in providers submitting prescriptions electronically and in the number of prescriptions submitted electronically, followed by sustained improvement for one year.

AHCCCS considered that a Contractor demonstrated improvement when it achieved one of the following:

- Met or exceeded the AHCCCS overall average for the baseline measurement if the baseline rate was below the average and the increase was statistically significant.
- Demonstrated a statistically significant increase if its baseline rate was at or above the AHCCCS overall average for the baseline measurement
- Was the highest-performing plan in any re-measurement and maintained or improved its rate in a successive measurement.

AHCCCS considered that a Contractor demonstrated sustained improvement when it achieved one of the following:

- Maintained or increased improvements in performance for at least one year after those improvements were first achieved.
- Demonstrated how the improvement could be reasonably attributable to interventions undertaken by the organization (i.e., improvement occurred due to the project and its interventions, rather than an unrelated reason).

In addition, the AHCCCS Quality Improvement Team implemented multiple process improvement efforts during CYE 2018, including AHCCCS Medical Policy Manual (AMPM) PIP policy updates, implementation of a revised PIP reporting template structure to capture the evolution and progress of the Contractor throughout the PIP cycle, as well as the creation of an AHCCCS PIP-specific review checklist that enhances interrater reliability for coordinator reviews and the provision of more extensive feedback to the Contractors.

Of those Contractors included within the PIP from CYE 2014 to CYE 2017, all demonstrated improvement in Remeasurement Year 1 and sustained improvement in Remeasurement Year 2 for both indicators. For Indicator 1—Providers Who Prescribed at Least One Prescription Electronically, BWY demonstrated the most improvement in the overall relative change from baseline with a score of 32.52 percent; while for Indicator 2—Percentage of Prescriptions Prescribed Electronically, MCP demonstrated the most improvement with a score of 39.58 percent for the overall relative percentage change from baseline.

Findings

This report is inclusive of the Remeasurement 2 (October 1, 2016, through September 30, 2017) reporting period for the *E-Prescribing* PIP. The Contractors implemented many solid interventions to improve rates for both indicators.

Figure 1-1 represents the overall relative percentage change for all ALTCS Contractors for Indicator 1; the percentage of AHCCCS-contracted providers who prescribed at least one prescription electronically.

Figure 1-1—Performance Improvement Projects—*E-Prescribing*—Indicator 1: The Percentage of Providers Who Prescribed at Least One Prescription Electronically—All ALTCS Contractors*
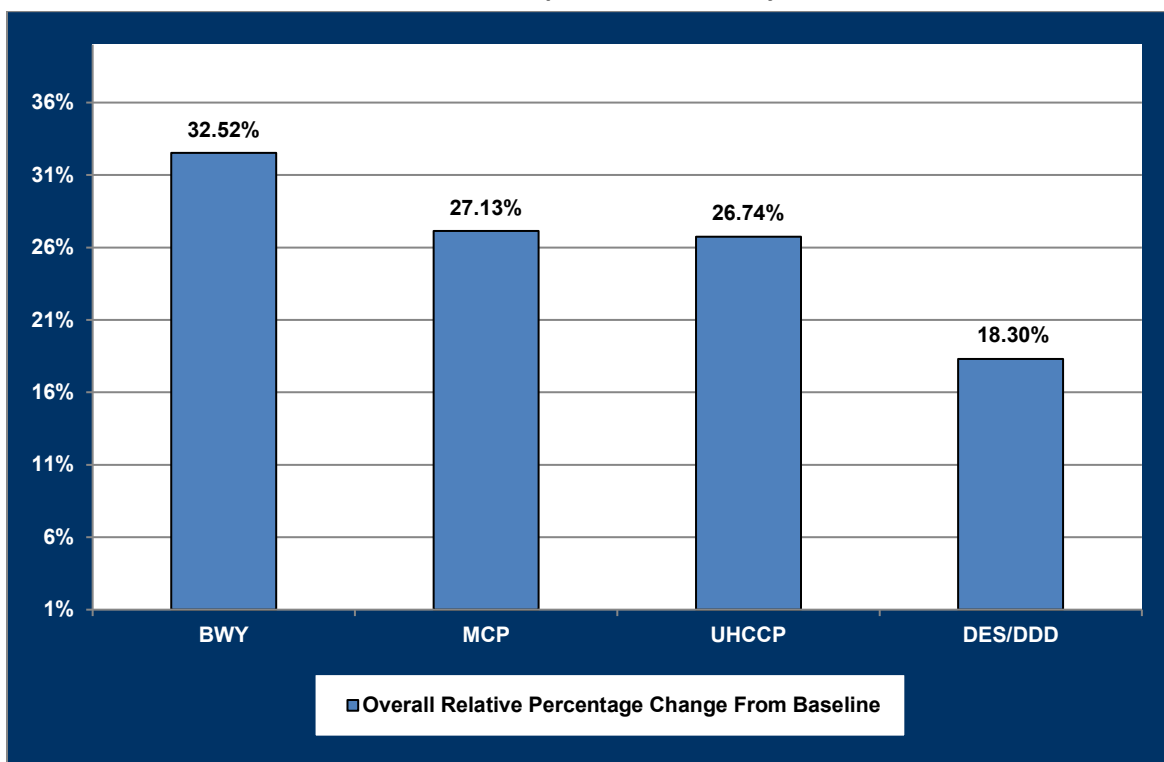
*Percentage totals have been rounded.

Figure 1-1 shows that the Contractor with the greatest improvement was BWY, with an overall relative percentage change from baseline of 32.52 percent. The Contractor with the most opportunity for improvement was DES/DDD as its overall relative percentage change from baseline at 18.30 percent was below all other Contractors' overall relative percentage rates. All Contractors tasked with the PIP exceeded respective baseline rates by statistically significant amounts at Remeasurement 2 for Indicator 1.

Figure 1-2 represents the overall relative percentage change for all ALTCS Contractors for Indicator 2; the percentage of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically.

Figure 1-2—Performance Improvement Projects—*E-Prescribing*—Indicator 2: The Percentage of Prescriptions Sent Electronically—All ALTCS Contractors*
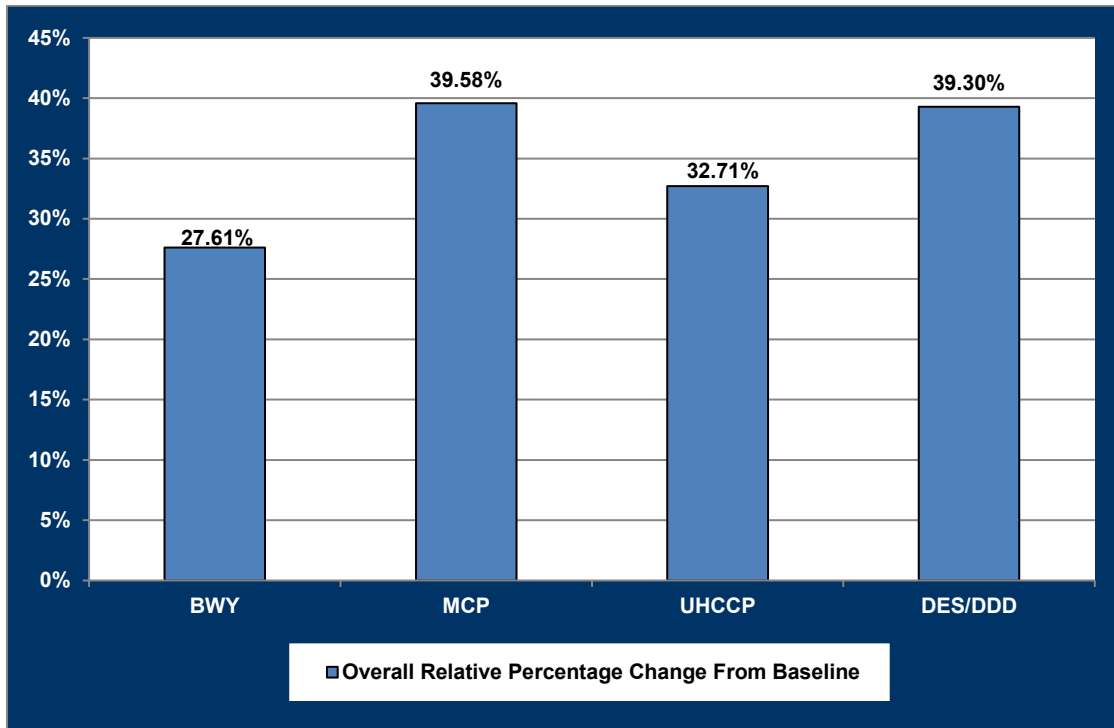
*Percentage totals have been rounded.

Figure 1-2 shows that the Contractor with the greatest improvement was MCP, with an overall relative percentage change from baseline of 39.58 percent. The Contractor with the most opportunity for improvement was BWY, with an overall relative percentage change from baseline of 27.61 percent. All Contractors tasked with the PIP exceeded respective overall relative percentage changes from baseline rates by statistically significant amounts.

Conclusions

All Contractors achieved statistically significant improvement for both Indicator 1 and Indicator 2 at Remeasurement 2. Contractors implemented strong interventions in CYE 2017 for the *E-Prescribing* PIP. All Contractors participated in an e-prescribing workgroup formed with other Arizona Contractors, Arizona Alliance of Health Plans (AzAHP) and Health Current (collectively referred to as "workgroup"). The workgroup developed two surveys. One survey asked providers to identify contributing factors to e-prescribing rates to identify best practices or barriers, and the other addressed Arizona electronic health record (EHR) vendors to determine their system capabilities for e-prescribing controlled substances. Other interventions included education to providers, facility staff, and members; targeting high-volume prescribers; and providing incentives to encourage e-prescribing.

Recommendations

This is the last measurement year for the *E Prescribing* PIP. Contractors are encouraged to monitor the progress of the PIP interventions employed to increase providers prescribing electronically and prescriptions sent electronically and to adjust interventions as needed to consolidate the gains made for this PIP. In addition, HSAG recommends that AHCCCS continue to encourage the collaboration among Contractors in the e-prescribing workgroup to improve these indicators.

Overall Assessment of Progress in Meeting EQRO Recommendations

During previous years, HSAG made recommendations in the annual reports for each activity conducted. Table 1-5 is a summary of the follow-up actions per activity that AHCCCS completed in response to HSAG's recommendations during State fiscal year (SFY) 2016–2017. Many of the Contractors have added rates in responses to the recommendations. Please note that AHCCCS has not approved or validated these rates.

Table 1-5—HSAG Recommendations With AHCCCS Actions

HSAG Recommendation	AHCCCS Action
Operational Review	
• AHCCCS should consider using the quarterly meetings with Contractors as forums in which to share lessons learned from both the State and Contractor perspectives. • AHCCCS should present identified best practices on the predominant issues for ALTCS Contractors' issues and facilitate a group discussion about Contractors' policies and procedures. In addition, AHCCCS should consider conducting a root cause analysis with the Contractors to determine why Contractors continue to have difficulty complying with specific standards.	AHCCCS held quarterly ALTCS Contractor meetings that included the following topics: Clarification for AMPM 1600, specifically Exhibit 1620-18 Decision Tree, 1620-G, and changes to Preadmission Screening and Resident Review (PASRR) Level 1 screening tool; clarification to the non-provision of service reporting, behavioral health re-insurance, and case management (CM) training in relation to new PASRR tool, with a special assistance program guest speaker; information regarding the PASRR tool and clarification (technical assistance [TA]); differences between behavioral health services within programs for those with developmental disabilities (DD) and for the elderly/physically disabled (E/PD). In addition, AHCCCS provided updates and next steps regarding Home and Community-Based Services (HCBS) rules at every quarterly meeting.

HSAG Recommendation	AHCCCS Action
AHCCCS could consider developing a template or checklist for the Contractors to ensure that Contractors include all minimum required information in remittance advice to providers. The element requiring that Contractors (and their subcontractors) must include the reason and detailed descriptions related to payments less than billed charges, denials, and adjustments on remittances has been out of compliance for both the CYE 2016 and CYE 2017 ORs for all but one Contractor. AHCCCS may also consider reviewing the data capture and transfer processes used for the claims processing systems to ensure alignment with the requirements set forth in the claims information systems standard. AHCCCS will be working with Contractors (in some cases, new Contractors) who will be providing integrated services, working with new populations, and operating in new geographic service areas; therefore, this is an important standard to target for compliance.	All requirements for the remit are found in contract and policy. It should be noted that most issues were found on the last round of OR reviews of remits related to the subcontractor and were not specific to the Contractors. This was the first round of ORs that AHCCCS reviewed and scored Subcontractor remits as well.
Within the CYE 2017 EQRO reports, HSAG included an indication that: AHCCCS should consider distributing TA documents to all Contractors and holding in-person meetings with Contractors who scored lowest in the OR standards, including guidance on how to complete a corrective action plan (CAP).	TA was provided to all Contractors prior to the CYE 2016 OR cycle. This TA went over changes made to the OR process, and included guidance on how to complete a CAP. Prior to the next OR cycle, AHCCCS intends to hold another OR kickoff/TA session with all Contractors. During this meeting, information on how to complete a CAP will be restated. Additionally, the AHCCCS Quality Improvement (QI) Team created a QI-specific CAP checklist that is currently awaiting AHCCCS Policy Committee review and approval. It is expected that this checklist will assist Contractors in the identification and inclusion of essential elements required by the Contractors when seeking AHCCCS review and approval for mandated CAPs required based on the Contractor performance related to performance measures and Consumer

HSAG Recommendation	AHCCCS Action
	Assessment of Healthcare Providers and Systems (CAHPS®)[1-7] surveys.
AHCCCS should consider using the quarterly meetings with Contractors as forums in which to share lessons learned from both the State and Contractor perspectives. AHCCCS should present identified best practices on the predominant issues for ALTCS Contractors and facilitate a group discussion on Contractors' policies and procedures. In addition, AHCCCS should consider conducting a root cause analysis with the Contractors to determine why Contractors continue to have difficulty complying with specific standards.	Evaluation of root cause concerns with Contractors that are not compliant with specific OR standards will be reviewed after the next round of ORs. This will be the first round of ORs since the request for proposal (RFP), wherein a number of changes were made to the Contract requirements.
AHCCCS should concentrate improvement efforts on the CC and CIS standards as both standards were problematic in CYE 2016 and CYE 2017 ORs. For example, AHCCCS should consider distributing TA documents to all Contractors and holding in-person meetings with Contractors who scored lowest in these standards.	TA is something that can be considered in the future with the Contractors. OR elements are reviewed and may be changed with each cycle. In addition, AHCCCS conducts an OR kickoff meeting with the Contractors to provide a summary of changes and expectations and to address questions raised by the Contractors related to the review process.
No recommendation.	AHCCCS is reviewing all standards for the upcoming ORs beginning January 2019 and making revisions as necessary.
Performance Measures	
HSAG recommends that more appropriate MPS be assigned to the performance measures, given that this special population may not benefit from exceeding the MPS currently assigned.	AHCCCS conducted a review and analysis of the finalized CYE 2015 and CYE 2016 performance measure rates per individual Contractor and specific line of business. When appropriate, AHCCCS compared Contractor and aggregate rates against the NCQA published Medicaid means.* Minimum performance standards (MPS) were reviewed and revised within the CYE 2019 contracts based on findings of the before-mentioned historical analysis and NCQA Medicaid mean

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[1-7] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

HSAG Recommendation	AHCCCS Action
	comparison(s). * AHCCCS noted that comparison with the NCQA Medicaid mean may be found inappropriate with select populations including ALTCS and seriously mentally ill (SMI), based on the unique complex needs and services of the members served within those populations.
Two of the three performance measure rates (*Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*) with MPS fell below those MPS by 21.8 percentage points and 19.2 percentage points, respectively. This suggests an opportunity for improvement in follow-up care after hospitalization.	AHCCCS noted the ALTCS opportunity for improvement for the *Follow-Up After Hospitalization for Mental Illness (7/30 Days)* specific to the ALTCS E/PD population. AHCCCS increased the MPS set within the CYE 2019 ALTCS E/PD contract to align expectations and performance with those measures found within the regional behavioral health authorities (RBHA) Contractors. It is AHCCCS' position that both the SMI and ALTCS E/PD populations represent members with unique, complex medical and behavioral health needs; thus, AHCCCS is currently evaluating and considering additional interventions related to this area, which may include any regulatory action deemed necessary and appropriate to address the identified disparity in performance for the ALTCS E/PD population.
Performance Improvement Projects	
AHCCCS may want to consider offering and facilitating training opportunities to enhance the Contractors' capacities to implement robust interventions and QI processes and strategies for the *E-Prescribing* PIP. Increasing the Contractors' efficacy with QI tools such as root cause analyses, key driver diagrams, process mapping, failure modes and effects analysis (FMEA), and Plan-Do-Study-Act (PDSA) cycles should help to remove barriers to successfully achieving improvement in the PIP indicator rates.	Based on the CYE 2017 closeout of the *E-Prescribing* PIP, as the final reports were not received until June 2018, AHCCCS was unable to implement those recommendations made by HSAG specific to this PIP. However, AHCCCS is currently considering how the associated recommendations can be incorporated into other AHCCCS-mandated activities, current and upcoming, related to the Contractors' PIP and performance measure evaluation and analysis efforts.

HSAG Recommendation	AHCCCS Action
AHCCCS may want to explore any connection to the Governor's Executive Order 2616-06, Prescription of Opioids, to see if the activities of the task force might impact the PIP.	Based on the CYE 2017 closeout of the *E-Prescribing* PIP, as the final reports were not received until June 2018, AHCCCS was unable to implement those recommendations made by HSAG specific to this PIP.
AHCCCS may want to use the quarterly meetings with Contractors as opportunities to identify and address, related to the PIP process, systemwide barriers which may be impacting ability to achieve meaningful improvement.	AHCCCS utilized various Contractor quarterly meetings as opportunities to identify and address a wide array of topics, providing education and the setting to address barriers that may impact the Contractors' abilities to achieve meaningful improvement in various focus areas.
AHCCCS should consider including in the workgroup additional stakeholders who may help with improvement of the PIP indicators' rates.	Based on the CYE 2017 closeout of the *E-Prescribing* PIP, as the final reports were not received until June 2018, AHCCCS was unable to implement those recommendations made by HSAG specific to this PIP. However, AHCCCS is currently considering how the associated recommendations can be incorporated into the AHCCCS QI PIP-related activities.
AHCCCS should continue the collaboration among Contractors in the workgroup to improve the PIP study indicator rates.	Based on the CYE 2017 closeout of the *E-Prescribing* PIP, as the final reports were not received until June 2018, AHCCCS was unable to implement those recommendations made by HSAG specific to this PIP. However, AHCCCS is currently considering how the associated recommendations can be incorporated into the AHCCCS QI PIP-related activities.
For systemwide barriers, AHCCCS may consider the following: facilitate a session to identify systemwide barriers impeding Contractors' abilities to impact Indicator 1 and Indicator 2; appoint a high-level AHCCCS manager as a champion for the workgroup; develop an action plan to address the systemwide barriers.	AHCCCS utilized various Contractor quarterly meetings as opportunities to identify and address a wide array of topics, providing education and the setting to address barriers that may impact the Contractors' abilities to achieve meaningful improvement in various focus areas.
No recommendation.	AHCCCS provided the following information regarding the ALTCS/EPD and Developmental Disabilities (DD) Long-Term Support Services (LTSS) Care Planning and Assessment PIP. During the latter portion of CYE 2018, the

HSAG Recommendation	AHCCCS Action
	AHCCCS QI Team collaborated with various teams within AHCCCS to select an ALTCS PIP with ability to support ongoing key initiatives related to HCBS. This methodology has since been posted on the AHCCCS website and distributed to Contractors. The baseline measurement period for this PIP is CYE 2018, with data collection anticipated to start January 2019.

Table 1-6 presents a summary of the follow-up actions per activity that the MCP-LTC and UHCCP-LTC reported completing in response to HSAG's recommendations during SFY 2016–2017. AHCCCS did not require BWY to submit follow-up actions due to the close out of the Contractor, and DES/DDD was granted an extension to submit follow-up actions resulting in the receipt of the documents occurring outside of the review cycle for this annual report.

Note: The text located after each HSAG recommendation box was submitted by the Contractor; only light proofing has been conducted.

Table 1-6—Contractors' Responses to HSAG's Follow-Up Recommendations

MCP-LTC
Performance Measures
HSAG Recommendation: Performance for two of three measure rates (*Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*) fell below established MPS, which demonstrates that ALTCS Contractors have opportunities for improvement. Therefore, HSAG recommends focusing efforts on increasing follow-up care after hospitalization. Results of these focused efforts should be used to identify strategies that can be applied to drive improvement for other performance measures.
MCP-LTC implemented new interventions during CYE 2018, including the following: • Educated all LTC case managers about this measure. • All LTC case managers were expected to contact members within three days of discharge, and to coordinate and ensure that these visits each occurred within seven days of the member's discharge. • Coordinate with provider relations to educate providers during Joint Operating Committee (JOC) about the billing requirements as they relate to this measure. • Coordinate with the billing expert to determine if providers can bill codes such as 99328 along with one of the Healthcare Effectiveness Data and Information Set (HEDIS®)[1-8] compliant codes.

[1-8] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

MCP-LTC

- Provide quarterly data to the LTC team, including: numerator count, denominator count, rate, and member-level detail

Additionally, MCP-LTC has convened a task force to further analyze the *Follow-Up After Hospitalization for Mental Illness* (FUH) rates, identify barriers, and discuss solutions. Among the initial barriers identified by the team; for LTC members who reside in a skilled nursing facility (SNF), a follow-up visit is occurring with a mental health practitioner; however, the place of service is listed as "31," which is an SNF. SNFs are not included in the outpatient place-of-service (POS) list from NCQA for the FUH measure; so those visits are not being marked as compliant, even though the current procedural terminology (CPT) code included in the claim is a part of the HEDIS Value Set Directory and the provider type is correct. MCP-LTC has selected this for its self-selected PIP topic for this population.

Performance Improvement Projects

HSAG Recommendation Specific to MCP-LTC: HSAG recommends that MCP-LTC continue to monitor outcomes associated with the reported interventions. MCP-LTC needs to sustain the improvement for an additional measurement cycle and has an opportunity for improvement for both HSAG indicators. In addition, HSAG recommends that AHCCCS continue the collaboration among Contractors in the workgroup to improve performance for these indicators.

Recommendation Not Specific to MCP-LTC: The Contractors should continue to identify and prioritize barriers so as to develop robust interventions for the *E-Prescribing* PIP.

The Contractors are encouraged to monitor the progress of the PIP interventions employed to increase providers prescribing electronically and prescriptions sent electronically, then adjust interventions as needed to ensure that the rates continue to increase by statistically significant amounts during the second remeasurement period.

