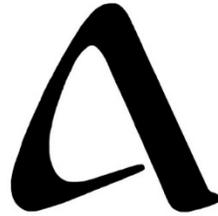


Arizona Health Care Cost Containment System



AHCCCS

**2015–16 External Quality Review
Annual Report**
for

ALTCS EPD and DES/DDD

January 2017



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1. Executive Summary

Section 1932(c) of the Medicaid managed care act requires state Medicaid agencies to provide for an annual external independent review of the quality and timeliness of, and access to, services covered under each managed care organization (MCO) and prepaid inpatient health plan (PIHP) contract. The Code of Federal Regulations (CFR) outlines the Medicaid managed care act requirements related to external quality review (EQR) activities.

The CFR describes the mandatory activities at 42 CFR, Part 438, Managed Care, Subpart E, External Quality Review, 438.358(b) and (c). The three mandatory activities are (1) validating performance improvement projects (PIPs), (2) validating performance measures, and (3) conducting reviews to determine compliance with standards established by the state to comply with the requirements of 42 CFR 438.204(g). According to 42 CFR 438.358(a), “The state, its agent that is not an MCO or PIHP, or an external quality review organization (EQRO) may perform the mandatory and optional EQR-related activities.”

The Arizona Health Care Cost Containment System (AHCCCS), the first statewide Medicaid managed care system in the nation, continues as a national leader and innovator in designing and administering effective and efficient financing, contracting, and service delivery models for Medicaid managed care programs.

As permitted by the Centers for Medicare & Medicaid Services (CMS), and as allowed under federal regulation, AHCCCS elected to retain responsibility for performing the three mandatory activities described in 42 CFR 438. 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 2015–2016 EQR technical report. This report presents AHCCCS’ and HSAG’s findings from conducting each activity as well as HSAG’s analysis and assessment of the Contractors’ performance and, as applicable, recommendations to improve Contractors’ performance.

HSAG is an EQRO that meets the competency and independence requirements of 42 CFR 438.354(b) and (c). HSAG has extensive experience and expertise in both conducting the mandatory activities and in using the information that either HSAG derived from directly conducting the activities or that a State Medicaid agency derived from conducting the activities. HSAG uses the information and data to draw conclusions and make recommendations about the quality and timeliness of, and access to, care and services the State’s MCOs provide.

To meet the requirements of 42 CFR 438.358(b), as the EQRO, HSAG must use the information AHCCCS obtained and provided to it, as well as information from the activities HSAG conducted to prepare and provide AHCCCS its EQR annual technical report. The report must include, at a minimum, HSAG’s:

- Analysis of the data and information.
- Conclusions drawn from the analysis of the quality and timeliness of, and access to, Medicaid managed care services provided to members by AHCCCS' Contractors.
- Recommendations for improving the Contractors' service quality, timeliness, and access.

HSAG has prepared the annual report for AHCCCS for 12 consecutive years. The report complies with requirements set forth at 42 CFR 438.364.

This Executive Summary includes an overview of HSAG's 2015–2016 (EQR) 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 requirements for AHCCCS-selected performance measures and for conducting valid and effective AHCCCS-required PIPs. AHCCCS also conducted a focused operational review (OR) for Contractors with the Arizona Long Term Care System (ALTCS) Elderly and Physically Disabled (EPD) and with the Arizona Department of Economic Security, Division of Developmental Disabilities (DES/DDD) Contractors during the Contract Year Ending (CYE) 2015; and the results are presented in this report. Sections of this annual 2015–2016 EQR technical report include the following:

- Section 2—An overview of the history of the AHCCCS program and a summary of AHCCCS' quality assessment and performance improvement (QAPI) strategy goals and objectives.
- Section 3—A description of the 2015–2016 EQR activities.
- Section 4—An overview of AHCCCS' statewide quality initiatives across its Medicaid managed care programs and those that are specific to its ALTCS and DES/DDD Contractors.
- Section 5—An overview of the Contractors' best and emerging practices.
- Section 6 (Organizational Assessment and Structure Performance)—A presentation of findings for the Contractors in complying with select AHCCCS contract requirements and, as applicable, HSAG's recommendations to improve Contractor performance and members' timely access to quality care and services. (Note: AHCCCS conducts ORs to assess each Contractor's compliance with AHCCCS' contract standards at least once during each three-year contract period. The CYE 2015 review was the second year of a new three-year review cycle.)
- Section 7 (Performance Measure Performance)—A presentation of rates for AHCCCS-selected performance measures for each ALTCS and DES/DDD Contractor as well as HSAG's associated findings and recommendations for CYE 2013 and 2014. (Note: Performance measurement rates data for CYE 2013 were under review at the time this report was written; therefore, the performance measure performance section was not included in the annual 2014–2015 EQR technical report.)
- Section 8 (Performance Improvement Project Performance)—A presentation of each Contractor's results for its AHCCCS-selected and required PIP for the ALTCS and DES/DDD Contractors as well as HSAG's associated findings and recommendations.