MCP-LTC continued to monitor data related to the *E-Prescribing* PIP and found the implemented interventions to be successful. MCP-LTC utilized the two proportion Z-test for statistical analysis of data calculated both internally and externally by AHCCCS. The comparison of internal data for Remeasurement 1 to Remeasurement 2 demonstrated a statistically significant rate increase. (A data issue prevented MCP-LTC from reporting reliable baseline date; thus, MCP-LTC was unable to compare internal baseline rates to the remeasurement periods).

The MCP-LTC rates for Indicator 1, as calculated by AHCCCS for CYE 2017, represented a 5.4 percentage point improvement over the CYE 2016 rate and a 12.9 percentage point improvement over CYE 2014, which is statistically significant and meets the goal of demonstrating a statistically significant increase in the number of providers submitting electronic prescriptions, followed by sustainment for one year.

The MCP-LTC rates for Indicator 2, as calculated by AHCCCS for CYE 2017, represented a 5.5 percentage point improvement over CYE 2016 and a 9.5 percentage point improvement over CYE 2014, which is statistically significant and meets the goal of demonstrating a statistically significant increase in the number of electronic prescriptions submitted, followed by sustainment for one year.

MCP-LTC
MCP-LTC has achieved the goals of increasing the number of prescribers electronically prescribing prescriptions and increasing the percentage of prescriptions which are submitted electronically in order to improve patient safety, and maintaining that improvement. These improvements are evidenced in both the AHCCCS calculated data and the MCP-LTC internal calculations.

UHCCP-LTC
Operational Reviews
HSAG Recommendation: Contractors should conduct internal reviews of operational systems to identify barriers that impact compliance with AHCCCS standards, State rules, and federal regulations. Specifically, Contractors should cross-reference existing policies, procedures, and information distributed to providers, subcontractors, and members with AHCCCS requirements and ensure, at a minimum, alignment with both the intent and content of AHCCCS standards, State rules, and federal regulations.
UHCCP-LTC adopts policies as needed and reviews said policies and procedures annually or as often as business or regulatory requirements dictate. UHCCP policies and procedures are instrumental in translating the laws and regulations as well as the company's strategies, mission, and values into documented guidelines for management and staff to follow and act upon.
HSAG Recommendations: Regular monitoring to ensure that updates are made to contracts with providers and that policy manual updates from AHCCCS are also included in Contractors' policies, procedures, and manuals (if impacted by the updates) in a timely manner.
UHCCP-LTC presents new and substantially revised policies and procedures to the Policy Committee. The Policy Committee recommends approval or denial to Contractor management. If approved by Contractor management, the Policy Committee finalizes approval of the policy and procedure. Policies and procedures are reviewed annually or as often as business needs or regulatory requirements dictate. The Policy Committee is comprised of a cross-functional team designated to provide oversight and to ensure that communication to all areas directly and indirectly impacted by these updates is provided and documented. Policies are then converted to Portable Document Format (PDF) and uploaded to the UHCCP HEART SharePoint, where they can be accessible.
HSAG Recommendations: Apply lessons learned from improving performance for one category of standards to other categories. Further, Contractors should use opportunities to address and discuss issues identified during ORs.
The UHCCP Quality Management Committee is responsible for reviewing the findings from the AHCCCS OR and for overseeing the internal corrective actions led by the subject matter experts to address deficiencies. Oversight includes discussion and review of best practices as noted in previous ORs as a means to correct policies, procedures, and practices to address deficient standards.

UHCCP-LTC
Performance Measures
HSAG Recommendation: All Contractors should improve the number and percentage of members seen within 7 and 30 days after discharge for mental illness.

UHCCP-LTC conducted a root cause analysis and identified the following factors negatively impacting the performance measure:

- LTC members discharged from an acute inpatient facility with a primary discharge diagnosis of mental illness are not referred directly to a mental health practitioner unless the discharge orders indicate that the members need further evaluation or treatment. Rather, when the case manager completes the post-hospital assessment (PHA) the member is referred to the assigned primary care physician (PCP) for follow-up medical services and to coordinate care.
- Often, medical conditions or admissions to hospitals may exacerbate mental health conditions; but the underlying issue of a member's admission to a hospital may stem from medical etiology.
- Members refuse a referral for behavioral health services (if they are not already established), preferring to seek treatment from their PCP or other specialty provider.
- Technical specifications do not allow for an outpatient service by a mental health practitioner on the same day of the discharge from the acute inpatient facility.

UHCCP-LTC also implemented the following:

- Updated the PHA instructions to expand upon a question in which the case manager asks the member "other reason that caused the member to be hospitalized" to include a question or discussion if the member had been discharged from an acute inpatient facility with a principle diagnosis of mental illness.
- Continued to analyze the FUH measure and member-specific data further to assess other potential underlying factors that may contribute to our not meeting this measure.
- Oversight process will include a post-hospital visit within two days of notification with follow-up with any member who had a principle diagnosis of mental illness upon discharge from an acute inpatient facility to ensure that the member had a follow-up outpatient visit with a mental health practitioner.

Performance Improvement Projects
HSAG Recommendation: Monitor progress of the PIP interventions employed to increase providers prescribing electronically and prescriptions sent electronically.

During CYE 2017 and into CYE 2018, UHCCP-LTC continued to monitor the performance on the number and percentage of providers who prescribed at least one prescription electronically as well as the number and percentage of all prescriptions prescribed electronically. The results of this ongoing monitoring process resulted in UHCCP-LTC performing well during the second remeasurement period. The e-prescribing rate for providers who prescribed at least one prescription showed a statistically significant increase, from 48.19 percent to 55.08 percent. The percentage of prescriptions prescribed electronically showed a statistically significant increase, from 27.42 percent to 31.91 percent.

Description of EQR Activities

Mandatory Activities

As permitted by CMS within federal regulation and described in Section 1—Executive Summary, AHCCCS retained the functions associated with the three CMS mandatory activities for its Contractors:

- Validate Contractor PIPs—validation performed by AHCCCS.
- Validate Contractor performance measures—validation performed by AHCCCS.
- Summary and findings of Contractor's performance in complying with the AHCCCS' contract requirements and the federal Medicaid managed care regulations—review performed by AHCCCS.

AHCCCS contracted with HSAG to aggregate and analyze the data AHCCCS obtained from conducting the three mandatory activities for its Contractors and to prepare this CMS-required CYE 2017 external quality review annual report of findings and recommendations.

For contracts starting on or after July 1, 2018, and no later than one year from the issuance of the revised EQR protocol, according to requirements set forth in 42 CFR §438.68, CMS will require validation of MCO, PIHP, and PAHP network adequacy as applicable. For the purposes of this report, network validation is not applicable.

Optional Activities

AHCCCS' EQRO contract with HSAG did not require HSAG to:

- Conduct any CMS-defined optional activities (e.g., validating encounter data, conducting focused studies of healthcare quality, or assessing information systems capabilities).
- Analyze and report results, including providing conclusions and recommendations based on optional activities that AHCCCS conducted.

AHCCCS has numerous sophisticated processes for monitoring both the Contractors and its own performance in meeting all applicable federal and State requirements, its goals and internal objectives, and its policies and procedures. AHCCCS regularly prepares meaningful, detailed, and transparent reports documenting the results of its assessments. AHCCCS is transparent with performance results, posting to its website both provider performance reports and the required quarterly reports it submits to CMS. AHCCCS uses the information provided in the CMS-required EQR annual reports to honor its commitment to transparency by posting final reports on its website. The EQR reports provide detailed information about the EQRO's independent assessment process; results obtained from the assessment; and, as applicable to its findings, recommendations for improvement. AHCCCS uses the information to

assess the effectiveness of its current strategic goals and related strategies and to provide a roadmap for potential changes and new goals and strategies.

Quality, Access, and Timeliness

CMS has identified the domains of quality, access, and timeliness as keys to evaluating MCO performance. HSAG used the following definitions to evaluate and draw conclusions about the performance of the MCOs in each of these domains.

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

- **Access**, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network Adequacy Standards) and §438.206 (Availability of Services). Under §438.206, availability of services means that each state must ensure that all services covered under the state's plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner. The State must also ensure that the MCO, PIHP, and PAHP provider networks for services covered in the contract meet the standards developed by the State in accordance with the network adequacy standards (§438.68). Any state that contracts with an MCO, PIHP, or PAHP to deliver Medicaid services is required by §438.68 to develop and enforce network adequacy standards.[2-2]

- **Timeliness**. Federal managed care regulations at 42 CFR §438.206 require the state to define its standards for timely access to care and services. These standards must take into account the urgency of the need for services. HSAG extends the definition of "timeliness" to include other federal managed care provisions that impact services to enrollees and that require timely response by the MCO/PIHP—e.g., processing expedited member grievances and appeals and providing timely follow-up care. In addition, NCQA defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[2-3] It further discusses the intent of this standard to minimize any disruption in the provision of healthcare.

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register* Vol. 81, No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.

[2-2] Ibid.

[2-3] National Committee for Quality Assurance. 2013 Standards and Guidelines for the Accreditation of Health Plans.

3. Overview of the Arizona Health Care Cost Containment System (AHCCCS)

This section of the report includes a brief history of the Arizona Health Care Cost Containment System (AHCCCS) Medicaid managed care programs and a description of AHCCCS' Strategic Plan for State Fiscal Years 2017–2022 (Strategic Plan). The description of the Strategic Plan includes the four goals:

- AHCCCS must pursue and implement long-term strategies that bend the cost curve while improving member health outcomes.
- AHCCCS must pursue continuous quality improvement.
- AHCCCS must reduce fragmentation driving toward an integrated healthcare system.
- AHCCCS must maintain core organizational capacity and workforce planning that effectively serves AHCCCS operations.

AHCCCS Medicaid Managed Care Program History

AHCCCS is the single state Medicaid agency for Arizona. AHCCCS operates under the authority of the federal Research and Demonstration 1115 Waiver, which has allowed for the operation of a total managed care model since 1982. AHCCCS uses State, federal, and county funds to administer healthcare programs to the State's acute, long-term care, children, and behavioral health Medicaid members.

AHCCCS has an allocated budget of approximately $11.4 billion to administer its programs, coordinating services through its Contractors and delivering care for 1.9 million individuals and families in Arizona through a provider network of over 60,000 healthcare providers.

AHCCCS' Acute Care program was incorporated from its inception in 1982. In 1988 AHCCCS added the Arizona Long Term Care System (ALTCS) program for individuals with developmental disabilities, and then expanded the program in January 1989 to include the elderly and physically disabled (EPD) populations. In October 1990, AHCCCS began coverage of comprehensive behavioral health services for seriously emotionally disabled (SED) children younger than 18 years of age who required residential care. Through further expansion, AHCCCS added comprehensive behavioral health coverage for all Medicaid-eligible individuals. The Children's Health Insurance Program (CHIP) was incorporated in Arizona in 1998 and is known as KidsCare. In 2009, due to a persistently severe budget shortfall, a freeze was placed on enrollment in KidsCare. In 2016, Governor Ducey signed Senate Bill (SB) 1457 into law, ending the enrollment freeze on the KidsCare program. Children who qualify for this program receive care through AHCCCS Contractors.

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

system. As a result, AHCCCS expects member health outcomes to improve. Service delivery has been restructured into the three geographical services areas (GSAs): North, Central, and South.

Members continue to have a choice of health plans in their geographic service areas and to have access to a network of providers and the same array of covered services. Regional Behavioral Health Authorities (RBHAs) continue to provide specific crisis services and to serve members with a serious mental illness, children in foster care, and Department of Economic Services/Division of Developmental Disabilities (DDD) eligible members. American Indian members have the choice of enrolling in an ACC managed care plan or the American Indian Health Program (AIHP) and a Tribal RBHA when available. American Indian members have the same access to Indian Health Service providers, Tribal 638 providers, and Urban Indian Health providers. No change occurred for Arizona Long Term Care System (ALTCS) .

Prior to implementation, AHCCCS monitored the ACC plans' readiness activity, including but not limited to the plans' effort in building networks which include those providers that have historically served Arizona's Medicaid population, their efforts to ensure the recruitment of high caliber staff with expertise in the full continuum of services and supports offered by integrated care products, and their adherence to the contractual mandate requiring availability of nurse triage services. ALTCS provides acute care, behavioral health services, long-term care, and case management to AHCCCS members who are elderly, physically disabled, or developmentally disabled and who meet the criteria for institutionalization.

Services for individuals with developmental disabilities in ALTCS are offered through the Arizona Department of Economic Security (DES), DDD. The ALTCS members account for less than 4.0 percent of the AHCCCS population, with approximately 21.7 percent of the costs. The ALTCS program encourages delivery of care in alternative residential settings. As in the Acute Care Program, EPD and developmentally disabled members of all ages receive care through AHCCCS contracted plans.

Most recently, as part of Governor Ducey's administrative simplification initiative, behavioral health services were integrated at AHCCCS, eliminating the Arizona Division of Behavioral Health Services (DBHS) that historically provided behavioral health services through a contract with AHCCCS and subcontracts with the RBHAs. AHCCCS has stated that this merger was a positive step toward increasing integration in the healthcare system and has already resulted in beneficial outcomes and forward-thinking policy decisions which factor in care for both the mental and physical health of individuals.

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

conditions. Starting on October 1, 2018, CRS members will need to choose an ACC health plan for all services.

AHCCCS Waiver Amendment Requests and Legislative Updates

AHCCCS submitted two waiver amendment requests in CYE 2018 that are still pending with CMS.

AHCCCS Works Waiver Amendment

Pursuant to Arizona Revised Statutes (ARS) 36-2903.09 and taking into consideration over 500 public comments, AHCCCS submitted to CMS a waiver amendment request on December 19, 2017, seeking authority to implement community engagement requirements and a five-year maximum lifetime benefit limit for certain able-bodied AHCCCS members. This waiver amendment, titled "AHCCCS Works," is designed to provide low-income, able-bodied adults with the tools needed to gain and maintain meaningful employment, job training, and education. AHCCCS proposed that able-bodied adults between the ages of 19 and 55 who do not qualify for an exemption will be required to meet the following activities or combination of activities for at least 20 hours per week to qualify for AHCCCS coverage: be employed or actively seek employment, attend school, or partake in an employment support and development program as defined in the waiver request.

AHCCCS sought broad-based stakeholder feedback regarding the AHCCCS Works waiver amendment in accordance with 42 CFR 431.408. In January 2017, over 140 participants attended AHCCCS community forums in Phoenix, Flagstaff, and Tucson and participated in an in-person tribal consultation. In addition, AHCCCS received more than 500 written public comments, including 14 letters from tribal nations and tribal affiliated organizations regarding this issue.

Prior Quarter Coverage Waiver Amendment

AHCCCS submitted a waiver amendment request on April 6, 2018, to CMS seeking to limit retroactive coverage to the month of application, consistent with Arizona's historical waiver authority prior to January 2014. AHCCCS sought stakeholder feedback regarding the Proposal to Waive Prior Quarter Coverage in accordance with 42 CFR 431.408. AHCCCS conducted public forum meetings in Flagstaff, Phoenix, and Tucson. In addition, the waiver amendment was presented at the State Medicaid Advisory Committee (SMAC) meeting on February 7, 2018, and in a tribal consultation meeting on January 11, 2018.

The following are the legislative bills, provisions of the state fiscal year (SFY) budget package, assigned workgroups, and changes to professional scope of practice and reporting requirements that impacted AHCCCS as written in the 2018 legislative report.

- House Bill (HB) 2228—Exempts American Indians and Alaska natives from the provisions outlined under ARS 36-2903.09 (work requirements, five-year limit, cost sharing).

- HB 2235—Formally recognizes and establishes scope of practice for Dental Health Aide Therapists (DHAT).
- HB 2324—Recognizes community health workers by requiring Arizona Department of Health Services (ADHS) to adopt rules relating to the establishment and administration of a voluntary certification process; including relevant scope of practice, minimum qualifications, and core competencies.
- SB 1296—Requires the State, counties, and municipalities to ensure that communications with persons with disabilities, including online communications and emergency communications, are equally as effective as its communications with persons without disabilities.
- SB 1450—Renames the Human Rights Committees to Independent Oversight Committees and transfers responsibility for these committees to the Arizona Department of Administration (ADOA), from the Department of Economic Security (DES), the Department of Child Safety (DCS), and AHCCCS.

The Opioid Special Session enacted the following provisions effective April 26, 2018:

- The sum of $10 million was appropriated from the state general fund in SFY 2017–2018 to the substance use disorder services fund established by ARS 36-2930.06 for the purpose of providing services for the Non-Title XIX population.
  - Monies are not to be used for those eligible under Title XIX or Title XXI.
  - Contractor payments are to be made in accordance with contracts or, in the absence of a contract, at the capped fee schedule rate established by AHCCCS.
  - The Contractor shall submit expenditure reports monthly for reimbursement of services provided under the agreement.

The SFY 2018–2019 budget package included the following:

- Total of $9,943,700 for behavioral health services in schools.
- Amount of $100,000 for a suicide prevention coordinator to assist school districts and charter schools in suicide prevention efforts.
- Funds to increase inpatient and outpatient hospital rates by 2.5 percent in SFY 2018–2019 based on hospital performance on established quality measures, in addition to rate adjustments that would otherwise be actuarially determined for SFY 2018–2019.
- Monies to increase skilled nursing facility and assisted living facility provider rates by 3 percent in SFY 2018–2019 in addition to rate adjustments that would otherwise be actuarially determined for SFY 2018–2019.
- Amounts of $11 million from the state General Fund and $25,460,100 from developmental disability (DD) Medicaid expenditure authority are appropriated in SFY 2018–2019 to DES for one-time assistance to address DD provider cost increases resulting from the enactment of Proposition 206.
- The sum of $2 million is appropriated from the state General Fund in SFY 2018–2019 to DES for a one-time increase for state-only room and board expenses funded by the DDD.

- The amount of $900,000 in savings is generated by eliminating the AHCCCS Hospital Loan Residency Fund (ARS 36-2921).
- If a behavioral health inpatient facility, as defined in rule by the Director of DHS, and a Contractor or RBHA do not enter into a contract, the reimbursement level for behavioral health services provided on dates of admission on or after July 1, 2018, for that behavioral health inpatient facility is 90 percent of the capped fee-for-services (FFS) schedule. This policy applies retroactively to as well as from and after June 30, 2018.
- Laws 2017, Chapter 309, Section 13, as amended by HB 2659 related to increased disproportionate share hospital (DSH) payments, applies retroactively to as well as from and after June 30, 2017. DSH amount is now $113 million rather than $108 million.
- The amount of $300,000 and 12 FTEs for the American Indian Health Program (AIHP) staffing and a reduction of $545,000 for the AIHP administrative shift.
- Incorporates $2.5 million in savings from ending prior quarter coverage as of July 1, 2018.

Enacted legislation requires the following new reports:

- On or before September 1, 2019, AHCCCS, in consultation with the Arizona Department of Education (ADE), shall report to the Governor, the President of the Senate, the Speaker of the House of Representatives, the Director of the Joint Legislative Budget Committee (JLBC) and the Director of the Office of Strategic Planning & Budgeting (OSPB) on the suicide prevention coordinator's accomplishments in SFY 2018–2019.
- On or before January 1, 2019, AHCCCS and ADHS shall jointly report to JLBC how grant monies for states to address the opioid epidemic included in the Consolidated Appropriations Act, 2018 (P.L. 115-141) will supplement the monies appropriated to AHCCCS pursuant to Laws 2018, First Special Session, Chapter 1.
- Effective January 1, 2019, requires ADHS to report "annually" from data gathered from AHCCCS (SB 1394) all of the following:
  – The total number of abortions partially or fully paid for with state monies through AHCCCS.
  – The total amount of state monies used to pay for abortions and expenses incidental to those abortions.
  – The total number of abortions, if any, paid for with state monies and performed out of state.
- On or before December 1, 2018, AHCCCS shall report the current number of behavioral health residential facility beds and supportive housing beds available in this state for adults who have a serious mental illness.

Enacted legislation established the Diabetes Action Plan Team within ADHS.

AHCCCS' Strategic Plan

AHCCCS' Strategic Plan for State Fiscal Years 2018–2023 presents the strategy and direction for AHCCCS, including new programs, initiatives, and past accomplishments. The strategic plan identifies AHCCCS' mission, vision, and the agency's core values:[3-1]

- AHCCCS Vision: Shaping tomorrow's managed healthcare…from today's experience, quality, and innovation.
- AHCCCS Mission: Reaching across Arizona to provide comprehensive quality healthcare to those in need.
- Core Values:
  - Passion: Good health is a fundamental need of everyone. This belief drives us, inspires and energizes our work.
  - Community: Healthcare is fundamentally local. We consult with, are culturally sensitive to, and respond to the unique needs of each community we serve.
  - Quality: Quality begins as a personal commitment to continual and rigorous improvement, self-examination, and change based on proper data and quality improvement practices.
  - Respect: Each person with whom we interact deserves our respect. We value ideas for change, and we learn from others.
  - Accountability: We are personally responsible for our actions and understand the trust our government has placed on us. We plan and forecast as accurately as possible. Solid performance standards measure the integrity of our work. We tell the truth and keep our promises.
  - Innovation: We embrace change, but accept that not all innovation works as planned. We learn from experience.
  - Teamwork: Our mission requires good communication among interdependent areas inside and outside the agency. Internally, we team up within and across divisions. Externally, we partner with different customers as appropriate.
  - Leadership: We lead primarily in two ways: by setting the standards by which other programs can be judged and by developing and nurturing our own future leaders.

The strategic plan offers four overarching goals:

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

- Increase use of alternative payment models and AHCCCS fee schedule differentiation for all lines of business.

[3-1] *AHCCCS Strategic Plan State Fiscal Years 2018-2023 Available at*:
https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan_18-23.pdfAccessed on: October 29, 2018.

- Reduce administrative burden on providers while expanding access to care.
- Successfully implement program integrity strategies.
- Modernize 1115 Waiver to provide new flexibilities to the State.

2. Pursue continuous quality improvement.

- Achieve and maintain improvement on quality performance measures.
- Leverage American Indian care coordination initiatives to improve health outcomes.
- Develop comprehensive strategies to curb opioid abuse and dependency.

3. Reduce fragmentation driving toward an integrated sustainable healthcare system.

- Establish a system of integrated plans and support provider integration to better serve all AHCCCS members.
- Leverage integrated Health Information Exchange to improve outcomes and reduce costs.
- Improve access for individuals transitioning out of the justice system.

4. Maintain core organizational capacity, infrastructure, and workforce planning that effectively serves AHCCCS operations.

- Promote activities that support employee engagement and retention and successful succession planning.
- Strengthen system-wide security and compliance with privacy regulations.
- Continue implementation of the Arizona Management System.

Key Accomplishments for AHCCCS

Following are key accomplishments highlighted by AHCCCS in the AHCCCS Strategic Plan, SFYs 2018–2023:

- AHCCCS successfully defended in court the current statutory structure of the Hospital Assessment funding.
- AHCCCS successfully awarded the ALTCS request for proposal (RFP) and transitioned over 9,000 members on October 1, 2017.
- The ALTCS program began implementing a new eligibility system in November 2017.
- The Office of Human Rights eliminated the waitlist for special assistance services and currently provides assistance to the largest number of individuals ever. The Office of Human Rights has 2,504 individuals identified as requiring special assistance and provides direct advocacy via assignment to 702 members.
- AHCCCS implemented a new assessment policy and streamlined demographic reporting to reduce provider and member administrative burdens.

- AHCCCS received approval from CMS to begin the American Indian Medical Home program and has begun the process of implementation.
- AHCCCS received approval for a $300 million Targeted Investments Program, helping facilitate integration at approximately 500 provider sites across the state.
- AHCCCS established new value-based purchasing (VBP) strategies for nursing facilities (NFs) and providers who utilize e-prescriptions.
- AHCCCS completed a rebase of the All Patient Refined Diagnosis Related Groups (APR-DRG) methodology, better aligning inpatient reimbursement with current data.
- AHCCCS Leadership Academy was established, providing an opportunity for 30 staff to broaden perspective about the Agency's mission, explore key issues within healthcare, better understand the healthcare delivery system, and build personal networks.
- AHCCCS expanded access to Hepatitis C medication while lowering overall drug costs.
- AHCCCS implemented several strategies to combat the opioid epidemic, including implementing seven-day opioid-naïve fills.
- Cross-agency collaboration between AHCCCS, Department of Corrections (DOC), and county justice partners resulted in over six thousand incarcerated individuals becoming eligible for AHCCCS prior to release.
- The number of Health Information Exchange (HIE) providers increased from 250 to 350.
- AHCCCS increased the funding for physicians who are affiliated with graduate medical education by $40 million.
- AHCCCS implemented a new reimbursement methodology for freestanding emergency departments.
- AHCCCS Office of the Inspector General completed a review by CMS; the results were positive.
- AHCCCS transitioned approximately 130,000 acute members as part of the closures of Phoenix Health Plan and Maricopa Health Plan.
- AHCCCS began registering board-certified behavior analyst (BCBA) providers.
- AHCCCS held four quarterly tribal consultations, which saw the largest turnout in AHCCCS history.
- AHCCCS completed a request for information (RFI), held public meetings, and released the largest procurement in the history of Arizona for AHCCCS Complete Care.
- AHCCCS participated in the Repeal and Replace discussions and published timely analysis of proposed legislation.
- For CYE 2018, the overall weighted average capitation rate increase was 2.9 percent, which continues the overall trend for capitation rate growth of below 3 percent for the program.
- AHCCCS continued to have overall employee engagement scores that far exceeded the statewide average.

AHCCCS Quality Strategy

The U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) Medicaid managed care regulations at 42 CFR §438.340 require Medicaid state agencies operating Medicaid managed care programs to develop and implement a written quality strategy for assessing and improving the quality of healthcare services offered to their members. The written strategy must describe the standards that a state and its contracted MCOs and PIHPs must meet. The Medicaid state agency quality strategy must include all of the following:

- The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs as well as examples of evidence-based clinical practice guidelines required by the State.

- The State's goals and objectives for continuous quality improvement, which must be measurable and take into consideration the health status of each population that the State serves.

- A description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP; the performance improvement projects to be implemented, including any interventions that the State proposes to improve access, quality, or timeliness of care.

- Arrangements for annual, external independent reviews of the quality outcome and timeliness of and access to, the covered services.

- A description of the State's transition of care policy.

- The State's plan to identify, evaluate, and reduce health disparities based on age, race, ethnicity, sex, primary language, and disability status, to the extent practicable.

- Appropriate use of intermediate sanctions for MCOs.

- A description of how the State will assess the performance and quality outcomes achieved by each primary care case management (PCCM) entity.

- The mechanisms implemented by the State to comply with requirements relating to the identification of persons who need long-term services and supports or persons with special healthcare needs.

- Information relating to non-duplication of EQR activities.

- The State's definition of "significant change" related to instances in which significant changes are made to the quality strategy or occur in the State Medicaid program.

AHCCCS has had a formal quality assessment and performance improvement (QAPI) plan in place since 1994 and AHCCCS' Quality Strategy was first established in 2003. Since that time, AHCCCS has revised the Quality Strategy to reflect AHCCCS' innovative approaches to member care and continuous quality improvement efforts. The AHCCCS quality strategy was set for revision in CYE 2017. However, due to the introduction of proposed changes to the managed care regulations, AHCCCS elected to delay this revision until final publication was posted by CMS. AHCCCS has established an internal workgroup to head the expansive revisions that incorporate AHCCCS goals and initiatives, Contractor oversight, and the new requirements found within the managed care regulations. The revised Quality

Strategy draft was completed, submitted to CMS for review and approval, and posted to the AHCCCS website on July 1, 2018.

AHCCCS' Quality Strategy is a coordinated, comprehensive, and pro-active approach to drive improved health outcomes by utilizing creative initiatives, ongoing assessment and monitoring, and results-based performance improvement. AHCCCS designed the Quality Strategy to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care, and quality of service. AHCCCS' Quality Strategy identifies and documents issues related to those standards and encourages improvement through incentives or, when necessary, through regulatory action.

The Quality Strategy aligns with AHCCCS' mission and vision and the Strategic Plan, all of which outline overarching goals that provide direction for SFYs 2018–2023. The Quality Strategy outlines AHCCCS' commitment to transparency, stakeholder engagement, and the provision of quality care and services to members. Since 2003, the emphasis of AHCCCS' Quality Strategy has shifted from process measures to more comprehensive outcomes-based measurement and innovative delivery system design. The Quality Strategy provides a framework for improving and/or maintaining members' health status, providing focus on resilience and functional health of members with chronic conditions.

AHCCCS continued to demonstrate innovative and collaborative approaches to managing costs while improving quality of systems, care, and services. The draft July 1, 2018, Quality Strategy, Assessment and Performance Improvement Report (Quality Strategy); the 2018–2023 strategic plan, and the quarterly quality assurance/monitoring activity reports provided compelling evidence of AHCCCS' vision and leadership in identifying and proactively pursuing opportunities to improve access to, and the quality and timeliness of, care and services, as well as improve member health outcomes.

Quality Initiative Selection and Initiation

AHCCCS has established an objective, systematic process for identifying priority areas for improvement and selecting new performance measures and PIPs. This process involves a review of data from both internal and external sources, while also taking into account factors such as the prevalence of a particular condition and population affected, the resources required by both AHCCCS and Contractors to conduct studies and impact improvement, and whether the areas are current priorities of CMS or State leadership and/or can be combined with existing initiatives. AHCCCS also seeks Contractor input in prioritizing areas for improvement.

In selecting and initiating new quality improvement initiatives, AHCCCS:

- Identified priority areas for improvement.
- Established realistic, outcome-based performance measures.
- Identified, collected, and assessed relevant data.
- Provided incentives for excellence and imposed financial sanctions for poor performance.
- Shared best practices with and provided technical assistance to the Contractors.
- Included relevant, associated requirements in its contracts.
- Regularly monitored and evaluated Contractor compliance and performance.
- Maintained an information system that supported initial and ongoing operations and review of AHCCCS' quality strategy.
- Conducted frequent evaluation of the initiatives' progress and results.

Systemwide Quality Initiatives/Collaboratives

Administrative Simplification and the Integrated Model

The Division of Behavioral Health Services (DBHS), as part of the Arizona Department of Health Services (ADHS) transitioned, along with the programs it manages, to AHCCCS, effective July 1, 2016.

The behavioral health services were "carved out" benefits administered by DBHS through contracts with the Contractors. Not only was this transition part of a more efficient government operation, it also coincides with a large integration effort for the seriously mentally ill (SMI) population in Arizona. Before the integration of services, a member with an SMI had to coordinate with several healthcare systems to obtain services. As such, the physical health services were provided through the acute health plan; the behavioral health services through the Regional Behavioral Health Authority (RBHA); and the Medicare system, if the member was also eligible for Medicaid and Medicare; and Medicare Part D for medications.

According to AHCCCS, navigating the complex healthcare system is one of the greatest barriers to obtaining medically necessary healthcare. AHCCCS indicates that for members with SMI, obtaining needed healthcare has been challenging and further complicated by concerns around poor medication management and stigma, sometimes causing many individuals to forgo physical healthcare. Many persons with SMI also experience co-morbidities; therefore, management of chronic diseases like diabetes or hypertension has also been deficient.

The integrated model was implemented first for the SMI members receiving services in Maricopa County. On April 1, 2014, approximately 17,000 SMI members were transitioned to a single plan, Mercy Maricopa Integrated Care, to manage both their behavioral and physical healthcare needs. For SMI members who do not reside in Maricopa County, since October 1, 2015, AHCCCS has contracted with two additional integrated health plans to provide both physical and behavioral healthcare services.

On October 1, 2018, AHCCCS offered fully integrated contracts to manage behavioral health and physical health services to children (including children with Children's Rehabilitative Services [CRS] eligible conditions) and adult AHCCCS members not determined to have SMI. AHCCCS also proposed to preserve the RBHAs as a choice option and to provide a mechanism for affiliated contractors to hold a single contract with AHCCCS for non-ALTCS members.

Contracts awarded to three MCOs throughout Arizona to administer Arizona's integrated long-term care system, were implemented on October 1, 2017. Contracts were awarded based on the bidder's proposed approaches for care and treatment of ALTCS individuals using a fully integrated care perspective at both the systemic and direct care levels (e.g., use of health homes, electronic health records, coordinated case management, collaboration between behavioral and physical health). An additional expectation is centered on their ability to demonstrate a more thorough understanding and use of Arizona's longstanding model of behavioral health service delivery, in conjunction with traditional ALTCS physical healthcare activities. Although Arizona's ALTCS model has historically provided integrated care that included behavioral health treatment, emphasis was added to promote greater use of Arizona's behavioral health model, particularly regarding individuals who have been determined to have a serious mental illness (SMI).

AHCCCS Complete Care (ACC)

AHCCCS states that that healthcare is most effective and efficient when it treats the patient holistically. Since its inception in 1982 and under the leadership of several directors, AHCCCS has worked to

integrate physical and behavioral healthcare service delivery. AHCCCS has found that evidenced-based studies demonstrate mental health and physical health are dependent on each another and that optimal care includes that link. AHCCCS also stated that studies demonstrate the significant cost-savings resulting from integrating care.

Prior to October 1, 2018, most of the 1.8 million AHCCCS members in Arizona were enrolled in at least two managed care health plans—one for physical healthcare services and a second for behavioral healthcare services.

Throughout 2017 and 2018, AHCCCS has been working to further this strategic goal of healthcare integration. In March 2018, AHCCCS took a large step toward this goal by awarding integrated managed care contracts to seven AHCCCS Complete Care (ACC) health plans. The seven ACC plans throughout the state will manage a network, provide all covered physical and behavioral health services, and be the only Medicaid payer to the ACC providers. The ACC plans will also provide services for members with Children's Rehabilitative Services (CRS) conditions. These CRS members had been restricted to a single plan and now have choice of all ACC health plans offered in their service area.

Success was achieved through a committed team of AHCCCS staff throughout the agency that over the last two years achieved all of the following:

- Obtained stakeholder feedback.
- Conducted community forums.
- Issued and scored a request for proposal.
- Awarded ACC plan contracts without protest.
- Worked with ACC plans to ensure system and plan readiness to serve members.
- Undertook significant information system changes to ensure that members were enrolled correctly for integrated services and ACC plans and that providers had access to information by October 1, 2018.
- Made comprehensive policy and contractual changes as well as provided ongoing communication and education to the community, members, and staff.

The results of the actual October 1 implementation and transition of members to ACC plans have been incredibly successful. From the contract awards that were not protested to health plan and agency system transition on October 1st, the reports have been positive.

With the implementation of AHCCCS Complete Care, more than 1.5 million AHCCCS members now have a single health plan for physical and behavioral healthcare services. A single health plan will be easier for members and providers to navigate, with one network and a single payer. One health plan can streamline care coordination at the health plan and provider levels and work to improve the member's whole health.

AHCCCS CARE: Choice, Accountability, Responsibility, Engagement

The AHCCCS CARE (Choice, Accountability, Responsibility, Engagement) program, approved by CMS on September 2016 as part of the waiver, promotes personal responsibility and accountability for participants in the Medicaid program. Some highlights of the program are listed below.

- Health Savings Account: Adults over 100 percent of the federal poverty level (FPL) are required to pay a monthly premium of 2 percent of household income or $25, whichever is lesser.

- Giving Citizens Tools to Manage Their Own Health: Member premium contributions go into their AHCCCS CARE accounts, which work like flexible health savings accounts. These funds can be withdrawn by members and used for non-covered services, including dental, vision, chiropractic care, recognized weight loss programs, nutrition counseling, gym membership, and sunscreen.

- Enforcing Member Contribution Requirements: Members will be disenrolled for failure to pay their monthly premium requirements.

- Engaging the Business and Philanthropic Community: Employers and charitable organizations may contribute funds into the AHCCCS CARE account to support a healthy workforce and to support members achieving health goals.

- Promoting Healthy Behaviors: The AHCCCS CARE program includes incentives to promote healthy behaviors. Members may defer their premium payments for six months if they meet healthy targets that include: meeting preventative health targets like getting a wellness exam, flu shot, mammogram, or cholesterol screening; or managing chronic illnesses like diabetes, asthma, or tobacco cessation. Meeting these healthy targets allows members to roll unused funds over into the next year and unlock funds available in the AHCCCS CARE account to be used for non-covered services.

- Supporting the Medical Home Through Strategic Coinsurance: The AHCCCS CARE program uses a strategic coinsurance strategy that only assesses payment requirements retrospectively so that members are not denied services and providers are not burdened with uncompensated care and administrative hassle. Strategic coinsurance only applies to: opioid use, use of brand name drugs when a generic is available, non-emergency use of the emergency department (ED), and seeing a specialist without a primary care provider's referral.

- Connecting to Employment Opportunities: Through an innovative partnership with the Arizona Department of Economic Security, all AHCCCS CARE members will be automatically enrolled in job-seeking programs.

All adults over 100 percent of the FPL in the adult group are required to participate, with the exception of those persons with SMI, American Indian/Alaska natives, individuals considered medically frail, and some members with hardship exemptions.

Member contributions will range from $4 for opioid prescriptions and between $5 and $10 for copays for specialist services without primary care physician (PCP) referrals. The program introduced other initiatives such as charitable contributions to the member's account, the AHCCCS work program, and health targets for preventative and chronic care. AHCCCS indicated that this program allows members to manage their own health and prepares adults to transition out of Medicaid into private coverage.

Executive Order 2016-06—Prescription of Opioids

On October 24, 2016, the Governor of Arizona, Douglas Ducey, signed Executive Order 2016-06 to address the opioid crisis affecting the nation and, in particular, the state of Arizona. In this order, the Governor indicated that Arizona has the ninth highest rate of opioid deaths in the nation, and that approximately 404 people in the state died of prescribed opioid overdoses in 2015. The State presented alarming statistics showing that during 2013 enough prescription pain medications were dispensed to medicate every adult in Arizona around the clock for two weeks.

The order authorized AHCCCS and the Arizona Department of Administration (ADOA) to adopt policies and rules that impose limitations to initial prescriptions of opioids for no more than seven days and initial and subsequent prescriptions to minors for the same period (seven days), except in cases of cancer and other chronic disease or traumatic injury.

As part of this initiative, the Governor also established the Arizona Substance Abuse Task Force to act as a coalition of leading experts, providers and members, and other community representatives. According to the Governor, this task force will provide recommendations on a variety of substance abuse-related issues, including access to treatment, evidence-based practices, neonatal abstinence syndrome, and medically assisted treatment best practices.

The overarching goal of this initiative is to reduce the prevalence of opioid use disorders and opioid-related overdose deaths. The initiative approach includes developing and supporting state, regional, and local-level collaborations and service enhancements to develop and implement best practices to comprehensively address the full continuum of care related to opioid misuse, abuse, and dependency. Strategies include:

- Increasing access to naloxone through community-based education and distribution as well as a co-prescribing campaign for individuals receiving opioid prescriptions exceeding morphine-equivalent daily doses and receiving combinations of opioids and benzodiazepines.
- Increasing access to and participation and retention in medication-assisted treatment (MAT).
- Reducing the number of opioid-naive members unnecessarily started on opioid treatment.
- Promoting best practices and improving care process models for chronic pain and high-risk members.

The Medication Assisted Treatment – Prescription Drug Opioid Addiction Program (MAT-PDOA) grant, awarded to AHCCCS in September 2016, aims to target states having the highest rates of primary treatment admission for heroin and opioids. The primary goal of AHCCCS' MAT-PDOA program is focused toward engaging individuals diagnosed with opioid use disorder and involved with the criminal justice system. Specifically, intention is to focus on outreaching and screening individuals within four months of their release date to engage them in medication-assisted treatment (MAT) and provide care coordination as they reenter the community. The project also seeks to improve access to MAT services for these individuals by improving infrastructure and collaboration among criminal justice entities and opioid treatment programs (OTPs). Additionally, the project will expand infrastructure and build capacity for State, regional, and local collaborators to implement integrated strength-based treatment

planning, screening, and assessment for co-occurring disorders for the target population by increasing participation in MAT services.

To date the MAT-PDOA program has enrolled 168 participants into the program to receive services. Among those enrolled, program outcomes include reductions in crimes committed, nights spent in jail, and drug-related arrests. The program has also produced an increase in gainful employment as well as increased housing acquirement and treatment retention. MAT-PDOA providers have expanded collaboration and engagement efforts with correctional facilities, re-entry centers, parole and probation departments, and drug courts. The program has also expanded services to the Graham County correctional facilities and drug court to assist an area that has been heavily impacted by the opioid epidemic and which, among other counties, has one of the highest overdose rates.

To expand training and education, AHCCCS will host two free MAT symposiums, in Mohave and Graham County, in efforts to display clinically effective prevention and treatment strategies to best serve those impacted by the opioid epidemic. Topics will also include current State initiatives being implemented to combat this rapidly emerging crisis. The content of the symposiums is designed for MAT providers, substance use disorder treatment providers, physical health providers, harm reduction organizations, justice system partners, and interested community members.

The Opioid State Targeted Response grant will enhance community-based prevention activities and treatment activities—to include offering 24/7 access to care points in "hotspot" areas throughout the state—increasing the availability of peer supports, providing additional care coordination efforts among high-risk and priority populations, and adding recovery supports.

During 2018, the following efforts supporting this initiative were made:

- Arizona opened five 24/7 centers of excellence (COE) for opioid treatment on demand during year one. The COE is an opioid treatment program in a designated "hotspot" that expanded its hours to be open for intakes around the clock and for warm handoff navigation care post intake. Arizona has also opened two medication units in rural Arizona to make MAT more accessible among those communities.
- AHCCCS launched a concentrated effort through the Opioid State Targeted Response (STR) grant to increase peer support utilization for individuals with opioid use disorder. Through the STR grant, 34 additional peer support navigators have been hired in identified hotspots in Arizona; and efforts to include peer support navigation in centers of excellence, jails, emergency departments, and for first responders at the scene in hotspot areas have increased. Through STR funding, Arizona has launched a real-time auto-dispatch model with Phoenix Fire Department (PFD); when PFD receives an opioid-related call, a peer support staff member from the 24/7 OTP clinic in Phoenix is also dispatched to arrive on the scene to help navigate individuals to resources. Arizona has also launched its first law enforcement "pre-booking" model in Tucson. Peers are called on scene to provide navigation to the 24/7 OTP as a mechanism for an alternative to incarceration.
- A total of 8,798 Naloxone kits were purchased for distribution to law enforcement agencies during the first year of the STR grant.

Targeted Investments Program

On January 18, 2017, CMS approved Arizona's request to implement the Targeted Investments (TI) Program to support the State's ongoing efforts to integrate the healthcare delivery system for AHCCCS members. The TI Program is AHCCCS' strategy to provide financial incentives to participating AHCCCS providers to develop systems for integrated care. The TI Program will make almost $300 million available over five years to Arizona providers who assist AHCCCS in promoting the integration of physical and behavioral healthcare, increasing efficiencies in care delivery and improving health outcomes.

Pursuant to 42 CFR 438.6 (c), the TI Program will fund time-limited, outcomes-based projects aimed at building the necessary infrastructure to create and sustain integrated, high-performing healthcare delivery systems that improve care coordination and drive better health and financial outcomes. The TI projects will support children and adults with behavioral health needs (including children with or at risk for Autism Spectrum Disorder and children engaged in the child welfare system) as well as individuals transitioning from incarceration who are AHCCCS-eligible. The TI program is expected to:

- Reduce fragmentation for both acute and behavioral health programs.
- Increase efficiency in service delivery for behavioral health members.
- Improve health outcomes for the affected populations.

As part of the AHCCCS Targeted Investments Program initiative, use of the Early Childhood Service Intensity Instrument (ECSII), an incentive-based requirement, was adopted by the providers who volunteered to participate in the program for use with children birth to 5 years of age. The ECSII is a screening tool designed to examine risk and protective factors in the environment of infants and toddlers through the use of six major domains: quality of the relationship between child and caregiver; caregiving environment; developmental, emotional, or functional status of the child; and degree of safety within the child's environment. Domain scores are used to help both the formal and informal systems of care that surround the child to coordinate services based on intensity of need.

The ECSII tool was developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and is designed to identify intensity of services needed to improve early intervention outcomes for at-risk infants and toddlers. The tool promotes a collaborative and integrated approach among the various systems working on behalf of the child (behavioral and physical health, educational, foster care system, and State agencies). The ECSII is based on a child-centered, family, and team-driven approach. It is expected to identify the need for behavioral health intervention sooner than what may otherwise be possible, and to thereby improve outcomes.

To satisfy specific requirements for the Targeted Investment Program ECSII, providers were required to document the practice's policies and procedures for use of the ECSII, and to attest that the results of the ECSII were in the electronic medical record, by September 30, 2018. By September 30, 2019, providers will attest that the practice performed the ECSII 85 percent of the time and incorporated service intensity recommendations into the integrated treatment plan.