As CYE 2014 performance measure results are still under review by AHCCCS and its Contractors, all CYE 2014 performance measure results provided in this report should be considered preliminary and are subject to change prior to finalization. CYE 2012, 2013, and preliminary 2014 performance

measurement rates, as well as the associated findings and recommendations, are included in the annual 2015–2016 EQR technical report.

Overview of the 2015–2016 External Review

During the time period of the review, AHCCCS contracted with three ALTCS Medicaid managed care Contractors and with DES/DDD.

Below are the three ALTCS Contractors and associated abbreviations used throughout this report:

- Bridgeway Health Solutions (BHS)
- Mercy Care Plan (MCP)
- UnitedHealthcare Community Plan (UHCCP)

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

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

Organizational Assessment and Structure Standards

CYE 2013 commenced a new, three-year cycle of ORs; and AHCCCS conducted a comprehensive OR for the ALTCS and DES/DDD Contractors in CYE 2014. During CYE 2015, AHCCCS monitored the progress of the Contractors implementing their CAPs for the recommendations from the 2014 OR. In addition, AHCCCS conducted a focused OR that targeted specific standards for review based on a combination of the Contractors’ 2014 OR results. AHCCCS elected not to perform a CAP follow-up process for the CYE 2015 focused OR; however, AHCCCS made it clear to the Contractors the expectation that any issues identified be addressed and corrected. AHCCCS will follow up at the next full OR.

Based on AHCCCS’ review findings and assessment of the degree to which the Contractor complied with the standards, AHCCCS assigned the applicable performance designation to the Contractor’s performance:

- Standards scored as 90 through 100 percent compliant were designated as *Full Compliance*.
- Standards scored as 75 through 89 percent compliant were designated as *Substantial Compliance*.
- Standards scored as 50 through 74 percent compliant were designated as *Partial Compliance*.
- Standards scored as 0 through 49 percent compliant were designated as *Noncompliance*.

If a standard was not applicable to a Contractor, AHCCCS noted this using an N/A designation. 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.

AHCCCS reviewed the following standards in the CYE 2015 focused OR:

- Case Management
- Claims and Information Systems
- General Administration
- Maternal and Child Health and the Early Periodic Screening, Diagnostic and Treatment (EPSDT)
- Medical Management
- Member Information
- Quality Management

Findings

Table 1-1 presents the overall compliance results and results for each Contractor reviewed. Rounded scores may not equal 100 percent.

Table 1-1—Overall Compliance Results

Contractor	Total No. of Standards	Full Compliance	Substantial Compliance	Partial Compliance	Non-compliance
BHS	14	8	1	1	4
MCP	9	8	0	1	0
UHCCP	1	0	1	0	0
DDD/DES	51	30	2	9	10
Totals	75	46	4	11	14
% Totals		61%	5%	15%	19%

Table 1-1 represents the total number of standards for each Contractor and the distribution of those standards into full compliance, substantial compliance, partial compliance, and noncompliance categories. Of the total 75 standards reviewed, DDD/DES had the greatest number of standards reviewed with 51 standards, and UHCCP had the fewest standards reviewed, one. Using AHCCCS’ definition of full compliance (90 percent to 100 percent compliant) and substantial compliance (75 percent to 89 percent compliant), 67 percent of standards reviewed were over 75 percent complaint. Using AHCCCS’ definition of partial compliance (50 percent to 74 percent compliant) and noncompliant (0 percent to 49 percent compliant), 32 percent of Contractors scored below 74 percent. UHCCP had only one standard scored at *Substantial Compliance*; and MCP had only one standard (of nine) that scored at *Partial Compliance*, with eight standards at *Full Compliance*. Both BHS and DES/DDD had 36 percent of standards scored at *Partial Compliance* or *Noncompliance*.