The following are highlights of the Targeted Investments (TI) program implementation activities conducted by AHCCCS during CYE 2018:

- AHCCCS developed a portal for TI participants and established the reporting system for TI program participants to submit attestations of milestone completion and to upload documents for validation.
- Collaborated with the State health information exchange (HIE) to onboard approximately 40 provider organizations to prepare them to receive admission, discharge, and transfer alerts from the HIE by September 2018.
- Made numerous presentations on the TI program to a range of internal and external stakeholders, explaining the integration and whole person care goals and objectives of the TI program.
- Engaged with TI participants through various means, including electronic and in-person forums for TI participants, surveys to gather feedback from all TI participants, webinars to review the attestation process and the document validation criteria with TI providers, monthly newsletters sent to all participants and including pertinent information such as program updates and upcoming due dates, and the TI webpage that includes resources and communications.
- Developed a peer/family training curriculum to meet a TI milestone for co-located justice clinics that require training of peer/family support staff. The TI program partnered with the Maricopa Integrated Health System to develop the first phase of the peer/family training curriculum, which is being used to train individuals providing peer/family services to the individuals involved in the justice system who are served by the 12 TI co-located justice sites.
- Established an ongoing dialogue between AHCCCS and AHCCCS Contractors to facilitate alignment between the TI program guidance on enhanced provider level integration and the Contractors' provider network initiatives.

American Indian Health Plan Integration

In addition to the implementation of integrated managed care plans with AHCCCS Complete Care, AHCCCS has worked throughout the last year to integrate physical and behavioral healthcare and services throughout the state for members with CRS conditions who choose to enroll in the American Indian Health Program (AIHP).

Eligible American Indians currently have a choice of using managed care or the AHCCCS fee-for-service program, AIHP.

Prior to October 1, 2018, most members enrolled in AIHP were also enrolled in a RBHA or Tribal Regional Behavioral Health Authority (TRBHA) for behavioral health services.

Effective October 1, 2018, American Indian members have the choice of integrated care: AIHP or an AHCCCS Complete Care (ACC) health plan. AIHP members will also be able to choose care coordination through a TRBHA (when available).

Quality Strategy

During CYE 2018, an internal workgroup was established to lead the most recent overhaul of the AHCCCS Quality Strategy. The Quality Strategy supports the mission and vision of AHCCCS and is aligned with AHCCCS' Strategic Plan, which outlines overarching goals that guide AHCCCS' direction for SFY 2015–2019. The report outlines AHCCCS' commitment to transparency, stakeholder engagement, and ultimately a commitment to the provision of quality care and services to those served through Arizona's Medicaid managed care and fee-for-service system.

Arizona Management System (AMS)

Arizona Governor Doug Ducey has deployed a professional, results-driven management system to transform the way agencies think and do business. AHCCCS has fully embraced this system and is committed to tracking and improving performance daily. Across the agency AHCCCS employees now meet regularly around huddle boards where staff can monitor performance and hold themselves accountable for results. AHCCCS continues to gather data and work toward delivering results for the people of Arizona.

Suicide Prevention Plan

According to officials at the World Health Organization (WHO), more than 800,000 people die by suicide annually; many more make an attempt. Suicide was the second leading cause of death among 15–29-year-olds globally in 2012. It is a global phenomenon in all regions of the world and accounted for 1.4 percent of all deaths worldwide, making it the fifth leading cause of death in 2012.

In Arizona, suicide is a primary public health concern that touches urban and rural communities including people of all ages and backgrounds.

- Among children ages 10–14 in Arizona, suicide is the leading cause of death.
- On average, a suicide occurs every seven hours in Arizona.
- Arizona ranks 12th in the nation for deaths by suicide.
- A total of 1,310 Arizonans died by suicide in 2016—the youngest was 9 years old.
- Among American Indians or Alaskan Natives, the median age of death by suicide is 27 years old (compared to age 51 among Caucasians).

Governor Ducey issued a proclamation declaring September Suicide Prevention Awareness Month in Arizona, encouraging citizens to take part in addressing suicide in communities.

As a member of the Arizona Suicide Prevention Coalition, AHCCCS collaborates with State agencies, organizations, healthcare plans, lawmakers, and other partners to create a community-based plan to end suicide in our state.

Learning Collaborative

AHCCCS developed a "Learning Collaborative" for clinical staff, where subject matter experts (SMEs) present on issues of topical interest. One such session was a review of the children's system of care. The session reviewed the topic from an historical perspective and considered how it has been modified in response to recent litigation for behavioral health services for children. The session also explored the impact to the new AHCCCS Complete Care plans as outlined in the contract. The audience was provided tools to use in reviewing contractual deliverables associated with behavioral health services for children. As part of its commitment to quality improvement, AHCCCS reviews the feedback provided by the attendees to improve future presentations to ensure that the material is pertinent and germane to the mission of the clinical departments.

System Improvements

AHCCCS hosts various meetings to continue to direct system improvements:

- Monthly collaborative meetings with Department of Children's Services/Comprehensive Medical and Dental Program (DCS/CMDP) to continue efforts to improve service delivery for children in the foster care system and to ensure availability of medically necessary services.
- Quarterly contractor meetings including DCS/CMDP, to review deliverable submissions and foster care data and to discuss system successes and improvements.
- Quarterly cross-divisional operational team meetings to further enhance service delivery efforts.

Through these meetings, various system improvements have been identified:

- Resource Packet—The frequently asked questions (FAQ) document has been expanded and renamed. It now includes more frequently asked questions, information, and resources for foster, kinship, and adoptive parents related to available physical and behavioral health services.
- Behavioral health and crisis services flyers for foster and kinship that are updated annually.

AHCCCS developed a specific policy (ACOM 449), which outlines specific requirements for behavioral health services for children within custody of the Department of Child Safety and for adopted children.

AHCCCS created a quarterly dashboard to track and trend utilization for children in foster care; this dashboard is posted on the AHCCCS foster care Web page.

Long-Acting Reversible Contraceptives (LARCs)

AHCCCS implemented the LARC initiative to allow for LARC devices to be reimbursed outside of regular hospital payment. Offering members access to LARC devices in the hospital after delivery is expected to increase utilization of such devices since many members do not attend their six-week post-partum office visits.

Summary of Activities Designed to Enhance the Medical Record Review Process

AHCCCS has initiated a statewide workgroup designed to develop a consistent behavioral health chart review tool. The tool will be designed to:

- Meet the CFR and State statutory requirements.
- Operate according to AHCCCS contractual guidelines.
- Provide consistency across the state with regard to clinical behavioral health practice.
- Allow for consistency of results in chart analysis and review.
- Allow for data comparisons across geographic service areas using consistent measurement of required chart elements.

Other Systemwide Quality Initiatives/Collaboratives

During the reporting period, AHCCCS participated in the following systemwide quality initiatives. (Note: This is not an all-inclusive list.)

- *Behavioral Health Needs of Children Involved with the Department of Child Safety: Psychotropic Prescribing Update*: AHCCCS is revising the Psychiatric and Psychotherapeutic Best Practices for Children Birth Through Five Years of Age guidance document to ensure that the most recent research on appropriate prescribing is provided to providers, children, and families. AHCCCS is also updating tools that provide best practice strategies related to infants and toddlers—including psychotropic prescribing, early childhood mental health intervention, and trauma-informed care. The document content focuses on the most current prescribing practices and psychotherapeutic approaches for use during early childhood, with the recommendation that psychotherapeutic approaches be the preferred method of treatment prior to implementation of psychopharmacologic intervention. To further ensure realization of the treatment recommendations within these tools, AHCCCS has begun a statewide Birth to Five initiative to address the unique needs of infants and toddlers. Additionally, AHCCCS is collaborating with CMDP for their Birth to Five learning collaborative.

- Recommendations to Office of the Arizona Governor Policy Advisor for Health and Human Services on Autism Spectrum Disorder (ASD): In February 2016, the ASD Advisory Committee (appointed by the Office of the Arizona Governor in spring 2015) publicized a report of recommendations to strengthen the healthcare system's ability to respond to the needs of AHCCCS members with or at- risk for ASD, including those with co-morbid diagnoses. During 2017, two centers of excellence opened in Maricopa County. AHCCCS Complete Care, the new contract for AHCCCS and the Contractors, is addressing the recommendation to integrate care for acute members. In addition, AHCCCS is developing a behavioral intervention policy that addresses this issue.

- Summary of Activities Designed to Enhance the Monitoring of Physical Health Providers: Arizona Association of Health Plans (AzAHP), comprised of all AHCCCS Contractors for Medicaid business except CMDP and the Arizona Department of Economic Security(DES)/Division of Developmental

Disabilities (DDD), offers a single point of contact for the Contractors and promotes consistency across the system. AzAHP works closely with AHCCCS discussing Contractor concerns, barriers, and challenges Contractors are asked to undertake. It also provides valuable feedback for consideration as the direct link to the care and services being provided. AHCCCS utilizes the AzAHP to provide stakeholder insight and to collaborate and promote new initiatives. AHCCCS has collaborated with AzAHP to provide consistent monitoring of physical health providers. This collaboration has historically allowed for uniform statewide review of primary care practitioners including internists, family practices, and obstetricians. AHCCCS began discussions with AzAHP regarding capacity to also monitor behavioral health providers throughout Arizona. Utilizing AzAHP as a monitoring agent facilitates consistency in quality monitoring and reduces burden on practitioners because AzAHP serves as the single reviewing entity for multiple MCOs. AHCCCS is currently combining this effort with the development of a consistent tool during meetings conducted with the RBHAs during 2017 and early 2018.

- AHCCCS Quarterly Contractors' Quality Management/Maternal and Child Health Meeting: To further promote the integration of medical and behavioral health services, targeted education is included within the AHCCCS Quarterly Contractor's Quality Management/Maternal and Child Health (MCH) Meeting.

- Clinical Integration: The Medical Management (MM) unit, which regularly partners with the Quality Management (QM) and MCH/EPSDT units, added a second behavioral health coordinator to support efforts for the entire clinical team. The addition of a behavioral health coordinator enhances the ability for clinical considerations, service delivery, and program and contract development—to encompass a holistic approach in all aspects of care. AHCCCS continues to hire additional staff with behavioral health expertise from within its workforce.

  Within the QM, QI, and MCH/EPSDT units, other activities designed to enhance integration have involved utilization of performance and quality measurement activities that provide a greater focus on specific aspects of integrated care. Highlights include:

  – Required tracking of performance on the frequency of diabetic screening for individuals with schizophrenia or bipolar disorder.

  – Tracking performance on prenatal and postpartum timeliness of care, with supplemental training provided to contracted health plan staff relative to physical and behavioral health aspects of perinatal mood disorders.

  – Implementation of regular community-based meetings open to AHCCCS membership—with focus on enhancing member and stakeholder involvement and investment in performance as well as on enhancing quality improvement activities for physical and behavioral healthcare.

- Involvement of Stakeholders and Community Subject Matter Experts: Throughout 2017, AHCCCS continually involved stakeholders and community subject matter experts as members of AHCCCS committees, quality meetings, policy workgroups, and advisory councils. Subject matter experts provided technical assistance, guidance, and advisement related to various areas and issues (e.g., special needs populations, consumer advocacy, ASD, early intervention, trauma-informed care, behavioral health system best practices, integrated care).

- Medical Director Meetings: AHCCCS involves medical directors from Contractors in quarterly meetings. These meetings are designed to inform medical directors of changes in policy, regulation,

billing practices, and current or future system updates. Additionally, these quarterly medical director meetings are designed to provide information on best practices in medical, behavioral care, and/or prescribing practices.

- ADHS Bureau of the United States Department of Agriculture (USDA) Nutrition Programs: AHCCCS works with ADHS Bureau of USDA Nutrition Programs on many initiatives ranging from Contractor education to Women, Infants, and Children promotion and obesity issues. The nutrition coordinators present the most up-to-date information at the AHCCCS Contractor quarterly meetings.

- Arizona Early Intervention Program: The Arizona Early Intervention Program (AzEIP), Arizona's IDEA Part C program, is administered by the Division of Developmental Disabilities. Maternal and child health (MCH) staff in the Clinical Quality Management unit at AHCCCS work with AzEIP to facilitate early intervention services for children younger than 3 years of age who are enrolled with AHCCCS Contractors. These services are closely monitored to ensure timely access and availability of services to members. AHCCCS and AzEIP continue to collaborate and meet regularly to ensure that members receive care in a timely manner. As an ongoing effort to promote care coordination and system clarification the MCH/EPSDT manager undertook extensive efforts to create detailed flow charts that outline the process from multiple points of entry and across many different MCO types and member conditions. These flow charts have been promoted at several stakeholder groups, with collaborative feedback. Once the charts undergo a final review, these tools will be made available on the AHCCCS website.

- The Arizona Partnership for Immunization (TAPI): Quality management staff attend on-going TAPI Steering Committee meetings and subcommittee meetings concerning community awareness, provider issues, and adult immunizations. TAPI regularly communicates immunization trends and best practices with AHCCCS and its Contractors. TAPI's Provider Awareness and Adult and Community Awareness committees continue to focus on long-term projects such as updating the TAPI website with the most current information for providers, parents, and the community at large. In addition to the website, TAPI provides vaccination handouts. TAPI has a teen vaccination campaign (Tdap, meningococcal and human papillomavirus [HPV] vaccines) that involves provider education as well as parent and teen outreach. Protect Me with 3, a parent-focused campaign, reminds parents that their children still need them to protect them and to help with healthy decisions. Take Control, a teen campaign, addresses teen vaccinations required to maintain health as teens begin to take control of their lives in the realms of college, driving, and even health decisions.

- Health Current: Formerly Arizona Health-e Connection, this non-profit organization is a health information exchange organization (HIO) and is the single statewide Health Information Exchange (HIE). Health Current currently has 500 unique participants, which include hospitals, accountable care organizations, health plans, behavioral health providers, laboratories, ambulatory practices, long-term care providers, and more. (For a complete list of participants, Health Current maintains a count on their website: https://healthcurrent.org/hie/the-network-participants/). To improve care coordination, AHCCCS requires all managed care contractors to join the HIE. Health Current electronically shares hospital data with several other out-of-state HIEs through a project called the Patient-Centered Data Home (PCDH). The PCDH project provides the technical and legal agreements to support cross-state data sharing for care coordination. Launched in early 2017, Southern Colorado, Arizona, Utah, and now Santa Cruz and San Diego HIEs are capable of sharing

hospital admission, discharge, or transfer information with a Medicaid member's home HIE if that member seeks care outside his or her Arizona or "home" HIE.

- ADHS Bureau of Tobacco and Chronic Disease: In collaboration with ADHS, AHCCCS monitors the utilization of and access to smoking cessation drugs and nicotine replacement therapy program. AHCCCS members are encouraged to participate in ADHS' Tobacco Education and Prevention Partnership (TEPP) smoking cessation support programs such as "ASHLine" and/or counseling in addition to seeking assistance from their PCPs. Additional efforts have been focused on the integrated SMI population in connecting members to smoking cessation and nicotine replacement programs.

- Medicare and Medicaid Alignment for Duals: Arizona leads the nation with the highest percentage of dual-eligible members aligned in the same plan for Medicaid and Medicare outside the demonstration authority. Arizona has over 64,000 members enrolled in the same plan for Medicare and Medicaid. AHCCCS conducted a study to determine the impact on plan alignment related to dual-eligible members. The study compared national data for dual-eligible members enrolled in traditional Medicare fee-for-service to data for aligned dual-eligible members served by one of the AHCCCS health plans. The study found that the aligned AHCCCS dual-eligible members exhibited a 31 percent lower rate of hospitalization, a 43 percent lower rate of days spent in a hospital, a 9 percent lower rate of ED use, and a 21 percent lower readmissions rate.

- Early Reach-In: Contractors are required to participate in criminal justice system "reach-in" care coordination efforts through collaboration with criminal justice partners (e.g., jails; sheriff's office; Correctional Health Services; and Arizona Department of Corrections, including community supervision and probation courts). AHCCCS is engaged in a data exchange process that allows AHCCCS to suspend member eligibility upon incarceration rather than terminating coverage. Upon the member's release, the member's suspension of AHCCCS eligibility is lifted, allowing for immediate care coordination activities. Using the 834 data file to identify incarcerated members who have been incarcerated for 30 days or longer and who have anticipated release dates, the Contractor conducts reach-in care coordination for members with chronic and/or complex care needs, including assessment and identification of MAT-eligible members. The Contractors, with the criminal justice partners, facilitate the transition of members out of jails and prisons and into communities. Members are provided with education regarding care, services, resources, appointments, and health plan case management contact information. Post-release initial physical and behavioral health appointments are scheduled within seven days of member release. Ongoing follow-up occurs with the member to assist with accessing and scheduling necessary services as identified in the member's care plan, including access to all three U.S. Food and Drug Administration (FDA)-approved MAT options covered under the AHCCCS Behavioral Health Drug List and assignment to peer support services to help navigate and retain the member in MAT when appropriate.

- Foster Care Initiative: AHCCCS is committed to providing comprehensive, quality healthcare for children in foster, kinship, or adoptive care. Foster children are eligible for medical and dental care, inpatient, outpatient, behavioral health, and other services through CMDP, RBHAs, or CRS. Adoptive children are typically AHCCCS eligible and enroll in a health plan/RBHA or CRS like any Medicaid-eligible child. AHCCCS holds a variety of meetings related to improving service delivery for children in foster care.

- Behavioral Health Learning Opportunities: With the advent of administrative simplification, AHCCCS recognized the need to provide learning opportunities for staff lacking behavioral healthcare experience and expertise due to previous historical hiring requirements for medically trained personnel. AHCCCS offers formal meetings as well as informal workshops, and lunch-hour trainings to ensure that staff had ample opportunities to increase behavioral health system knowledge. Internal behavioral health subject matter experts, licensed behavioral health practitioners, and community professionals have been procured to offer training on topics such as infant/toddler mental health, trauma-informed care, perinatal mood disorders, and adult system-of-care processes for individuals with general mental health needs and SMI.

Quality Management (QM) is providing additional behavioral health "Lunch and Learn" trainings for QM and quality of care (QOC) staff especially, with attendance open to other departments based on department need. Topics include the following:

  - Regulatory requirements for individuals designated as having an SMI versus having general mental health and/or substance abuse needs (GMH/SA)
  - Grant-based housing for individuals with SMI
  - Short-term behavioral health residential services
  - Crisis process and requirements
  - Diagnostic categories and symptoms
  - Best-practice and evidence-based clinical approaches for adults and children
  - Mental health awareness
  - AHCCCS Waiver process
  - Meeting the needs of members with developmental disabilities and behavioral health challenges
  - Coordination of benefits (e.g., AHCCCS, Medicare, commercial coverage)

ALTCS Quality Initiatives/Collaboratives

During the reporting period, AHCCCS participated in the following quality initiatives. (Note: This is not an all-inclusive list.)

- ADHS Immunization Program and Vaccine for Children (VFC) program: Ongoing collaboration with ADHS helps ensure efficient and effective administration and oversight of the federal Vaccines for Children (VFC) program. The VFC program representatives provide education to Contractors, regular notification to AHCCCS regarding vaccine-related trends and issues, and updates regarding the Arizona State Immunization Information System (ASIIS), an immunization registry that can capture immunization data on individuals within the state. Staff also provide monthly data sharing regarding AHCCCS members receiving immunizations and ongoing collaboration regarding Stage 1 and Stage 2 meaningful use (MU) public health requirements.

- Arizona Head Start Association: The Arizona Head Start and Early Head Start programs provide education, development, health, nutrition, and family support services to qualifying families. The Arizona Head Start grantees—including the City of Phoenix, Maricopa County, Chicanos Por La Causa, and Southwest Human Development—continue to host community meetings quarterly. The

meetings are attended by families participating in the Head Start program along with AHCCCS staff members and the AHCCCS Contractor MCH/EPSDT coordinators.

Continuing or New AHCCCS Actions and Collaborative Initiatives to Improve Performance for the ALTCS Contractors

Examples of continuing or new AHCCCS actions and collaborations specific to ALTCS Contractors include the following: (Note: This is not an all-inclusive list.)

- Work Force Development: Beginning October 1, 2017, with the ALTCS contract for members who are elderly and/or who have physical disabilities, AHCCCS instituted a requirement for Contractors to develop a Workforce Development (WFD) Plan as part of the Network Development and Management Plan. The WFD requirements have since been adopted formally into policy in the AHCCCS Contractors Operations Manual, Policy 407; and the scope of the WFD requirements has expanded. Contractors spanning all lines of business are required to maintain an operational infrastructure for workforce policy management. This requirement addresses each Contractor's internal staffing and resource capacity to conduct needs assessments, collect data, develop the workforce development plan, and monitor subcontracted providers to ensure adherence to AHCCCS training requirements outlined in policy.

  Each Contractor's WFD plan must incorporate required elements such as forecasts of workforce capacity and competency needs and must identify strategic goals and implement initiatives to address those needs. The flexibility built in to the planning process affords the Contractors opportunity to develop a plan responsive to membership and network needs. The Contractors also have opportunity to jointly develop priorities that address common areas of need. For example, the Contractors worked in collaboration with AHCCCS' Workforce Development Administrator and the provider industry leaders to create standard metrics to measure worker retention, time required to fill vacant positions, and turnover.

The following are the best practices as reported by the Contractors to AHCCCS.

Bridgeway Health Solutions (BWY)

BWY was not required to submit Best Practices to AHCCCS as the company is no longer a Contractor.

Mercy Care Plan-Long Term Care (MCP-LTC)

- Follow-Up On Appointments: Members who see their primary care providers (PCPs) at least once every 90 days are more likely to be adherent with their medications, seek early intervention for medical problems, complete timely screenings, and have reduced avoidable hospitalizations. Primary care visits have been found to reduce hospitalizations among Medicare beneficiaries at the end of life. MCP-LTC members are encouraged by their case managers (CMs), at each assessment visit, to see their PCPs or specialist at least every 90 days. The CM provides assistance with scheduling appointments and helps with transportation arrangements if necessary.

  MCP-LTC members tend to have multiple comorbidities which require ongoing medical attention to be effectively managed. Members who are seriously mentally ill or have dementia may fail to schedule and receive ongoing care without reminders and assistance. Members who have ongoing relationships with their PCPs or specialists are more likely to be seen within seven days of discharge from the hospital.

  Medical appointments are documented by the CM in a Dynamo (case management medical record) event at each assessment visit. Collected data are reportable and monitored by management. Reports are run monthly to determine compliance with the initiative. Based on the results of the reports, education is provided to CMs demonstrating inadequate performance.

- Measuring Effectiveness of an In-Home Pharmacy-Based Medication Review Program (In-Home PMRP): The In-Home PMRP is a CM referral-based program focused on coordinating care between CMs and clinical pharmacists to deliver in-home clinical pharmacy services. The purpose of the program is to evaluate the effectiveness of in-home based clinical pharmacy services for the MCP-LTC population in Arizona.

  MCP-LTC reported that home-based pharmacist programs have been shown to increase medication adherence, improve patient self-management of chronic conditions, and reduce rates of hospital visits and readmissions. The advantage of providing clinical pharmacy services in a member's home versus telephonic outreach or office-based services is that a pharmacist can assess a member's living conditions and corroborate member-provided information with their medications and prescription labels present. The 2003 National Assessment of Adult Literacy found that 60 percent of adults with

Medicaid have a health literacy cognitive level below what is needed to read instructions on a prescription label. In addition, in-home clinical services are especially valuable for members who may have challenges in communicating their prescription information over the phone. CMs commonly serve as the primary points of contact between the health plan and members with complex medical needs. CMs assess their members' needs for clinical pharmacy services before providing referrals to care management programs. At this time, no published research studies have evaluated the integration of pharmacy and CMs for the provision of home-based medication reviews. More so, current research centers on in-home clinical pharmacy services after a hospital discharge, evaluating a reduction in hospital readmission rates, perceived value of services, or number of identified medication problems.

• Advance Directives: Ensuring that members complete advance directives is one example of how MCP-LTC puts the member at the center and supports members' rights of self-determination. Through interactions with the members, the CM builds trusting relationships. Consequently, when they discuss end-of-life planning and the need for advance directives, members are more receptive to completing living wills or power-of-attorney documents. Several conversations with members may be required before finalization of wishes in a formal document transpires.

CMs discuss advance directives with adult members or with the members' guardians. CMs routinely bring copies of blank advance directive forms to their members' homes and provide continuing education to the members and their families about the importance of completing these documents.

At the initial assessment, and at each review for members who have not completed advance directives, CMs continue to encourage the member or family to determine preference for advance directives and to complete the paperwork indicating those choices. CMs also encourage members to speak with their PCPs about advance care planning, which may also include advance directive completion. CMs use the "Preferred Intensity Form" for members in a nursing facility. This form records the member's preference for treatment if the member becomes unable to communicate.

For tracking purposes, completion dates for advance directives are recorded and tracked in Dynamo. Supervisors can run reports out of Dynamo at any time to check CM progress in obtaining advance directives. Monthly reports are run to track the overall percentage of members with completed advance directives.

UnitedHealthcare Community Plan-Long Term Care (UHCCP-LTC)

• Affiliated Practice Dental Hygienist (APDH): APDHs are direct-access providers established to address unmet oral healthcare needs in Arizona. However, due to the inability of APDHs to be credentialed and contracted with Medicaid plans, the model has been highly underutilized. Through an agreement with an affiliated practice dentist, APDHs can provide preventative and therapeutic dental hygiene services as determined appropriate, without direct supervision by a dentist. In an affiliated practice model, an unsupervised APDH can provide dental hygiene services in nontraditional community-based settings and receive direct reimbursement from Medicaid plans.

UHCCP-LTC's initiative integrates medical and dental services to concurrently close preventative medical and dental gaps in care. The APDH at the San Luis Walk-In Clinic (SLWIC) provides dental hygiene services in a medical primary care setting. As the medical provider completes an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visit, the APDH provides an oral screening, education, fluoride varnish, and referral to a dentist.

This innovative initiative utilizes a mid-level dental provider to integrate medical and dental care. The integration raises awareness of the systemic link between poor oral health and medical conditions (i.e., diabetes, cardiovascular disease, pre-term labor, low birth weight). The targeted pilot population has higher risk for and prevalence of dental disease and low attendance of dental visits. The initiative reinforces the importance of oral health and captures services provided by APDHs to count toward the annual dental visits (ADV) HEDIS measure.

The health plan dental clinical practice consultant (CPC) engages medical and dental offices in developing integrated APDH models. Currently, UHCCP-LTC is working with several community partners throughout Arizona to implement 21 APDH models. The dental CPC connects community partners, assists in determining strategies for delivery of dental services, provides resources, and guides medical and dental practices in establishing the APDH provider for reimbursement. As outlined in the UHCCP-LTC business agreements, medical and dental offices coordinate patient care and referral.

The Institute of Medicaid Innovation awarded UHCCP-LTC the "2017 Medicaid Best Practice Award" for bringing dental care to the primary care setting.

- Assisted Living Facility (ALF) Enhanced Contracting Process: The goal of the enhanced contacting process was to ensure that UHCCP ALTCS members reside in homes that adhere to safety, care, and service standards. The contract and re-contract process for ALFs (homes and centers) reviews insurance requirements, the Arizona Department of Health Services (ADHS) license and most recent survey, the Federal Exclusion List, Sex Offender Registry, sample CMS1500, and other documents. UHCCP-LTC identified that the only quality component in this process was review of the ADHS survey. To enhance quality review, a UHCCP-LTC team composed of representatives from Provider Services, Case Management, and Quality Management (QM) developed criteria that indicated when enhanced quality review should be conducted. QM created a review tool to standardize the process for any facilities referred to by provider services for the in-depth review. The review tool included a review of quality-of-care referral trends, evaluation of substantiated concerns and corrective action plans, review of the required annual regulatory audits, review of any State sanctions, review of manager license and any disciplinary action as necessary, and detailed review of the ADHS survey results and any civil penalties.

- Assisted Living Facility Enhanced Annual Monitoring: The goal of the AFL enhance monitoring program is to ensure that UHCCP ALTCS members reside in homes that adhere to safety, care, and service standards. UHCCP will collaborate with the contracted vendor to identify AFLs that require areas of focused review with regard to the care and services they provide to UHCCP-LTC members. The Alternative Residential Monitoring Tool used by all participating health plans in the Arizona Long-Term Care Collaborative, provides a broad overview of individual members' care and

services. UHCCP contracts the annual monitoring function to a vendor, Foundation for Senior Living (FSL). A focused review (as part of the annual monitoring) it was determined, could drill down to specific areas that could impact the health and safety of all members. Prior to conducting the annual monitoring, FSL is required to review the previous annual monitoring results and the previous two years of the ADHS' annual compliance survey results. FSL provides UHCCP-LTC QM staff with advance notice of the next month's audit schedule so that QM staff can track and trend quality-of-care issues for those facilities. A report is provided to FSL regarding which areas— such as medication management, service plans, environmental issues, or diabetic management— require focused review. This feedback allows FSL auditors to focus on UHCCP-LTC identified areas for focused review and to verify independently any previous improvement action plans (IAPs) which may be in place. If the auditor from FSL identifies an area of concern that needs attention, UHCCP-LTC QM staff are notified within 24 hours of the monitoring visit. IAPs can be modified and/or initiated based on the feedback from FSL, or a QM nurse may conduct a site visit. Case Management and Provider Relations are notified of areas of concern as applicable.

Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD)

DES/DDD submitted no best practices to AHCCCS.

In accordance with 42 CFR §438.358, which describes activities related to external quality review, a state Medicaid agency; its agent that is not an MCO, PIHP, PAHP, or PCCM entity; or an EQRO must conduct a review within the previous three-year period to determine the Contractor's compliance with state standards set forth in subpart D of 42 CFR §438 and the quality assessment and performance improvement requirements described in 42 CFR §438.330. AHCCCS meets the requirement by conducting operational reviews (ORs) of its Contractors' performance in complying with federal and AHCCCS' contract requirements, ensuring that it reviews each requirement at least once every three years.

AHCCCS has extensive experience preparing for, conducting, and reporting findings from its reviews of Contractors' compliance with federal and AHCCCS contractual requirements. As permitted by 42 CFR §438.358(a), AHCCCS elected to conduct the activities associated with the federal Medicaid managed care mandatory compliance reviews. In accordance with and satisfying the requirements of 42 CFR §438.364, AHCCCS then contracted with HSAG as an EQRO, to use the information AHCCCS obtained from its compliance review activities to prepare this section of the annual EQR report.

Conducting the Review

AHCCCS conducted comprehensive ORs for each ALTCS Contractor in CYE 2016. Included in this section are the updates on CAPs issued during CYE 2016 that remained open. Details regarding the standards reviewed for each Contractor are included in the findings.

For details on the review objectives, methodologies for conducting the review and for scoring, and criteria for requiring Contractors to submit corrective action plans, please see Appendix A. Validation of Organizational Assessment and Structure Performance Methodology.

Standards

The CYE 2016 OR was organized into 12 standard areas. For the ALTCS Contractors, each standard area consisted of several elements designed to measure the Contractor's performance and compliance. The following are the 12 standards and number of elements involved in each standard:

- Case Management (CM), 18 elements
- Corporate Compliance (CC), five elements
- Claims and Information Systems (CIS), 12 elements
- Delivery Systems (DS), nine elements
- General Administration (GA), three elements
- Grievance Systems (GS), 17 elements

- Adult, EPSDT, and Maternal Child Health (MCH), 14 elements
- Medical Management (MM), 20 elements
- Member Information (MI), nine elements
- Quality Management (QM), 28 elements
- Reinsurance (RI), four elements
- Third-Party Liability (TPL), seven elements

Contractor-Specific Results

For CYE 2016 review cycle, AHCCCS conducted an OR for 12 standards for each Contractor in CYE 2016. Contractor-specific results are presented in the CYE 2016 and CYE 2017 annual reports. CAPs for UHCCP-LTC and BWY were closed in CYE 2017. Contractor-specific CAP results for MCP-LTC and DES/DDD are presented following.

Outstanding CAPs From Plans With ORs in CYE 2016

Mercy Care Plan-Long Term Care (MCP-LTC)

Corrective Action Plans

On September 8, 2018, AHCCCS closed the two CAPs in the CC and CIS standards that remained open. To close the CAPs, MCP-LTC was required to submit a CAP update with supporting documentation demonstrating completion of the CAPs. MCP-LTC provided a revised policy detailing the process for reporting fraud, waste, and abuse using the online form on the AHCCCS website and the revised language in the dental subcontractor's remittance that directs providers to send claims disputes to the Contractor's physical/local address.

Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD)

Corrective Action Plans

On June 8, 2018, AHCCCS closed the five CAPs that remained open in the CIS and DS standards. To close the CAPs, DES/DDD was required to submit a CAP update with supporting documentation demonstrating completion of the CAPs. DES/DDD provided the following: sufficient documentation showing interest paid on a hospital claim, non-hospital claim, and ALTCS claim; examples of new claims received and processed with a quick-pay discount for DES/DDD's fee-for-service population; an updated sampling methodology for auditing its contracted providers and draft process for auditing of contract loading; documentation demonstrating that DES/DDD staff training addressed member claim

disputes and member appeals procedures; and the revised sections of the policy manual and provider manual that addressed the requirements listed in the AHCCCS Contractor's Operation Manual (ACOM) 416.

AHCCCS' closure of the CAPs was contingent on the staff training addressing member claim disputes and member appeal procedures, including that a dispute should be paid with the applicable interest when rendered and that additional clarifications be made in the provider manual regarding the requirements in ACOM 416.

Strengths

CAPs that remained open were closed for MCP-LTC and DES/DDD in CYE 2018. No CAPs remain open for the ALTCS Contractors for the CYE 2016 review cycle.

Overall Opportunities for Improvement and Recommendations

Only CAP updates for these Contractors were included in Section 6. Please see the Executive Summary for the overall recommendations for all Contractors over the 2016 three-year review cycle.

Methodology

The following section presents the results for the mandatory performance measure activity conducted during the CYE 2017 reporting period. To evaluate performance levels and to provide an objective, comparative review of the Contractors' performance, AHCCCS required its Contractors to report CYE 2017 data (i.e., October 1, 2016–September 30, 2017). HSAG calculated results on AHCCCS' behalf for a variety of performance measures to address different quality initiatives using the following technical specifications: NCQA's HEDIS, CMS Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), and CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set). AHCCCS approved the CYE 2017 rates for inclusion in this report.

For a detailed explanation of the methodology, please see Appendix B, "Conducting the Review," of this report.

Required Performance Measures

The performance measures selected by AHCCCS for CYE 2017 were grouped into the following domains of care: Access to Care, Behavioral Health, Pediatric Health, Preventive Screening, and Utilization. While performance is reported primarily at the measure indicator level, grouping these measures into domains encourages the Contractors and AHCCCS to consider the measures as a whole rather than in isolation and to develop strategic changes required to improve overall performance.

Table 7-1 and Table 7-2 display the CYE 2017 performance measures presented within this report; the associated measure specifications used to calculate each measure rate; and the established MPS, if applicable, for the ALTCS Contractors and DES/DDD. Of note, an MPS had not yet been established for all reported performance measure rates.

Table 7-1—CYE 2017 Performance Measures for ALTCS Contractors

Performance Measure	Measure Specification	MPS
Behavioral Health		
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	HEDIS	85.0%
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up	HEDIS	95.0%
Utilization		
Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*	HEDIS	80.0

Performance Measure	Measure Specification	MPS
Inpatient Utilization—General Hospital/Acute Care—Total— Days per 1,000 Member Months (Total Inpatient)—Total	HEDIS	—
*Plan All-Cause Readmissions—Total**	Adult Core Set	17.0%

* A lower rate indicates better performance for this measure; therefore, rates must fall at or below the established MPS in order to exceed the CYE 2017 MPS.
— Indicates that an MPS had not yet been established by AHCCCS.

Table 7-2—CYE 2017 Performance Measures for DES/DDD

Performance Measure	Measure Specification	MPS
Access to Care		
Adults' Access to Preventive/Ambulatory Health Services—Total	HEDIS	75.0%
Annual Dental Visits—2–20 Years	HEDIS	60.0%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	Child Core Set	93.0%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	Child Core Set	84.0%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	Child Core Set	83.0%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	Child Core Set	82.0%
Pediatric Health		
Adolescent Well-Care Visits	Child Core Set	41.0%
Dental Sealants for Children Ages 6 to 9 at Elevated Caries Risk	Child Core Set	—
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Child Core Set	66.0%
Preventive Screening		
Breast Cancer Screening	Adult Core Set	50.0%
Cervical Cancer Screening	Adult Core Set	64.0%
Chlamydia Screening in Women—Total	Adult Core Set and Child Core Set	63.0%
Utilization		
*Ambulatory Care (per 1,000 Member Months)—ED Visits— Total**	HEDIS	43.0
Inpatient Utilization—General Hospital/Acute Care—Days per 1,000 Member Months (Total Inpatient)—Total	HEDIS	—
*Plan All-Cause Readmissions—Total**	Adult Core Set	11.0%

— Indicates that an MPS had not yet been established by AHCCCS.
* A lower rate indicates better performance for this measure; therefore, rates must fall at or below the established MPS in order to exceed the CYE 2017 MPS.

Performance Measure Results—ALTCS Contractors

Table 7-3 presents the CYE 2017 performance measure rates with an MPS for each ALTCS Contractor and the statewide aggregate. Performance measure rate cells shaded green indicate that the Contractor met or exceeded the CYE 2017 MPS established by AHCCCS. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the established MPS are shaded green.

Table 7-3—CYE 2017 Performance Measure Results—ALTCS Contractors

Performance Measure	BWY-LTC	MCP-LTC	UHCCP-LTC	Aggregate
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	NA	29.3%	31.2%	30.3%
30-Day Follow-Up	NA	50.0%	54.1%	51.0%
Utilization				
Ambulatory Care (per 1,000 Member Months)				
*ED Visits—Total**	71.1	72.9	58.2	66.7
Plan All-Cause Readmissions				
*Total**	16.1%	17.3%	12.2%	15.9%

* For this indicator, a lower rate indicates better performance.
NA indicates that the rate was withheld because the denominator was less than 30.

| | Cells shaded green indicate that the rate met or exceeded the CYE 2017 MPS established by AHCCCS.|

Table 7-4 presents a comparison of the ALTCS Contractors' CYE 2016 to CYE 2017 rates for the *Plan All-Cause Readmissions* performance measure. Performance measure rates were compared to determine if there was a significant difference between CYE 2016 and CYE 2017 using a Chi-square test of proportions. In cases where the cell size was less than five (i.e., fewer than five people were either numerator positive or numerator negative for either reporting year), a Fisher's exact test was used in place of a Chi-square test. The results of the statistical tests were considered significant when the *p* value was ≤0.05. A green upward arrow (↑) indicates a significant improvement in performance, a red downward arrow (↓) indicates a significant decline in performance, and a dash (—) indicates that the change in performance was not significant.

For some measures, significance testing was not performed, either because comparison to the prior year was not appropriate due to technical specification changes (i.e., *Follow-Up After Hospitalization for Mental Illness*), or the measure data were not appropriate for statistical testing (i.e., *Ambulatory Care* and *Inpatient Utilization*); therefore, Table 7-4 shows the results of the trend analysis for *Plan All-Cause Readmissions* only.

Table 7-4—Trend Analysis From CYE 2016 to CYE 2017—ALTCS Contractors

Performance Measure	BWY-LTC	MCP-LTC	UHCCP-LTC	Aggregate
Utilization				
Plan All-Cause Readmissions				
Total	↓	↓	↓	↓

↑   *Indicates a significant improvement in the Contractor's rate from CYE 2016 to CYE 2017.*
↓   *Indicates a significant decline in the Contractor's rate from CYE 2016 to CYE 2017.*
—   *Indicates no significant difference in the Contractor's rate from CYE 2016 to CYE 2017.*

Strengths and Opportunities for Improvement

For CYE 2017, the ALTCS Contractors were high performers for the measure rates within the Utilization domain as seven of eight (87.5 percent) rates exceeded the MPS. Of note, BWY-LTC and UHCCP-LTC exceeded the MPS for both performance measure rates within this domain. Although the *Plan All-Cause Readmissions* performance measure rates are considered an area of strength, the rates for all three Contractors and the ALTCS aggregate declined significantly from CYE 2016 to CYE 2017. Despite the high performance for this measure, the Contractors should assess the cause of this decline to ensure that performance stays above the MPS in future years.

Conversely, all three ALTCS Contractors and the ALTCS aggregate demonstrated opportunities for improvement related to *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*, with the reportable performance measure rates falling below the MPS by at least 53.8 and 40.9 percentage points, respectively. Ineffective transitions of care following an inpatient hospital admission have shown to increase the likelihood of readmission and exacerbation of symptoms for individuals with mental illness.[7-1] The Reducing Avoidable Readmissions Effectively (RARE) Campaign—a collaboration of the Institute for Clinical Systems Improvement, Minnesota Hospital Association, and Stratis Health—recommends improving care transitions following an inpatient hospital admission by focusing on patient and family engagement, medication management, comprehensive transition planning, care transition support, and transition communications. Patients should have follow-up appointments scheduled prior to discharge, and mental health practitioners should ensure availability to review each patient's progress and care plan within the first seven days post discharge.[7-2]

[7-1] Viggiano T, Pincus HA, and Crystal S. Care Transition Interventions in Mental Health. *Current Opinion in Psychiatry*. Vol. 25. No. 6. Nov. 2012.

[7-2] Reducing Avoidable Readmissions Effectively. *Recommended Actions for Improved Care Transitions: Mental Illness and/or Substance Use Disorders*. Available at: http://www.rarereadmissions.org/documents/Recommended_Actions_Mental_Health.pdf. Accessed on: Apr. 16, 2019.

Following a member's discharge from an inpatient admission, Contractors should perform a follow-up call with that member within three days to address any questions or concerns and to discuss progress of the care plan.[7-3,7-4] AHCCCS and the ALTCS Contractors should ensure that these follow-up calls are being conducted and confirm during each call that the member has a follow-up visit scheduled with a mental health practitioner and access to necessary community resources.

Performance Measure Results—DES/DDD

Table 7-5 presents the CYE 2016 and CYE 2017 performance measure results for DES/DDD. The table displays the following information: CYE 2016 performance, where available; CYE 2017 performance; the relative percentage change between CYE 2016 and CYE 2017 rates, where available; and the significance of the relative percentage change, where available. Performance measure rate cells shaded green indicate that DES/DDD met or exceeded the CYE 2017 MPS established by AHCCCS. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the established MPS are shaded green.

Table 7-5—CYE 2016 and CYE 2017 Performance Measure Results—DES/DDD

Performance Measure	CYE 2016 Performance	CYE 2017 Performance	Relative Percentage Change	Significance Level (*p* value)[1]
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	86.0%	85.8%	-0.2%	P=0.679
Annual Dental Visits				
2–20 Years	51.9%	56.5%	8.9%	**P<0.001**
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	100.0%	96.2%	-3.8%	P=0.234
25 Months–6 Years	89.6%	89.2%	-0.4%	P=0.645
7–11 Years	92.0%	92.1%	0.1%	P=0.854
12–19 Years	88.5%	89.6%	1.2%	**P=0.048**
Pediatric Health				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	43.5%	43.4%	-0.2%	P=0.923
Dental Sealants for Children Ages 6 to 9 at Elevated Caries Risk[2]				
Dental Sealants for Children Ages 6 to 9 at Elevated Caries Risk	—	18.0%	—	—

[7-3] Arizona Health Care Cost Containment System. *How A Hospital Discharge Plan Helps AHCCCS Members Return to Good Health*. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/HospitalDischarge.pdf. Accessed on: Apr. 23, 2019.

[7-4] Arizona Health Care Cost Containment System. *AHCCCS Presentation Care Coordination Discharge Planning*. Available at: http://files.constantcontact.com/b108b018001/a0e54380-8b8a-4cda-abfa-464c2a417bbf.pdf. Accessed on: Apr. 23, 2019.

Performance Measure	CYE 2016 Performance	CYE 2017 Performance	Relative Percentage Change	Significance Level (*p* value)[1]
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	51.2%	53.4%	4.3%	P=0.102
Preventive Screening				
Breast Cancer Screening[3]				
Breast Cancer Screening	—	45.9%	—	—
Cervical Cancer Screening				
Cervical Cancer Screening	17.4%	16.6%	-4.6%	P=0.296
Chlamydia Screening in Women				
Total	9.7%	10.5%	8.2%	P=0.651
Utilization				
Ambulatory Care (per 1,000 Member Months)				
ED Visits—Total*	43.0	39.1	-9.1%	—
Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total[2]				
Days per 1,000 Member Months (Total Inpatient)—Total	48.2	43.4	-10.0%	—
Plan All-Cause Readmissions				
Total*	7.3%	11.3%	54.8%	**P=0.004**

* A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2016 and CYE 2017 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
[2] An MPS had not yet been established for this measure.
[3] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between CYE 2017 and prior years; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
— Indicates that the Contractor was not required to report the measure for the CYE 2016 reporting period, or that a comparison of performance between CYE 2016 and CYE 2017 was not possible or appropriate.

Cells shaded green indicate that the rate met or exceeded the CYE 2017 MPS established by AHCCCS.

Strengths and Opportunities for Improvement

For CYE 2017, DES/DDD exceeded the MPS for seven of 13 (53.8 percent) performance measure rates, including six of eight (75.0 percent) rates within the Access to Care and Pediatric Health domains, demonstrating strength. Despite improvement in rates from CYE 2016 to CYE 2017, the performance measure rates for *Annual Dental Visits* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* fell below the MPS by 3.5 and 12.6 percentage points, respectively. AHCCCS and DES/DDD should focus efforts on identifying the factors contributing to low rates for these measures and implementing improvement strategies to increase well-child visits for members 3 to 6 years of age and dental screenings.