The Contractors' strongest performance was for the standards associated with the Quality Management category at 100 percent. The overall outcomes from the scoring tools indicate high performance in the Maternal and Child Health and EPSDT category as the majority of the Contractors in this category were scored as fully compliant. Based on AHCCCS' review, the outcomes for the Claims and Information Systems category identify opportunities for improvement. For instance, AHCCCS scored BHS as non-compliant in four standards and partially compliant in one of five total standards. In addition, although MCP received three *Full Compliance* scores, the Contractor received one *Partial Compliance* score. In the same category, of six standards total, DES/DDD received two *Noncompliance* scores, two *Partial Compliance* scores, and one each of *Substantial Compliance* and *Full Compliance*.

Conclusions

Four Contractors were in full compliance with 61 percent of the 75 standards reviewed, with varied performance across six of the seven categories. Three Contractors were fully compliant in the Case Management category. The General Administration (DES/DDD), Member Information (DES/DDD), and Claims and Information Systems (BHS, MCP, and DES/DDD) demonstrated the greatest opportunities for improvement. Three Contractors (BHS, MCP, and DES/DDD) had standards scored *Partial Compliance* or *Noncompliance*. Both BHS and DES/DDD had approximately one-third of standards scored at *Partial Compliance* or *Noncompliance*.

Recommendations

Based on AHCCCS' review of the ALTCS and DES/DDD Contractor performance in CYE 2015 and the associated opportunities for improvement identified as a result of the focused OR, HSAG recommends the following:

- Contractors should conduct internal reviews of operational systems to identify barriers that impact their compliance with AHCCCS standards, State rules, and federal regulations. Specifically, Contractors should cross-reference existing policies and procedures 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 assess their current monitoring programs and activities to identify strengths and vulnerable areas. When deficiencies are noted, the Contractors should develop mechanisms to address such areas and enhance the existing properties.
- Contractors should apply lessons learned from improving performance in one category of standards to other categories. Specifically, Contractors can learn from earlier completed CAPs as identified in previous ORs to determine best practices specific to their organization, identifying and correcting deficient standards, and monitoring the subsequent compliance.

Performance Measures

AHCCCS collected data and reported Contractor performance for a set of performance measures selected by AHCCCS for both the CYE 2013 and CYE 2014 measurement periods. With the exception of two performance measures, AHCCCS selected different measures for reporting by the DES/DDD Contractor than for the three ALTCS EPD Contractors.

Results are presented for the CYE 2013 and CYE 2014 measurement periods. For CYE 2013, AHCCCS selected three performance measures for the ALTCS EPD Contractors and 10 performance measures for DES/DDD. For CYE 2014, AHCCCS selected 19 measures for the ALTCS EPD Contractors and 24 measures for DES/DDD. Only two measures for the ALTCS EPD Contractors and eight measures for DES/DDD had reportable rates for both CYE 2013 and CYE 2014.

Findings

Table 1-2 presents aggregate performance measure rates for all ALTCS EPD Contractors for CYE 2012 and CYE 2013. The table displays the following information for each measure: CYE 2012 performance, CYE 2013 performance, the relative percentage change between the CYE 2012 and CYE 2013 rates, the statistical significance of the relative percentage change, and AHCCCS' CYE 2013 minimum performance standard (MPS).

Table 1-2—CYE 2013 Performance Measurement Review for ALTCS EPD Contractors

Performance Measure	CYE 2012 Performance	CYE 2013 Performance	Relative Percentage Change	Significance Level ^A (<i>p</i> value)	Minimum Performance Standard
<i>Dental Participation</i>	26.6%	29.1%	9.8%	<i>p</i> =0.351	46.0%
<i>EPSDT Participation</i>	32.3%	29.6%	-8.3%	<i>p</i> =0.371	68.0%
<i>Initiation of HCBS^B</i>	96.3%	95.9%	-0.4%	<i>p</i> =0.797	92.0%

^A Significance levels (*p* values) noted in the table were calculated by AHCCCS and HSAG and demonstrate the statistical significance between performance during the previous measurement period and performance during the current measurement period. Statistical significance is traditionally reached when the *p* value is ≤ 0.05.

^B HCBS = Home and Community-Based Services

Table 1-2 shows that the aggregate rate for the *Initiation of HCBS* measure met the AHCCCS MPS during CYE 2013, despite a small decrease from CYE 2012. Conversely, the aggregate rates for *Dental Participation* and *EPSDT Participation* failed to meet the CYE 2013 AHCCCS MPS values and the *EPSDT Participation* rate declined slightly from CYE 2012 to CYE 2013. However, changes observed in the aggregate rates from CYE 2012 to CYE 2013 were not statistically significant for any measures reported by the ALTCS EPD Contractors.

Table 1-3 presents the performance measure rates for DES/DDD. The table displays the following information for each measure: CYE 2012 performance, CYE 2013 performance, the relative percentage

change between the CYE 2012 and CYE 2013 rates, the statistical significance of the relative percentage change, and AHCCCS' CYE 2013 MPS.

Table 1-3—CYE 2013 Performance Measurement Review for DES/DDD

Performance Measure	CYE 2012 Performance	CYE 2013 Performance	Relative Percentage Change	Significance Level ^A (p value)	Minimum Performance Standard
<i>Adolescent Well-Care Visits</i>	35.4%	35.1%	-1.1%	<i>p</i> =0.655	40.0%
<i>Annual Dental Visits—2–21 Years</i>	47.7%	49.4%	3.5%	<i>p</i>=0.004	49.0%
<i>Children’s Access to Primary Care Practitioners (PCPs)</i>	86.5%	87.7%	1.5%	<i>p</i>=0.002	**
<i>12–24 Months</i>	93.7%	99.0%	5.6%	<i>p</i> =0.054	85.0%
<i>25 Months–6 Years</i>	86.3%	88.1%	2.1%	<i>p</i>=0.028	80.0%
<i>7–11 Years</i>	88.0%	89.5%	1.7%	<i>p</i>=0.031	80.0%
<i>12–19 Years</i>	85.2%	86.0%	0.9%	<i>p</i> =0.254	80.0%
<i>Dental Participation</i>	36.9%	40.8%	10.5%	<i>p</i><0.001	46.0%
<i>EPSDT Participation</i>	48.1%	42.9%	-10.8%	<i>p</i><0.001	68.0%
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	51.5%	48.8%	-5.2%	<i>p</i>=0.038	52.0%

^A Significance levels (*p* values) noted in the table were calculated by AHCCCS and HSAG and demonstrate the statistical significance between performance during the previous measurement period and performance during the current measurement period. Statistical significance is traditionally reached when the *p* value is ≤ 0.05. Rates in bold font indicate statistically significant values.

** The minimum performance standards for the *Children’s Access to Primary Care Practitioners (PCPs)* measure were established for each age group rather than, as in previous years, for the aggregate. Aggregated data are presented for informational purposes.

Five measures displayed statistically significant increases: *Children’s Access to Primary Care Practitioners (PCPs)—Total, 25 Months–6 Years, and 7–11 Years; Annual Dental Visits—2–21 Years; and Dental Participation*. Of these five measures, three measures exceeded the MPS in CYE 2013, *Annual Dental Visits—2–21 Years and Children’s Access to PCPs—25 Months–6 Years and 7–11 Years*. Additionally, the aggregate rates for *Children’s Access to PCPs—12–24 Months and 12–19 Years* for CYE 2013 exceeded the MPS values and demonstrated increases from CYE 2012, although these increases were not statistically significant. Conversely, two measures, *EPSDT Participation and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, showed statistically significant decreases from the previous measurement period and failed to meet their respective AHCCCS MPS values. The aggregate rates for *Adolescent Well-Care Visits and Dental Participation* for CYE 2013 also fell below the MPS.

At the time of the production of this report, AHCCCS elected to forgo CAPs for CYE 2013 due to Contractor challenges and had not yet formally placed CAPs on Contractors for CYE 2014 performance measure rates. As a result, no CAP data are included in the report for this year.

Table 1-4 presents aggregate performance measure rates for all ALTCS EPD Contractors for CYE 2013 and CYE 2014. The table displays the following information for each measure: CYE 2013 performance, CYE 2014 performance, the relative percentage change between the CYE 2013 and CYE 2014 rates, the statistical significance of the relative percentage change, and AHCCCS’ CYE 2014 MPS. As CYE 2014 performance measure results are still under review by AHCCCS and its Contractors, all CYE 2014 performance measure results provided in this report should be considered preliminary and are subject to change prior to finalization.