Conversely, DES/DDD fell below the MPS for all performance measures within the Preventive Screening domain (*Breast Cancer Screening*, *Cervical Cancer Screening*, and *Chlamydia Screening in Women*), demonstrating opportunity to ensure that women receive appropriate screenings. Research shows that women with intellectual and developmental disabilities (IDDs) experience disparities in timely screening for preventive diseases and care; yet, women with IDDs develop cancer at the same rate as the general population.[7-5] Women with IDDs have indicated aversion to mammography and Pap tests due to a general lack of understanding of the procedures, inadequate preparation, and increased anxiety.[7-5,7-6] Women with IDDs have also noted that provider misconceptions (e.g., lack of provider training and understanding of patient knowledge deficit) have resulted in the avoidance of preventive screenings and increased anxiety during screenings (e.g., patient feeling singled out by provider, inability to communicate effectively with provider).[7-5,7-6] Additionally, women with IDDs disclose sexual activity less frequently than those without and exhibit higher incidence of sexual abuse, both actions of which lead to potential increased risk of sexually transmitted diseases (STDs) like chlamydia.[7-7] AHCCCS and DES/DDD should focus efforts on identifying the factors contributing to low rates for these measures and implement improvement strategies to increase screenings for breast cancer, cervical cancer, and chlamydia in women.

[7-5] Wilkinson JE, Deis CE, Bowen DJ, et al. 'It's Easier Said Than Done': Perspectives on Mammography From Women With Intellectual Disabilities. *Ann Fam Med*. 2011 Mar; 9(2): 142–147.

[7-6] Parish SL, Swaine JG, Son E, et al. (2013). Determinants of cervical cancer screening among women with intellectual disabilities: Longitudinal evidence from medical record data. *Public Health Reports*. 128, 519-526.

[7-7] Greenwood NW, and Wilkinson J. Sexual and Reproductive Health Care for Women with Intellectual Disabilities: A Primary Care Perspective. *Int J Family Med*. 2013; 2013: 642472.

One of the three EQR-related activities mandated by the federal Medicaid managed care requirements and described at 42 CFR §438.358(b)(1)(i) is the annual validation, performed by AHCCCS, of Contractors' PIPs underway during the preceding 12 months. In accordance with 42 CFR §438.330, and as required by AHCCCS, Contractors must establish and implement an ongoing comprehensive quality assessment and performance improvement (QAPI) program for the services furnished to members. The QAPI program must focus on clinical and nonclinical areas and include PIPs designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. These PIPs must include the following:

- Measurement of performance using objective quality indicators
- Implementation of interventions to achieve improvement in the access to and quality of care
- Evaluation of the effectiveness of interventions based on performance measures
- Planning and initiation of activities to increase and sustain improvement

42 CFR §438.330(d)(3) also requires each Contractor to report the status and results of each PIP no less than once per year.

Conducting the Review

In the AHCCCS Medical Policy Manual, 980—Performance Improvement Projects, AHCCCS mandates that Contractors participate in PIPs selected by AHCCCS. In addition, with AHCCCS approval, Contractors may select and design additional PIPs specific to needs and data identified through internal surveillance of trends. Mandated PIP topics are selected through AHCCCS' analysis of internal and external data and trends that may include Contractor input. AHCCCS considers topics such as comprehensive aspects of enrollee needs, care, and services for a broad spectrum of members or for a focused subset of the population, including those members with special healthcare needs or receiving Long Term Services and Supports (LTSS).

AHCCCS may mandate that a PIP be conducted by a Contractor or group of Contractors, according to standardized methodology developed by AHCCCS.

In CYE 2015 (October 1, 2014, through September 30, 2015), AHCCCS implemented a new PIP, *E-Prescribing*, for all lines of business. The baseline measurement period covered CYE 2014 (data from October 1, 2013, through September 30, 2014), to be followed by two remeasurement periods: Remeasurement 1 (October 1, 2015, through September 30, 2016) and Remeasurement 2 (October 1, 2016, through September 30, 2017). AHCCCS implemented the *E-Prescribing* PIP because research suggested that an opportunity existed to improve preventable errors in using the standard, handwritten paper method to communicate a medication between prescriber and pharmacy. Research indicated that

clinicians make seven times fewer errors (decreasing from 42.5 per 100 prescriptions to 6.6 per 100 prescriptions after one year) when using an electronic system rather than writing prescriptions by hand.[8-1] AHCCCS found that sending a clear and legible prescription electronically can reduce mistakes related to medication types, dosages, and member information. In addition, AHCCCS noted that electronic prescribing can assist pharmacies in identifying potential problems related to medication management and potential reactions that members may encounter, especially for those taking multiple medications.

The purpose of the *E-Prescribing* PIP is to increase the number of providers ordering prescriptions electronically and the percentage of prescriptions submitted electronically in order to improve patient safety. AHCCCS' goal is to demonstrate a statistically significant increase in the number of providers submitting prescriptions electronically and the number of prescriptions submitted electronically, followed by sustained improvement for one year.

This annual report includes CYE 2014 recalculated baseline measurement data; CYE 2016 Remeasurement 1 data; CYE 2017 Remeasurement 2 data; relative percentage change from Remeasurement 1 to Remeasurement 2; overall relative percentage changes from baseline data; statistical significance data; qualitative analyses, including limitations and lessons learned identified by the Contractors; and interventions.

Contractor-Specific Results

AHCCCS provided HSAG with its Contractors' CYE 2017 *E-Prescribing* PIP information; including qualitative analysis, with limitations and lessons learned, and interventions for the ALTCS Contractors, including BWY, MCP-LTC, UHCCP-LTC, and DES/DDD.

This section includes Contractors' PIP Remeasurement 2 results as calculated by AHCCCS, along with specific activities conducted during Remeasurement 2, from October 1, 2016, through September 30, 2017.

Bridgeway Health Solutions (BWY)

Findings

Table 8-1 presents the baseline, Remeasurement 1, and Remeasurement 2 results for the *E-Prescribing* PIP for BWY members, including those members from 0 through 64 years of age and those members 65 years of age and over. The table also presents the relative percentage changes from Remeasurement 1 to Remeasurement 2 and the statistical significance of changes in rates.

[8-1] Kaushal R, Kern LM, Barrón Y, et al. Electronic prescribing improves medication safety in community-based office practices. *Journal of General Internal Medicine*, 2010 Jun;25(6):530-6.

Table 8-1—BWY *E-Prescribing* PIP*

PIP Measure	Baseline Period Oct. 1, 2013, Through Sept. 30, 2014	Remeasurement 1 Oct. 1, 2015, Through Sept. 30, 2016	Remeasurement 2 Oct. 1, 2016, Through Sept. 30, 2017	Relative Percentage Change From Remeasurement 1 to Remeasurement 2	Statistical Significance
Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically	37.70%	45.42%	49.96%	10.00%	**P=.001**
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	21.29%	23.39%	27.17%	16.14%	**P<.001**

*Percentages represent a combination of members 0 through 64 years of age and 65 years of age and over.

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-1 shows that, during the baseline period, 37.70 percent of BWY's providers prescribed at least one prescription electronically and that 21.29 percent of prescriptions were sent by an AHCCCS-contracted provider electronically. For Remeasurement 2, 49.96 percent of BWY's providers prescribed at least one prescription electronically and 27.17 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. BWY's Remeasurement 2 rate for Indicator 1 demonstrated a relative percentage change from Remeasurement 1 of 10.00 percent, and Indicator 2 demonstrated a relative percentage change from Remeasurement 1 of 16.14 percent. BWY demonstrated statistically significant improvements for both quality indicators for this PIP but a substantively large improvement for Indicator 2.

Table 8-2 presents the baseline and overall relative percentage change and statistically significant results for Indicator 1 and for Indicator 2 for BWY members, including those members from 0 through 64 years of age and those members 65 years of age and over.

Table 8-2—BWY *E-Prescribing* PIP

PIP Measure	Baseline Period Oct. 1, 2013, Through Sept. 30, 2014	Overall Relative Percentage Change From Baseline	Overall Statistical Significance
Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically	37.70%	32.52%	**P<.001**
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	21.29%	27.61%	**P<.001**

*Percentages represent a combination of members 0 through 64 years of age and 65 years of age and over.

BWY demonstrated a significant improvement in the overall relative percentage change in both indicators: the change for Indicator 1 at 32.52 percent was above the change for Indicator 2 of 27.61 percent.

BWY submitted the following qualitative analysis:

- BWY reported that since electronic prescribing began the long-term care sector has lagged in terms of adoption and use of this technology. When electronic prescribing was added to the meaningful-use incentive created by CMS, the long-term care sector was excluded from this mandate as well as from any subsequent grants to adopt the new technology. Additionally, members requiring long-term care who live outside of skilled nursing facilities contributed to the fragmentation that already existed related to services in the sector.

- BWY reported that the largest barrier that providers face in the adoption of electronic prescribing technology in the long-term care sector is being mobile and relying on the facility or parent company to provide them with electronic prescribing tools. Although some facilities are large national providers, most are independently owned by small business providers that cannot afford the upgrade in medical record systems that would allow electronic prescribing. Only in the last year has Point Click Care, the largest provider of electronic medical records for long-term care facilities in Arizona, added the functionality of electronic prescribing to their system. At this time the cost for installation of the system is approximately $50,000, cost prohibitive for most facility owners. An option of obtaining a stand-alone electronic prescribing system does exist. While this reduces the costs associated with e-prescribing, the system would not be integrated into the medical record; therefore, the provider would necessarily record two sets of data entry. This option doubles the work for the provider and adds the burden of checking another system every time a refill or new prescription is needed.

- As part of BWY's efforts to understand and overcome barriers to electronic prescribing in long-term care, BWY held multiple education events with its largest providers and with the Arizona Health Care Association. BWY has discussed the current workflow process for physicians with Independent

Pharmacy Cooperative (IPC) and with nurse practitioners through Optum and Pop Health to see if using an electronic prescribing system would be feasible. Finally, BWY purchased its own stand-alone electronic prescribing system through MD Toolbox and gave access to 15 nurse practitioners who see BWY members in the community. This initiative has resulted in a 5 percent increase in electronic prescribing for BWY members within three months of initiation.

- BWY stated that many challenges in the adoption of electronic prescribing in long-term care remain. Each facility type, from assisted living to skilled nursing facility, has different rules for the prescribing and medical recordkeeping of prescriptions. This use of multiple systems makes it difficult for a provider who operates in multiple venues to use electronic prescribing. Some slow gains are being made nationally, which will ultimately improve electronic prescribing in this sector. In 2016 several providers of long-term care medical record systems added electronic prescribing to their systems. As this market grows, the price should decrease, making the adoption of e-prescribing more likely for all facilities and providers. In talks with national provider groups such as Independent Pharmacy Cooperative (IPC), Optum, Ensign, and Lifecare, BWY learned that all are in process of creating individual electronic prescribing systems to integrate with their internal medical records. BWY will continue to look for short-term solutions and to educate providers until more cost-effective options are available.

BWY summarized the following information:

- Providers working in long-term care facilities relied on the facilities' medical records to allow them to e-prescribe.
- Providers were resistant to purchase a stand-alone e-prescribing program due to the necessity of double entry into the medical record and e-prescribing system.
- Long-term care facilities and providers were exempt from the meaningful use mandate and had no financial incentive to add e-prescribing to their medical record.
- Long-term care facilities that did want to add e-prescribing through their electronic health record (EHR) found it cost prohibitive. Initial cost estimates for facilities exceed $50,000 to add e-prescribing to their EHR.

BWY reported the following interventions in CYE 2017 to improve both the rate of providers ordering prescriptions electronically and the rate of prescriptions sent electronically:

- Reviewed 2015 survey results as part of the Arizona Alliance of Health Plans E-Prescribing Workgroup (workgroup) formed with other AHCCCS Contractors and developed goals for 2016. One survey asked providers to identify contributing factors to e-prescribing rates to identify best practices or barriers, while another asked Arizona EHR vendors to determine system capabilities for e-prescribing controlled substances.
- Began coordinating with Health Net Quality department to integrate education materials and initiatives for the e-prescribing PIP and co-branded current education flyers with both Contractor logos and information.
- Purchased a stand-alone electronic prescribing module that can be given to contracted prescribers to use when writing new prescriptions for BWY members.

- Performed analysis to identify the top 20 prescribers who fax prescriptions to pharmacies that do not use electronic prescribing, with the goal of enrolling all 20 prescribers to use the stand-alone system to send new prescriptions electronically.
- BWY submitted no new PIP-related interventions for CYE 2018.

Strengths

BWY increased its percentage rate for Indicator 1, the percentage of AHCCCS-contracted providers who prescribed at least one prescription electronically, to 49.96 percent, an increase of 10 percent. BWY increased its percentage rate for Indicator 2: the percentage of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically, to 27.17 percent, an increase of 16.14 percent. BWY's overall relative percentage change was 32.52 percent for Indicator 1 and 27.61 percent for Indicator 2. All increased rates were statistically significant.

Opportunities for Improvement and Recommendations

BWY's percentage rate increases were significant, especially for Indicator 2, the percentage of prescriptions prescribed by an ACCCS-contracted provider and sent electronically. However, BWY remains significantly below the AHCCCS aggregate rates for both Indicator 1 and Indicator 2. BWY reported no new qualitative analysis or interventions for Remeasurement 2. Although this is the last measurement year, HSAG recommends that BWY conduct a barrier analysis, prioritize the barriers, and formulate new interventions to consolidate the gains made. In addition, HSAG recommends that BWY continue to monitor outcomes associated with the interventions that have been implemented.

Mercy Care Plan-Long Term Care (MCP-LTC)

Findings

Table 8-3 presents the baseline, Remeasurement 1, and Remeasurement 2 results for the *E-Prescribing* PIP for MCP-LTC's members, including those members from 0 through 64 years of age and those members 65 years of age and over. The table also presents the relative percentage change from Remeasurement 1 to Remeasurement 2 and the statistical significance of the change in rates.

Table 8-3—MCP-LTC *E-Prescribing* PIP*

PIP Measure	Baseline Period Oct. 1, 2013, Through Sept. 30, 2014	Remeasurement 1 Oct. 1, 2015,Through Sept. 30, 2016	Remeasurement 2 Oct. 1, 2016, Through Sept. 30, 2017	Relative Percentage Change From Remeasurement 1 to Remeasurement 2	Statistical Significance
Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically	47.62%	55.11%	60.54%	9.86%	**P<.001**
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	23.99%	27.98%	33.49%	19.68%	**P<.001**

*Percentages represent a combination of members 0 through 64 years of age and 65 years of age and over.

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-3 shows that, during the baseline period, 47.62 percent of MCP-LTC's providers prescribed at least one prescription electronically and 23.99 percent of prescriptions were sent by an AHCCCS-contracted provider electronically. For Remeasurement 2, 55.11 percent of MCP-LTC's providers prescribed at least one prescription electronically and 27.98 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. MCP-LTC's Remeasurement 2 rate for Indicator 1 had a relative percentage change from Remeasurement 1 of 9.86 percent and for Indicator 2 had a relative percentage change from Remeasurement 1 of 19.68 percent. MCP-LTC demonstrated a statistically significant improvement in performance for this PIP.

Table 8-4 presents the baseline and overall relative percentage change and statistical significance results for Indicator 1 and Indicator 2 for MCP-LTC members, including those members from 0 through 64 years of age and those members 65 years of age and over.

Table 8-4—MCP-LTC *E-Prescribing* PIP*

PIP Measure	Baseline Period Oct. 1, 2013, Through Sept. 30, 2014	Overall Relative Percentage Change	Overall Statistical Significance
Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically	47.62%	27.13%	**P<.001**
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	23.99%	39.58%	**P<.001**

*Percentages represent a combination of members 0 through 64 years of age and 65 years of age and over.

MCP-LTC demonstrated significant improvement in both indicators, with the overall relative percentage change in Indicator 1 at 27.13 percent and the change for Indicator 2 at 39.58 percent.

MCP-LTC submitted the following qualitative analysis:

Limitations:

MCP-LTC used a survey of providers conducted by all Contractors in the workgroup to identify the following barriers:

- Prescriptions written in a hospital setting rather than in a clinic did not allow for providers to use e-prescribing software.
- Lack of understanding exists about the ability to use e-prescribing for all prescriptions, including controlled substances.
- Belief exists that prescriptions are submitted electronically when, in reality, the prescription is submitted into an EHR, then converted to a fax or paper script.
- Additional cost is assessed to the practice to add to the practice's EHR system the ability to e-prescribe.
- EHR system limitations exist—multiple providers reported that their EHR systems did not allow e-prescribing of narcotics.
- Providers reported that pharmacies rejected any controlled substances e-prescribed, indicating that it was "illegal" to e-prescribe as an original signature is required on the script.

- One practice was told that to be able to e-prescribe they would need to add a fingerprinting security system to their current EHR, which could be costly and time-consuming for the practice.
- Usually, a two-day delay exists for pharmacies to process and dispense prescriptions for members if those prescriptions are submitted electronically, which may cause an issue if the medication is needed urgently or emergently.
- Providers that have e-prescribed controlled medications reported the process to be difficult, including the requirement of having a different password and a key tag to facilitate revolving identification.
- Additional costs exist to add MCP-LTC's EHR the ability to e-prescribe controlled substances.

MCP-LTC reported the following barriers:

- EHR system glitches sometimes caused electronic prescription transmission errors.
- Provider preference for writing prescriptions and physicians' preference to hand prescriptions to members exist.
- System limitations exist related to e-prescribing.
- Difficulty was expressed related to pharmacies accepting prescriptions electronically, specifically in rural areas.

MCP-LTC noted in The National Center for Biotechnology Information article "Electronic Prescribing: Improving the Efficiency and Accuracy of Prescribing in the Ambulatory Care Setting" published April 1, 2014,[8-2] "Results of this research study suggest that e-prescribing reduces prescribing errors, increases efficiency, and helps to save on healthcare costs. Medication errors have been reduced to as little as a seventh of their previous level, and cost savings due to improved patient outcomes and decreased patient visits are estimated to be between $140 billion and $240 billion over 10 years for practices that implement e-prescribing. However, significant barriers to implementation have existed, including cost, lack of provider support, lack of patient privacy, system errors, and legal issues." This research also identified the following barriers to implementation of e-prescribing:

- Cost of implementing an e-prescribing system—per the research, more than 80 percent of primary care providers report a lack of financial support necessary for implementation, training, and information technology (IT) support for installation and maintenance of an e-prescribing system.
- E-prescribing system errors—system errors include:
  - System alerts which lack specificity and/or are produced excessively. This may lead to "alert fatigue," in which prescribers tend to stop reading the alerts and just quickly scroll through them, causing significant system alerts to be ignored.
- Hardware problems.
- Workflow issues.

[8-2] Porterfield A, Engelbert K, Coustasse A. Electronic prescribing: improving the efficiency and accuracy of prescribing in the ambulatory care setting. *Perspectives in Health Information Management*. 2014 Apr 1;11:1g.

- Software problems.
- Other problems such as cost, time consumption, and connection issues.
- Privacy and legal issues:
  - Potential exists for patient information to be leaked from a web-based EHR system as proper firewalls and intrusion prevention systems are not in place.
  - EPCS has the potential to cause legal issues. Although the Drug Enforcement Agency (DEA) made a final ruling on e-prescribing of controlled substances in 2010, many standards are contained in the ruling, including the following:
    - o Identity proofing
    - o Two-factor authentication
    - o Digital certificates
    - o Monthly logs
    - o Third-party software audits
    - o Requirement to keep two years of records

In the final PIP report, MCP-LTC reported that although the PIP met goals the following barriers and limitations existed:

- A data issue prevented MCP-LTC from reporting reliable baseline data.
- The AHCCCS reported CYE 2014 time period for reporting did not include a full contract year.

Lessons learned:

- Implementation of data-driven, provider-specific interventions, such as providing prescribers with "report cards" that include their rates for providing electronic prescriptions, has proven to be a difficult task.
- An inability to determine the root cause for providers who report that they provide electronic prescriptions at a higher rate than what the data indicate was noted.
- Recognition was made of a need for identification of the cause for data discrepancies between AHCCCS-calculated data and MCP-LTC internal data.

MCP-LTC reported no new interventions to improve either the rate of providers prescribing prescriptions electronically or the rate of prescriptions sent electronically; however, MCP-LTC concluded that since the number of prescribers electronically prescribing prescriptions and the percentage of prescriptions are increasing, thus the interventions are working. MCP-LTC continued to track e-prescribing data through the QI Committee, Quality Management/Utilization Management Committee and the Quality Committee of the Board of Directors. MCP-LTC reported that the current interventions will be continued and that new interventions may be developed if a new opportunity for improvement is identified or if MCP-LTC begins to identify a decline in performance. The current interventions that MCP-LTC has had in place are as follows:

- Continue MCP-LTC medical director and provider relations staff on-site visits and distribution of EPCS fact sheets.
- Conduct targeted review and outreach to larger practices to show variances across providers.
- Continue to develop member educational materials to communicate the benefits of e-prescribing on the MCP website and/or Facebook posts.
- Provide updated information about each provider's e- prescribing rate to practice representatives, and discuss the results with each practice periodically. MCP-LTC made the information specific to individual doctors and concentrated on outlier low users.
- Continue to post a provider toolkit to educate providers on the benefits and value of e-prescribing.

Strengths

MCP-LTC was successful in increasing performance rates for Indicator 1, with a rate increase of 9.86; and especially for Indicator 2, with a rate increase of 19.68 percent. In addition, MCP-LTC made significant gains since the baseline period, with an overall relative percentage change of 27.13 percent for Indicator 1 and 39.58 percent for Indicator 2. MCP-LTC reported that it used the Plan-Do-Study-Act (PDSA) problem-solving cycle as a tool to increase performance of the indicators. Using this approach, MCP-LTC developed a plan to implement an intervention, tested the effectiveness of the intervention, evaluated the results of the intervention, and determined what changes may be needed before implementation. Before the PDSA cycle is initiated, MCP-LTC used the FOCUS approach (**F**ind the problem, **O**rganize the team, **C**larify the problem, **U**nderstand the problem, and **S**elect interventions to address the barriers) as well as the "5 Whys" and a fishbone diagram.