Table 1-4—CYE 2014 Performance Measurement Review for ALTCS EPD Contractors

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level ^A (p value)	Minimum Performance Standard
<i>7 Day Follow-Up After Hospitalization for Mental Illness</i>	—	17.9%	—	—	—
<i>30 Day Follow-Up After Hospitalization for Mental Illness</i>	—	32.3%	—	—	—
<i>Advance Directives</i>	—	61.6%	—	—	55.0%
<i>Ambulatory Care—Emergency Department (ED) Visits—Total per 1,000 Member Months</i>	—	63	—	—	—
<i>Asthma in Younger Adults Admission Rate</i>	—	212.8	—	—	—
<i>Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate</i>	—	1329.9	—	—	—
<i>Dental Participation</i>	29.1%	33.4%	14.6%	<i>p</i> =0.153	46.0%
<i>Diabetes Short-Term Complications Admission Rate</i>	—	170.6	—	—	—
<i>EPSDT Participation</i>	29.6%	38.3%	29.3%	<i>p</i>=0.006	68.0%
<i>Heart Failure Admission Rate</i>	—	1156.5	—	—	—
<i>Members With an Influenza Immunization—50–64 Years of Age</i>	—	54.2%	—	—	55.0%
<i>Members With an Influenza Immunization—65 Years of Age and Older</i>	—	52.2%	—	—	60.0%

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level ^A (p value)	Minimum Performance Standard
<i>Inpatient Utilization—General Hospital/Acute Care—Total Inpatient Discharges per 1,000 Member Months</i>	—	33	—	—	—
<i>Inpatient Utilization—General Hospital/Acute Care—Maternity Discharges per 1,000 Member Months</i>	—	0	—	—	—
<i>Inpatient Utilization—General Hospital/Acute Care—Surgery Discharges per 1,000 Member Months</i>	—	12	—	—	—
<i>Inpatient Utilization—General Hospital/Acute Care—Medicine Discharges per 1,000 Member Months</i>	—	21	—	—	—
<i>Plan All-Cause Readmissions^B</i>	—	15.5%	—	—	—
<i>18–64 Years of Age^B</i>	—	19.8%	—	—	—
<i>65+ Years of Age^B</i>	—	12.2%	—	—	—
^A Significance levels (p values) noted in the table were calculated by AHCCCS and HSAG and demonstrate the statistical significance between performance during the previous measurement period and performance during the current measurement period. Statistical significance is traditionally reached when the p value is ≤ 0.05. Rates in bold font indicate statistically significant values.					
^B A lower rate for this measure indicates better performance.					
— CYE 2014 is a baseline reporting year for this measure; therefore, CYE 2013 Performance, Relative Percentage Change, and Significance Level are not displayed. Additionally, this measure may not yet have a CYE 2014 AHCCCS Minimum Performance Standard established.					
* CYE 2014 performance measure results are still under review by AHCCCS and its Contractors; therefore, all performance measure results provided in this report should be considered preliminary and are subject to change prior to finalization.					

Table 1-4 shows a statistically significant increase in the aggregate rate for the *EPSDT Participation* measure from CYE 2013 to CYE 2014; the rate for *Dental Participation* also increased, although this change was not statistically significant. Nonetheless, the aggregate rates for neither of these measures met the AHCCCS MPS for CYE 2014. For the first year reporting the *Advance Directives* measure, the Contractors met the AHCCCS MPS for CYE 2014. Conversely, aggregate rates for *Members With an Influenza Immunization—50–64 Years of Age* and *65 Years of Age or Older* did not meet their respective MPS values. The remaining measure rates are presented in the table preceding for information purposes.

Table 1-5 presents the performance measure rates for DES/DDD. The table displays the following information for each measure: CYE 2013 performance, CYE 2014 performance, the relative percentage change between the CYE 2013 and CYE 2014 rates, the statistical significance of the relative percentage change, and AHCCCS' CYE 2014 MPS.