Opportunities for Improvement and Recommendations

MCP-LTC remains below the AHCCCS aggregate rate for the percentage of providers using e-prescribing (AHCCCS aggregate rate: 73.42 percent) and for the percentage of e-prescriptions (AHCCCS aggregate rate: 55.76 percent). For Remeasurement 2, MCP-LTC again reported a barrier analysis that was reported in the Remeasurement 1 reporting period. In addition, the interventions that MCP-LTC reported were the same interventions as in Remeasurement 1. Although this is the last measurement period, HSAG recommends that MCP-LTC conduct a current barrier analysis to determine what interventions might be prioritized to increase performance in both indicators. MCP-LTC identified a data error that prevented accurate and reliable baseline data. Consequently, MCP-LTC reported that the internal baseline rates to Remeasurement 1 and Remeasurement 2 outcomes were not comparable. However, MCP-LTC used the two-proportion Z-test for statistical analysis and compared internal Remeasurement 1 and Remeasurement 2 indicator rates. HSAG recommends that MCP-LTC request a meeting with AHCCCS to reconcile the PIP indicator data.

UnitedHealthcare Community Plan-Long Term Care (UHCCP-LTC)

Table 8-5 presents the baseline, Remeasurement 1, and Remeasurement 2 results for the *E-Prescribing* PIP for UHCCP-LTC's members, including those members from 0 through 64 years of age and those members 65 years of age and over. The table also presents the relative percentage changes from Remeasurement 1 to Remeasurement 2 and the statistical significance of changes in rates.

Table 8-5—UHCCP-LTC *E-Prescribing* PIP*

PIP Measure	Baseline Period Oct. 1, 2013, Through Sept. 30, 2014	Remeasurement 1 Oct. 1, 2015, Through Sept. 30, 2016	Remeasurement 2 Oct. 1, 2016, Through Sept. 30, 2017	Relative Percentage Change From Remeasurement 1 to Remeasurement 2	Statistical Significance
Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically	48.19%	55.08%	61.07%	10.88%	**P<.001**
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	27.42%	31.91%	36.39%	14.05%	**P<.001**

*Percentages represent a combination of members 0 through 64 years of age and 65 years of age and over.

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-5 shows that, during the baseline period, 48.19 percent of UHCCP-LTC's providers prescribed at least one prescription electronically and 27.42 percent of prescriptions were sent by an AHCCCS-contracted provider electronically. For the Remeasurement 2 period, 61.07 percent of UHCCP-LTC's providers prescribed at least one prescription electronically and 36.39 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For the Remeasurement 2 period, UHCCP-LTC demonstrated for Indicator 1 a relative percentage change from Remeasurement 1 of 10.88 percent and demonstrated for Indicator 2 a relative percentage change from Remeasurement 1 of 14.05 percent. UHCCP- LTC demonstrated statistically significant and substantively large improvements in performance for this PIP.

Table 8-6 presents the baseline and overall relative percentage change and statistical significance results for Indicator 1 and for Indicator 2 for UHCCP-LTC members, including those members from 0 through 64 years of age and those members 65 years of age and over.

Table 8-6—UHCCP-LTC *E-Prescribing* PIP

PIP Measure	Baseline Period Oct. 1, 2013, Through Sept. 30, 2014	Overall Relative Percentage Change From Baseline	Overall Statistical Significance
Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically	48.19%	26.74%	**P<.001**
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	27.42%	32.71%	**P<.001**

*Percentages represent a combination of members 0 through 64 years of age and 65 years of age and over.

UHCCP-LTC demonstrated a significant improvement in both indicators, with the overall relative percentage change in Indicator 1 at 26.74 percent and the change for Indicator 2 at 32.71 percent.

UHCCP-LTC submitted the following qualitative analysis:

Limitations:

UHCCP-LTC identified several limitations regarding the PIP. UHCCP-LTC used paid claims for members for internal monitoring; however, the pharmacy claims system was currently set to pay for all licensed prescribers and did not differentiate between UHCCP contracted and non-contracted prescribers. UHCCP-LTC reported that as some of these providers may not be contracted with AHCCCS, these claims may not have been included in the AHCCCS results. As a result of this issue, UHCCP-LTC concluded that the internal monitoring may have yielded a slightly higher rate of change than did the AHCCCS results.

UHCCP-LTC noted that the interventions implemented resulted in increased provider use of e-prescribing and the e-prescribing rate; however, the Contractor reported that other factors could be associated with the increases. UHCCP-LTC stated that all AHCCCS Contractors participated in this PIP; consequently, many prescribing providers contracted with multiple Contractors. UHCCP-LTC hypothesized that e-prescribing education, intervention, and messaging coming repeatedly from multiple Contractors could attribute to increased provider adoption. In addition, UHCCP-LTC noted that the increase in e-prescribing rates occurred during a time of wider adoption and use of EHRs, which frequently have e-prescribing capabilities. UHCCP-LTC speculated that the increase in e-prescribing rates could have been aided by the increased use of electronic records technology along with increased awareness of the benefits of e-prescribing.

Lessons learned:

UHCCP-LTC concluded that, given the issues presented in the "Limitations" section, the impact of multiple Contractor interventions and technology adoption cannot be easily ascertained.

UHCCP-LTC developed the following interventions to improve both the rate of providers prescribing prescriptions electronically and the rate of prescriptions sent electronically:

- Presentation of e-prescribing information at provider forums.
- PreCheck MyScript, a new program that encourages providers to generate prescriptions electronically while giving real-time information regarding medication formulary status, need for prior authorization, and point-of-sale drug utilization information.

Strengths

UHCCP-LTC achieved a rate increase of 61.07 percent that represented an increase from baseline of 10.88 percent for Indicator 1. UHCCP-LTC's rate of 36.39 percent represented a 14.05 percent increase for Indicator 2. Rates for both indicators demonstrated statistically significant increases. UHCCP-LTC's overall relative percentage change was 27.13 percent for Indicator 1 and 39.58 percent for Indicator 2 All increased rates were statistically significant. UHCCP-LTC conducted an analysis regarding the increases of the PIP indicators and concluded that, due to interventions from multiple Contractors, the increased rates could not be attributed directly to the interventions that the Contractor implemented. UHCCP-LTC has instituted a new technology via several EHR systems and the UHCCP provider portal, PreCheck MyScript. PreCheck MyScript provides real-time information regarding medication formulary status, need for prior authorization, and point-of-sale drug utilization information that may improve both indicator rates in the future.

Opportunities for Improvement and Recommendations

UHCCP-LTC identified that the internal monitoring was performed using all paid claims for ALTCS members; however, the pharmacy claims system was set to pay for all licensed prescribers and not to differentiate between UHCCP contracted and non-contracted prescribers. Therefore, some prescribers may not have been contracted with AHCCCS, resulting in questions as to whether the claims were included in the AHCCCS results. UHCCP-LTC reported that internal monitoring may have yielded slightly higher rates of change than did the AHCCCS results. This is an opportunity for improvement for UHCCP-LTC. Although this is the last measurement period, HSAG recommends that UHCCP-LTC analyze this situation and develop interventions that alleviate the potential discrepancies between UHCCP-LTC and AHCCCS data. HSAG also recommends that UHCCP-LTC monitor whether the PreCheck MyScript intervention makes a difference in the rates of improvement.

Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD)

Findings

Table 8-7 presents the baseline, Remeasurement 1, and Remeasurement 2 results for the *E-Prescribing* PIP for DES/DDD members, including those members from 0 through 64 years of age and those members 65 years of age and over. The table also presents the relative percentage changes from Remeasurement 1 to Remeasurement 2 and the statistical significance of changes in rates.

Table 8-7—DES/DDD *E-Prescribing* PIP*

PIP Measure	Baseline Period Oct. 1, 2013, Through Sept. 30, 2014	Remeasurement 1 Oct. 1, 2015, Through Sept. 30, 2016	Remeasurement 2 Oct. 1, 2016, Through Sept. 30, 2017	Relative Percentage Change From Remeasurement 1 to Remeasurement 2	Statistical Significance
Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically	56.97%	62.82%	67.40%	7.29%	**P<.001**
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	44.51%	57.89%	62.00%	7.09%	**P<.001**

*Percentages represent a combination of members 0 through 64 years of age and 65 years of age and over.

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-7 shows that, during the baseline period, 56.97 percent of DES/DDD providers prescribed at least one prescription electronically and 44.51 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For Remeasurement 2, 67.40 percent of DES/DDD providers prescribed at least one prescription electronically and 62.00 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For DES/DDD's Remeasurement 2 period, Indicator 1 demonstrated a relative percentage change from Remeasurement 1 of 7.29 percent and Indicator 2 demonstrated a relative percentage change from Remeasurement 1 of 7.09 percent. DES/DDD demonstrated statistically significant improvements in performance for this PIP.

Table 8-8 presents the baseline and overall relative percent change and statistical significance results for Indicator 1 and for Indicator 2 for DES/DDD members, including those members from 0 through 64 years of age and those members 65 years of age and over.

Table 8-8—DES/DDD *E-Prescribing* PIP

PIP Measure	Baseline Period Oct. 1, 2013, Through Sept. 30, 2014	Overall Relative Percentage Change From Baseline	Overall Statistical Significance
Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically	56.97%	18.30%	**P<.001**
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	44.51%	39.30%	**P<.001**

*Percentages represent a combination of members 0 through 64 years of age and 65 years of age and over.

DES/DDD demonstrated a significant improvement in both indicators, with the overall relative percentage change in Indicator 1 at 18.30 percent and the change for Indicator 2 at 39.30 percent. DES/DDD submitted the following qualitative analysis.

Limitations:

DES/DDD identified three limitations applicable to this PIP:

- The effect that the Medicare Improvements for Patients and Providers Act (MIPPA) and implementation of Meaningful Use (MU) measures have had on the number of e-prescribers and prescriptions generated electronically prior to implementation of the PIP is a limitation. DES/DDD concluded that the impact of these existing initiatives combined may affect the Contractor's ability to continue to achieve significant improvement for the PIP.
- The proposed intervention to explore funding sources to assist selected providers with technical upgrades and other fees in order to have e-prescribing functionality was not implemented. This intervention was discussed by the workgroup as a strategy as many prescribers need financial assistance in order to make the needed upgrades to implement e-prescribing.
- The internal monitoring performed using all paid claims for DES/DDD members by subcontracted health plans may not be able to differentiate between contracted and non-contracted providers. As some of these prescribers may not be AHCCCS Contractors, these claims may not have been included in the AHCCCS results. Consequently, the internal monitoring may yield a slightly higher rate of change than the AHCCCS results. This impact will continue to be considered for all future internal data monitoring.

In addition, DES/DDD conducted a systematic literature review and found that the primary "general categories" of barriers to greater use of e-prescribing are the following:

- Cost of implementing an e-prescribing system
- E-prescribing system errors
- Privacy and legal issues

DES/DDD's three subcontracted health plans participated in the e-prescribing workgroup to discuss barriers to adoption of e-prescribing. The workgroup surveyed providers to formally explore which perceived barriers were of concern to prescribers.

The following general perceived barriers were identified by the survey:

- Members and/or physicians prefer hard-copy prescriptions.
- Technical problems exist with the e-prescribing transmission.
- Belief that controlled substances cannot be electronically transmitted.
- EHR used by the provider did not support EPCS.
- EPCS is more time-consuming.
- Inconsistent messaging and provider information overload exist.
- The hospital setting did not allow for prescribers to use their e-prescribing software.
- The mistaken belief exists that prescriptions are being submitted electronically when, in fact, the prescription was submitted into an EHR but then converted to a fax or paper script.
- A two-day delay for pharmacies to process and dispense the prescription for the members occurs if submitted electronically.
- E-prescribed control meds may require a different password and use of a key tag to facilitate a revolving identification.
- Additional cost is incurred to add ability to EPCS to existing EHRs.

Barriers identified by other Contractors included:

- EHR system glitches sometimes caused e-prescription transmission errors.
- Prescriber and member preference is for hard-copy prescriptions.
- Pharmacies (specifically in rural areas) are unable to accept e-prescriptions.

The workgroup surveyed nine EHR vendors to see if their respective systems were capable of supporting EPCS. Four of the nine (44 percent of the respondents) did not support EPCS in Arizona. Two of the four stated that their EHR systems were targeted to support EPCS by the end of 2015. Prescribers using EHR systems that do not support EPCS would not be able to increase their EPCS rates. These results do support the EHR systems-related barriers listed preceding.

DES/DDD found that analysis of the literature, surveys, and EHR vendor input indicated that most barriers fell into one of the four categories of barriers; cost, EHR system limitations, privacy/legal issues, or prescriber and member preference.

Lessons learned:

DES/DDD learned that during the implementation of this PIP, the following issues require further discussion and planning:

- Provider reluctance to use e-prescribing for controlled substances continues.
- Provider- and prescriber-specific "reporting" is a difficult task because to be effective a mechanism to determine root cause for lower e-prescribing rates must be present.
- Discrepancies between internal and AHCCCS data require adjustments in the way internal data are used and analyzed as well as how data are addressed with the DES/DDD's subcontracted health plans.
- Implemented interventions cannot always or specifically be linked in a causal mode to actual results of the project.

DES/DDD has reported the following interventions to improve both the rate of providers prescribing prescriptions electronically and the rate of prescriptions sent electronically:

- Data mining, including data extracts by pharmacy and by prescriber, merged into a software tool that will allow for data analysis and target identification.
- Subcontracted health plans created reporting to rank prescribers and practices by their e- prescribing levels. This report was used to conduct targeted outreach to prescribers showing low rates.
- Internal periodic data analysis of prescribing rates as well as analysis of baseline and re-measurement data from AHCCCS—DES/DDD also analyzed national data such as that provided by Surescripts.
- Subcontracted health plan participated and collaborated with the workgroup to improve e-prescribing rates.
- Educated members about the benefits of e-prescriptions using repeated communications in member newsletter articles, and engaged providers to educate members.
- Subcontracted health plans posted member educational materials to communicate the benefits of e-prescribing using websites and/or Facebook.
- Educated providers about the benefits of e-prescribing, how to get started, and solutions to barriers—including clarifying that EPCS is legal in Arizona as well as presenting the specific requirements for EPCS.
- Participated in provider survey and results analysis conducted by the workgroup.
- Conducted on-site visits by the medical director and/or provider relations staff, including distribution of a fact sheet and discussion.
- Targeted outreach to larger practices to show variances across prescribers.

- Provided updated information on each practice's e-prescribing rate to practice representatives as a targeted intervention.
- Developed and posted a provider toolkit for providers on the benefits of e-prescribing.
- Presented e-prescribing and educational materials and resources at provider forums and engagement meetings conducted by subcontracted health plans.
- Built incentives into value-based purchasing (VBP) agreements to encourage providers to improve rates of e-prescribing.
- Participated with the workgroup (including DES/DDD subcontracted health plans).
- Developed a fact sheet for providers on the topic of EPCS.

DES/DDD reported the following system-level changes made or pending implementation:

- More judicious care about how internal periodic data are viewed and used to avoid overestimating progress.
- Additional discussion and reporting in quality committees and to key upper management using dashboards and comparison performance analysis.
- Increased focus on e-prescribing for controlled substances and associated interventions.
- Continued focus on provider and member education to support the system-level changes made.
- Increase of systems for monitoring controlled substance prescriptions in light of the opioid epidemic and incorporation of a goal to increase e-prescribing for controlled substances.
- Provision of resources and education to members and residential service providers which will enable and encourage greater member acceptance of e-prescribing.

Strengths

DES/DDD achieved a rate increase of 67.40 percent, which represented an increase from baseline of 7.29 percent for Indicator 1. DES/DDD's rate of 62.00 percent represented a 7.09 percent increase for Indicator 2. Rates for both indicators demonstrated statistically significant increases. DES/DDD's overall relative percentage change was 18.30 percent for Indicator 1 and 39.30 percent for Indicator 2 All increased rates were statistically significant. From the report that DES/DDD submitted, it was apparent that the Contractor invested time and energy into performance improvement for the two PIP indicators. DES/DDD conducted a thorough analysis of the limitations and barriers to achieving success with this PIP, identifying that internal monitoring performed using all paid claims for DES/DDD members by subcontracted health plans may yield a different rate than the rate from AHCCCS. DES/DDD will consider the impact of this discrepancy for all future internal data monitoring. DES/DDD had many solid interventions and even included a listing of system-level changes that have either occurred or will occur in the future. For example, DES/DDD focused on a targeted outreach to larger practices to show variances across prescribers, provided updated information on each practice's e-prescribing rate to the practice representatives, and developed and posted a provider toolkit for providers on the benefits of e-prescribing. DES/DDD provided incentives that were built into VBP agreements to encourage providers to improve rates of e-prescribing. One of the system-level changes that DES/DDD

identified was additional discussion and reporting in quality committees and to key upper management using dashboards and comparison performance analysis.

Opportunities for Improvement and Recommendations

DES/DDD identified that the internal monitoring performed using all paid claims for DES/DDD members by subcontracted health plans may not be able to differentiate between contracted and non-contracted providers; therefore, some prescribers may not be AHCCCS-contracted, and these claims may not have been included in the AHCCCS results. Consequently, the internal monitoring may yield a slightly higher rate of change than do the AHCCCS results. Although this is the last measurement year, HSAG recommends that DES/DDD meet with AHCCCS to ensure that accurate data are used for the calculation of the PIP rates. DES/DDD has developed many interventions and plans to make systemwide changes in the future. HSAG recommends that DES/DDD continue to monitor the outcomes associated with the interventions and systemwide changes.

Comparative Results for ALTCS Contractors

Findings

Figure 8-1 presents comparison rates for the *E-Prescribing PIP* Indicator 1: The percentage of AHCCCS-contracted providers who prescribed at least one prescription electronically. The figure presents baseline and Remeasurement 2 rates for each ALTCS Contractor tasked with completing this PIP.

Figure 8-1—Performance Improvement Projects—*E-Prescribing:* Indicator 1: The Percentage of Providers Who Prescribed at Least One Prescription Electronically—All ALTCS Contractors
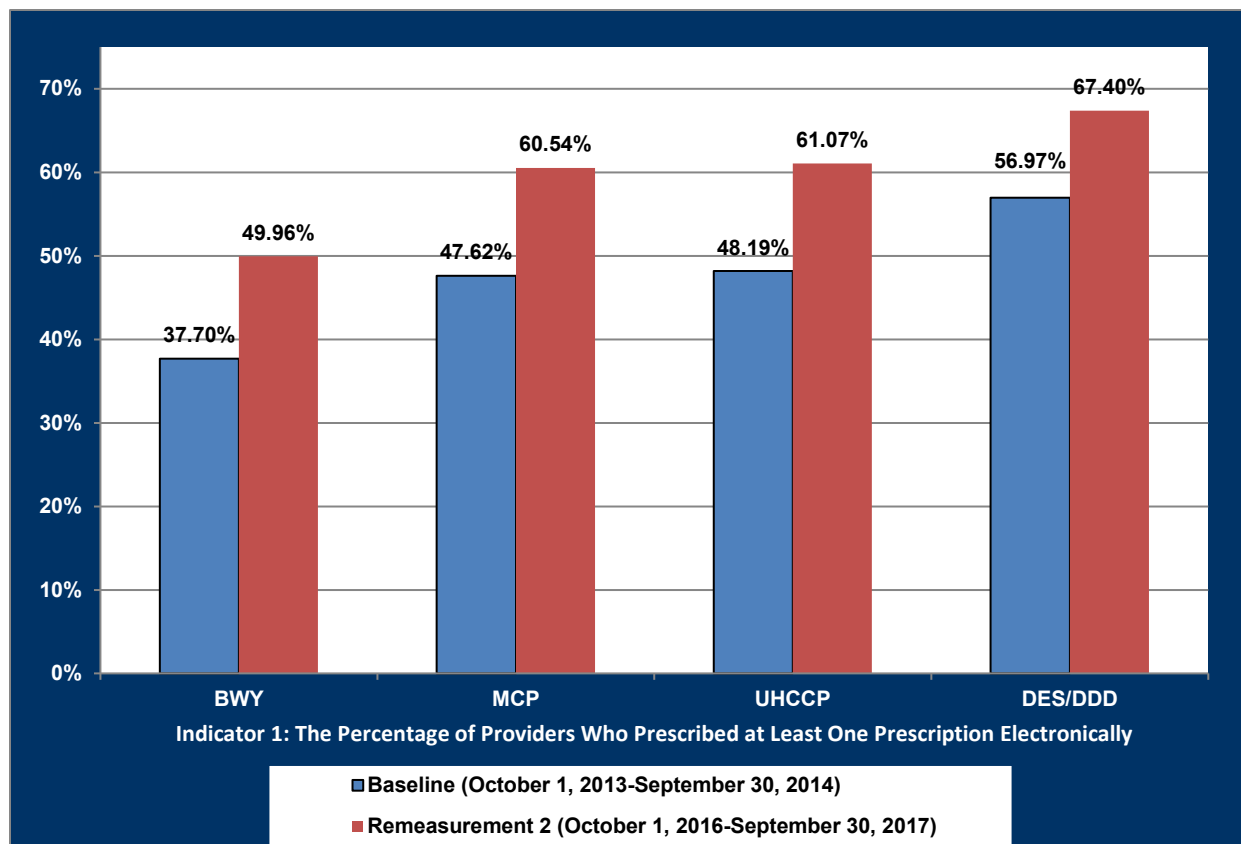

Figure 8-1 shows that each Contractor exceeded the respective baseline rate by a statistically significant amount at Remeasurement 2 for Indicator 1: the percentage of providers who prescribed at least one prescription electronically. UHCCP-LTC had the highest relative percentage change at 10.88 percent, while DES/DDD had the lowest change at 7.29 percent. However, of the included Contractors, DES/DDD's rate of 67.40 percent was the highest percentage of providers who prescribed at least one prescription electronically and was closest to the AHCCCS aggregate rate of 78.42 percent. BWY's rate of 49.96 percent was the lowest percentage of any of the Contractors. These findings indicate that all

Contractors have improved and need to continue barrier analysis and prioritized interventions in order to consolidate gains made and to demonstrate improvement.

Figure 8-2 presents the ALTCS Contractors' comparison rates for the *E-Prescribing* PIP Indicator 2: the percentage of prescriptions sent electronically. The figure presents baseline and Remeasurement 2 rates for each ALTCS Contractor tasked with completing this PIP.

Figure 8-2—Performance Improvement Projects—*E-Prescribing:* Indicator 2: The Percentage of Prescriptions Sent Electronically—All ALTCS Contractors
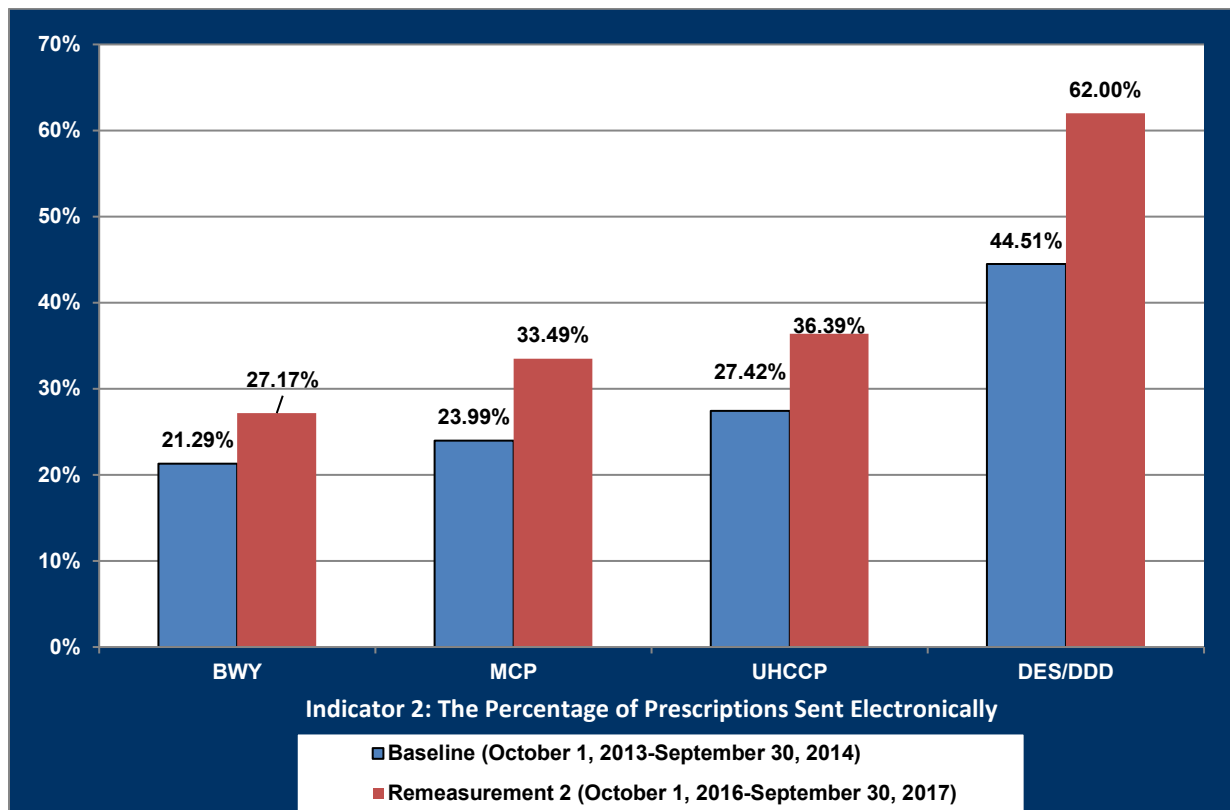

Figure 8-2 shows that each Contractor exceeded the respective baseline rate by a statistically significant amount at Remeasurement 2 for Indicator 2: the percentage of prescriptions sent electronically. MCP-LTC had the highest relative percentage change at 19.68 percent, while DES/DDD had the lowest change at 7.09 percent. DES/DDD had the highest rate at 62.00 percent, while BWY had the lowest rate at 27.17 percent. DES/DDD exceeded the AHCCCS aggregate rate of 55.76 percent. These findings indicate that all Contractors have improved and need to continue barrier analysis and prioritized interventions in order to consolidate gains made and to demonstrate improvement.

Strengths

Figure 8-1 and Figure 8-2 demonstrate the strength of the ALTCS Contractors' performance in the *E-Prescribing* PIP. All Contractors participated in the workgroup formed with other AHCCCS Contractors. Several years ago, the workgroup surveyed providers to identify contributing factors to e-

prescribing rates so as to highlight best practices or barriers. The ALTCS Contractors have all used the results of the survey to develop interventions to improve the rates for this PIP. Many of the Contractors used VBP to provide incentives to providers to use e-prescribing. DES/DDD specifically used incentives and had a 39.30 percent overall relative percentage change increase for Indicator 2: the percentage of prescriptions sent electronically. In addition, all Contractors provided education to providers, with several Contractors including facilities staff and members in their education interventions. Several plans targeted high-volume prescribers. All Contractors improved their rates during their second remeasurement cycle for this PIP.

Opportunities for Improvement and Recommendations

The AHCCCS QI Team implemented multiple process improvement efforts during CYE 2018, which included:

- Updated the PIP policy in the AHCCCS Medical Policy Manual (AMPM).
- Implemented a revised PIP reporting template structure that better captured the evolution and progress of the Contractor throughout the PIP cycle.
- Created an AHCCCS PIP-specific review checklist that will be used for future AHCCCS PIP submission reviews to:
  - Align coordinator reviews to enhance interrater reliability.
  - Provide more feedback to the Contractors to enhance the quality and comprehensiveness of the reports submitted.
  - Change the formatting to allow AHCCCS to provide item-specific feedback and associated updates, if resubmission is required.

HSAG noted that all Contractors except BWY used the new reporting template for the PIP submission. Based on the submitted results from the Contractors and the information submitted to HSAG from AHCCCS regarding the *E-Prescribing* PIP, HSAG offers the following recommendations related to the PIP rates:

- AHCCCS may want to review and compare the data for these indicators with the Contractors' data as several Contractors reported issues with data as a barrier to improvement.
- AHCCCS has made significant progress in making PIP process improvements in the past year, including the development of a new reporting template. Some Contractors submitted comprehensive reports using the new template; however, some Contractors did not include current barrier analysis or interventions. AHCCCS may want to consider offering and facilitating training opportunities to enhance the Contractors' abilities to use the quality improvement tools, such as root cause analyses, key driver diagrams, process mapping, failure modes and effects analysis (FMEA) to assist the Contractors to improve not only the e-prescribing PIP, but subsequent PIPs.
- AHCCCS may want to use the quarterly meetings with Contractors as opportunities to identify and address, related to the PIP process, systemwide barriers which may be impacting the ability to achieve meaningful improvement.

- AHCCCS should continue collaboration among Contractors in the workgroup to improve the PIP study indicator rates and consider including in the workgroup additional stakeholders who may help with improvement of the PIP indicators' rates as many of the Contractors reported that the workgroup helped performance.

- All Contractors may want to consider offering incentives to encourage the providers to adopt e-prescribing as those Contractors that use this intervention reported more success with this intervention than with others.

- Contractors are encouraged to monitor the progress of the PIP interventions employed to increase providers prescribing electronically and prescriptions sent electronically, then adjust interventions as needed to ensure that the rates continue to increase by statistically significant amounts during the second remeasurement period.

Objectives for Conducting the Review

AHCCCS' objectives for conducting ORs are to:

- Determine if the Contractor satisfactorily met AHCCCS' requirements as specified in its contract, AHCCCS policies, Arizona Revised Statutes, the Arizona Administrative Code (AAC), and Medicaid managed care regulations (42 CFR §438).
- Increase AHCCCS' knowledge of the Contractor's operational encounter processing procedures.
- Provide technical assistance and identify areas in which the Contractor can improve as well as areas of noteworthy performance and accomplishments.
- Review the Contractor's progress in implementing recommendations that AHCCCS made during prior ORs.
- Determine if the Contractor complied with its own policies and evaluate the effectiveness of those policies and procedures.
- Perform oversight of the Contractor as required by CMS in accordance with AHCCCS' 1115 waiver.

Provide information to HSAG as AHCCCS' EQRO to use in preparing this report as described in 42 CFR 438.364.

Methodology for Conducting the Review

While AHCCCS reviews the operational and financial performance of the Contractors throughout the year, it also conducts formal reviews on a schedule that ensures it reviews all applicable CMS and AHCCCS contract requirements at least once every three years. AHCCCS follows a CMS-approved process to conduct the ORs that is also consistent with CMS' protocol for EQROs that conduct the reviews.[A-1]

AHCCCS' methodology for conducting the OR included the following:

- Reviewing activities that AHCCCS conducted to assess the Contractor's performance
- Reviewing documents and deliverables that the Contractor was required to submit to AHCCCS
- Conducting interviews with key Contractor administrative and program staff

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[A-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-1.pdf. Accessed on: February 14, 2019.

AHCCCS conducted activities following the review that included documenting and compiling the results of the review, preparing the draft report of findings, and issuing the draft report to the Contractor for review and comment. In the report, each standard and element was individually listed with applicable performance designations based on AHCCCS' review findings and assessment of the degree to which the Contractor complied with the standards.

AHCCCS' review team members included employees of the Division of Health Care Management (DHCM) in Medical and Case Management, Operations, Clinical Quality Management, and Finance and Reinsurance; the Division of Budget and Finance (DBF); Office of Administrative Legal Services; and Office of the Inspector General (OIG).

As needed throughout the preparation of this report, AHCCCS clarified any remaining questions regarding the accuracy and completeness of the data and information that HSAG would use to prepare this section of the EQR report.

Using the verified results that AHCCCS obtained from conducting the OR, HSAG organized and aggregated the performance data for each Contractor. HSAG then analyzed the data by performance category (e.g., Quality Management).

Based on its analysis, HSAG identified strengths and opportunities for improvement for each Contractor. When HSAG identified opportunities for improvement, HSAG also included the associated AHCCCS recommendations to further improve the quality and timeliness of, and access to, the care and services each Contractor provided to AHCCCS members.

Scoring Methodology

Each standard area contains elements designed to measure the Contractor's performance and compliance with the federal managed care rules and the AHCCCS ALTCS contract provisions. A Contractor may receive up to a maximum possible score of 100 percent for each standard measured in the CYE 2017 OR. Within each standard are specific scoring detail criteria worth defined percentages of the total possible score.

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

Corrective Action Statements

As part of the AHCCCS methodology, each Contractor receives a report containing review findings. The Contractor has opportunity to respond to AHCCCS concerning any disagreement related to the findings. AHCCCS reviews and responds to any Contractor disagreements based on review of the Contractor information, and then revises the report if necessary. AHCCCS issues the final report to the

Contractor, describing the findings, scores, and required CAPs.

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

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

In accordance with 42 CFR §438.240(b), AHCCCS requires Contractors to have a Quality Management/Performance Improvement (QM/PI) program that includes measuring and submitting data to AHCCCS related to Contractor performance. Validating MCO and PIHP performance measures is one of the three mandatory EQR activities described at 42 CFR 4§38.358(b)(2). The requirement §438.358(a) allows states, their agents that are not MCOs or PIHPs, or an EQRO to conduct the mandatory activities. MCOs/PIHPs may report performance results to a state (as required by the state), or the state may calculate the MCOs'/PIHPs' performance on the measures for the preceding 12 months. Performance must be reported by the MCOs/PIHPs—or calculated by the state—and validated annually.

As permitted by 42 CFR §438.358(a), AHCCCS elected to conduct the functions associated with the mandatory activity of validating performance measures. In accordance with and satisfying the requirements of 42 CFR §438.364(a)(1–5), AHCCCS contracted with HSAG as an EQRO to use the information that AHCCCS obtained from the performance measure calculations and data validation activities to prepare this CYE 2018 annual report.

Conducting the Review

HSAG calculates and reports rates on AHCCCS' behalf for a variety of Contractor-specific and statewide aggregate performance measures to address different quality initiatives. HSAG calculated the measure rates for CYE 2017.

Using the results and statistical analysis of Contractors' performance measure rates, HSAG organized, aggregated, and analyzed the performance data. From the analysis, HSAG was able to draw conclusions about Contractor-specific and statewide aggregate performance related to the quality of, access to, and timeliness of care and services provided to AHCCCS members for CYE 2017.

Objectives for Conducting the Review

As part of its objectives to measure, report, compare, and continually improve Contractor performance, AHCCCS conducted the following activities:

- Provided key information about AHCCCS-selected performance measures to each Contractor.
- Collected Contractor data for use in calculating performance measure rates.

Methodology for Conducting the Review

For the CYE 2017 review period (i.e., measurement year ending September 30, 2017), AHCCCS conducted the following activities:

- Collected Contractor encounter data associated with each State-selected measure.
- Calculated Contractor-specific performance rates and statewide aggregate rates for all Contractors for each measure.
- Reported Contractor performance results by individual Contractor and a statewide aggregate.
- Compared Contractor performance rates with minimum performance standards (MPS) defined by AHCCCS' contract, if available.

CAPs, key components of the AHCCCS Quality Strategy, are used as foundational elements to improve performance measure rates that fall below the contractual MPS. During CYE 2018, AHCCCS required Contractors to propose and implement CAPs for CYE 2016 contractually required performance measures that did not meet the MPS. The Contractors then submitted CAP proposals. Once a CAP proposal was approved by AHCCCS and implemented, the Contractors were required to provide CAP updates as required by AHCCCS.

HSAG calculated results on AHCCCS' behalf for a variety of performance measures to address different quality initiatives using the following technical specifications: NCQA's HEDIS, CMS Adult Core Set, and CMS Child Core Set. The Contractors' performance rates were calculated for AHCCCS-selected measures using administrative data collected from the automated managed care data system known as the Prepaid Medicaid Management Information System (PMMIS). The administrative methodology used for data collection in the current measurement did not differ from the methodology used for the previous measurement period. NCQA and CMS update their respective methodologies annually to add new codes to better identify the eligible populations and/or services being measured or to delete codes retired from standardized coding sets used by providers.

HSAG analyzed Contractor-specific and statewide aggregate performance results for each measure to determine if performance rates met or exceeded each corresponding AHCCCS MPS. Relative rate changes and statistical analyses are presented to show the magnitude and direction of any change in rates from the previous measurement period and whether that change was significant.

Using the performance rates that HSAG calculated on AHCCCS' behalf, HSAG organized, aggregated, and analyzed the data to draw conclusions about Contractor performance related to providing quality, timely, and accessible care and services to AHCCCS members. When applicable, HSAG formulated and presented recommendations to improve Contractor performance rates.

Performance Measures Results—ALTCS Contractors

The following tables include performance measure results for the ALTCS Contractors. The tables display the following information: CYE 2016 performance, where available; CYE 2017 performance; the relative percentage change between CYE 2016 and CYE 2017 rates, where available; the significance of the relative percentage change, where available; and the AHCCCS MPS, where available. Performance measure rate cells shaded green indicate that performance met or exceeded the CYE 2017 MPS established by AHCCCS. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the established MPS are shaded green.

Bridgeway Health Solutions-LTC (BWY-LTC)

Table B-1—CYE 2016 and CYE 2017 Performance Measure Results—BWY-LTC

Performance Measure	CYE 2016 Performance	CYE 2017 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness[2]					
7-Day Follow-Up	—	NA	—	—	85.0%
30-Day Follow-Up	—	NA	—	—	95.0%
Utilization					
Ambulatory Care (per 1,000 Member Months)					
ED Visits—Total*	68.7	71.1	3.5%	—	80.0
Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total					
Days per 1,000 Member Months (Total Inpatient)— Total	205.5	210.8	2.6%	—	—
Plan All-Cause Readmissions					
Total*	11.1%	16.1%	45.0%	**P=0.009**	17.0%

* A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.
NA indicates that the rate was withheld because the denominator was less than 30.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2016 and CYE 2017 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between CYE 2017 and prior years; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
— Indicates that the CYE 2016 rate was not displayed due to technical specification changes, that a comparison of performance between CYE 2016 and CYE 2017 was not possible or appropriate, or that an MPS had not yet been established by AHCCCS.

Cells shaded green indicate that the rate met or exceeded the CYE 2017 MPS established by AHCCCS.

Mercy Care Plan-LTC (MCP-LTC)

Table B-2—CYE 2016 and CYE 2017 Performance Measure Results—MCP-LTC

Performance Measure	CYE 2016 Performance	CYE 2017 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness[2]					
7-Day Follow-Up	—	29.3%	—	—	85.0%
30-Day Follow-Up	—	50.0%	—	—	95.0%
Utilization					
Ambulatory Care (per 1,000 Member Months)					
ED Visits—Total*	77.3	72.9	-5.7%	—	80.0

Performance Measure	CYE 2016 Performance	CYE 2017 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total					
Days per 1,000 Member Months (Total Inpatient)— Total	275.4	268.0	-2.7%	—	—
Plan All-Cause Readmissions					
*Total**	13.3%	17.3%	30.1%	**P=0.001**	17.0%

* A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2016 and CYE 2017 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between CYE 2017 and prior years; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
— Indicates that the CYE 2016 rate was not displayed due to technical specification changes, that a comparison of performance between CYE 2016 and CYE 2017 was not possible or appropriate, or that an MPS had not yet been established by AHCCCS.

▢ Cells shaded green indicate that the rate met or exceeded the CYE 2017 MPS established by AHCCCS.

UnitedHealthcare Community Plan-LTC (UHCCP-LTC)

Table B-3—CYE 2016 and CYE 2017 Performance Measure Results—UHCCP-LTC

Performance Measure	CYE 2016 Performance	CYE 2017 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness[2]					
7-Day Follow-Up	—	31.2%	—	—	85.0%
30-Day Follow-Up	—	54.1%	—	—	95.0%
Utilization					
Ambulatory Care (per 1,000 Member Months)					
*ED Visits—Total**	66.0	58.2	-11.8%	—	80.0
Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total					
Days per 1,000 Member Months (Total Inpatient)— Total	129.1	110.2	-14.6%	—	—
Plan All-Cause Readmissions					
*Total**	8.1%	12.2%	50.6%	**P=0.009**	17.0%

* A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2016 and CYE 2017 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between CYE 2017 and prior years; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
— Indicates that the CYE 2016 rate was not displayed due to technical specification changes, that a comparison of performance between CYE 2016 and CYE 2017 was not possible or appropriate, or that an MPS had not yet been established by AHCCCS.

▢ Cells shaded green indicate that the rate met or exceeded the CYE 2017 MPS established by AHCCCS.

ALTCS Aggregate

Table B-4—CYE 2016 and CYE 2017 Performance Measure Results—ALTCS Contractors

Performance Measure	CYE 2016 Performance	CYE 2017 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness[2]					
7-Day Follow-Up	—	30.3%	—	—	85.0%
30-Day Follow-Up	—	51.0%	—	—	95.0%
Utilization					
Ambulatory Care (per 1,000 Member Months)					
ED Visits—Total*	71.3	66.7	-6.4%	—	80.0
Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total					
Days per 1,000 Member Months (Total Inpatient)—Total	205.8	194.4	-5.5%	—	—
Plan All-Cause Readmissions					
Total*	11.7%	15.9%	35.9%	**P<0.001**	17.0%

* A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2016 and CYE 2017 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between CYE 2017 and prior years; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
— Indicates that the CYE 2016 rate was not displayed due to technical specification changes, that a comparison of performance between CYE 2016 and CYE 2017 was not possible or appropriate, or that an MPS had not yet been established by AHCCCS.

Cells shaded green indicate that the rate met or exceeded the CYE 2017 MPS established by AHCCCS.

Performance Improvement Project Design

AHCCCS updated the AHCCCS Medial Policy Manual, 980—Performance Improvement Projects in CYE 2018. AHCCCS' PIPs, either mandated or Contractor-initiated, are developed according to 42 CFR §438.330, Quality Assessment and Performance Improvement Program. AHCCCS requires Contractors to conduct PIPs that focus on both clinical and nonclinical areas. AHCCCS designs PIPs to correct significant system problems and/or achieve significant improvement in health outcomes and member satisfaction. Improvements need to be sustained over time through the measurement of performance using objective quality indicators, implementation and evaluation of interventions to achieve improvement in access to and quality of care, and planning and initiation of activities for increasing or sustaining improvement.

AHCCCS' clinical focus topics may include primary, secondary, and/or tertiary prevention of acute, chronic, or behavioral health conditions; care of acute, chronic, or behavioral health conditions; high-risk services; and continuity and coordination of care.

AHCCCS' nonclinical focus topics may include availability, accessibility, and adequacy of the Contractors' service delivery systems; cultural competency of services; interpersonal aspects of care; and appeals, grievances, and other complaints.

Data Collection Methodology

AHCCCS' evaluation of the Contractors' performance on the selected measures is based on systematic, ongoing collection and analysis of accurate, valid, and reliable data, as collected and analyzed by AHCCCS. The Contractors' methodology (including project indicators, procedures, and timelines) aligns with the guidance and direction provided for all AHCCCS-mandated PIPs. The Contractors are required to include internal rates and results used as the basis for analysis (both quantitative and qualitative) and selection/modification of interventions, within the Contractors' annual PIP report submissions. Depending on the PIP, AHCCCS may direct Contractors to collect all or some of the data used to measure performance. In such cases, AHCCCS requires that the Contractors have qualified personnel collect data and ensure inter-rater reliability if more than one person is collecting and entering data. Contractors must submit specific documentation to verify that indicator criteria were met.

Measurement of Significant Improvement

AHCCCS expects Contractors to implement interventions to meet a benchmark level of performance for any PIP. AHCCCS defines this benchmark level in advance for all AHCCCS-mandated PIPs. The Contractors must initiate interventions that result in significant improvement, sustained over time, in their performance for the quality indicators being measured. AHCCCS requires that improvement be

evidenced in repeated measurements of the quality indicators specified for each PIP undertaken by the Contractors.

AHCCCS determines a Contractor has demonstrated significant improvement when the Contractor:

- Meets or exceeds the AHCCCS overall average for the baseline measurement, if its baseline rate was below the average and the increase is statistically significant;
- Demonstrates a statistically significant increase, if its baseline rate was at or above the AHCCCS overall average for the baseline measurement; or
- Demonstrates the highest-performing (benchmark) plan in any remeasurement and maintains or improves its rate in a successive measurement.

AHCCCS determines a Contractor has demonstrated sustained improvement when the Contractor:

- Establishes how the significant improvement can be reasonably attributable to interventions implemented by the Contractor (i.e., improvement occurred due to the project and its interventions, not another unrelated reason), and
- Maintains, or increases, the improvements in performance for at least one year after the improvement in performance was first achieved.

Performance Improvement Project Time Frames

AHCCCS-mandated PIPs begin on a date that corresponds with a contract year. Baseline data for the PIP are collected and analyzed at the beginning of the PIP. Depending on the PIP topic, AHCCCS may provide baseline data by Contractor and include additional data by age, race, sex, ethnicity, and/or geographic area to assist Contractors in refining interventions. During the first year of the PIP, AHCCCS requires the Contractors to implement interventions to improve performance based on an evaluation of barriers to care/use of services and evidence-based approaches to improving performance. An intervention may consider any unique factors, such as a Contractor's membership, provider network, or geographic area(s) served.

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

AHCCCS will conduct annual measurements to evaluate Contractor performance and may conduct interim measurements, depending on the resources required, to collect and analyze data. Contractors must include internal annual measurements/rates and results, used as the basis for analysis (both quantitative and qualitative) and selection/modification of interventions, within the Contractors' annual PIP report submissions.

AHCCS requires Contractors' participation in the PIP to continue until demonstration of significant and sustained improvement is shown, as outlined above.