Table 1-5—CYE 2014 Performance Measurement Review for DES/DDD

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level ^A (p value)	Minimum Performance Standard
<i>Adolescent Well-Care Visits</i>	35.1%	35.8%	2.1%	<i>p</i> =0.365	41.0%
<i>Ambulatory Care—ED Visits—Total per 1,000 Member Months</i>	—	41	—	—	—
<i>Annual Dental Visits—2–21 Years</i>	49.4%	52.9%	7.1%	<i>p</i><0.001	60.0%
<i>Asthma in Younger Adults Admission Rate</i>	—	70.3	—	—	—
<i>Children’s Access to Primary Care Practitioners (PCPs)</i>	87.7%	88.1%	0.4%	<i>p</i> =0.343	**
<i>12–24 Months</i>	99.0%	93.4%	-5.6%	<i>p</i> =0.090	93.0%
<i>25 Months–6 Years</i>	88.1%	86.6%	-1.8%	<i>p</i> =0.064	84.0%
<i>7–11 Years</i>	89.5%	90.1%	0.8%	<i>p</i> =0.294	83.0%
<i>12–19 Years</i>	86.0%	87.3%	1.6%	<i>p</i>=0.032	82.0%
<i>Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate</i>	—	99.5	—	—	—
<i>Dental Participation</i>	40.8%	43.5%	6.6%	<i>p</i><0.001	46.0%
<i>Diabetes Short-Term Complications Admission Rate</i>	—	63.7	—	—	—
<i>EPSDT Participation</i>	42.9%	36.6%	-14.7%	<i>p</i><0.001	68.0%
<i>Heart Failure Admission Rate</i>	—	47.8	—	—	—
<i>Members With an Influenza Immunization—50–64 Years of Age</i>	—	45.8%	—	—	75.0%
<i>Members With an Influenza Immunization—65 Years of Age and Older</i>	—	46.0%	—	—	75.0%
<i>Inpatient Utilization—General Hospital/Acute Care—Total Inpatient Discharges per 1,000 Member Months</i>	—	8	—	—	—
<i>Inpatient Utilization—General Hospital/Acute Care—Maternity Discharges per 1,000 Member Months</i>	—	0	—	—	—

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level ^A (p value)	Minimum Performance Standard
<i>Inpatient Utilization—General Hospital/Acute Care—Surgery Discharges per 1,000 Member Months</i>	—	3	—	—	—
<i>Inpatient Utilization—General Hospital/Acute Care—Medicine Discharges per 1,000 Member Months</i>	—	6	—	—	—
<i>Plan All-Cause Readmissions^B</i>	—	11.5%	—	—	—
<i>18–64 Years of Age^B</i>	—	11.7%	—	—	—
<i>65+ Years of Age^B</i>	—	10.1%	—	—	—
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	48.8%	47.9%	-1.6%	p=0.545	66.0%
^A Significance levels (p values) noted in the table were calculated by AHCCCS and HSAG and demonstrate the statistical significance between performance during the previous measurement period and performance during the current measurement period. Statistical significance is traditionally reached when the p value is ≤ 0.05. Rates in bold font indicate statistically significant values.					
^B A lower rate for this measure indicates better performance.					
— CYE 2014 is a baseline reporting year for this measure; therefore, CYE 2013 Performance, Relative Percentage Change, and Significance Level are not displayed. Additionally, this measure may not yet have a CYE 2014 AHCCCS Minimum Performance Standard established.					
* CYE 2014 performance measure results are still under review by AHCCCS and its Contractors; therefore, all performance measure results provided in this report should be considered preliminary and are subject to change prior to finalization.					
** The minimum performance standards for the Children’s Access to Primary Care Practitioners measure were established for each age group, rather than, as in previous years, for the aggregate. Aggregated data are presented for informational purposes.					

Table 1-5 shows that DES/DDD’s performance during CYE 2014 demonstrated mixed results when compared to CYE 2013 and compared to the MPS values. Three aggregate measure rates exceeded the AHCCCS MPS: *Children’s Access to PCPs—12–24 Months*, *25 Months–6 Years*, and *12–19 Years*. Of these three measures, one measure, *Children’s Access to PCPs—12–19 Years*, demonstrated statistically significant increase from CYE 2013 to CYE 2014. Conversely, *EPSDT Participation* showed a statistically significant decline from the previous measurement period and failed to meet the respective AHCCCS MPS. Additionally, the rates for *Adolescent Well-Care Visits; Annual Dental Visits—2–21 Years; Dental Participation; Members With an Influenza Immunization—50–64 Years of Age and 65 Years of Age or Older; and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* fell below the AHCCCS MPS values. The remaining measure rates are presented in the table preceding for information purposes.

Conclusions

Based on HSAG’s review of the aggregate ALTCS EPD rates, positive performance was observed related to the *Initiation of HCBS* measure in CYE 2013 and *Advance Directives* measure in CYE 2014. Conversely, in both CYE 2013 and 2014, the aggregate ALTCS EPD rates indicated opportunities for improvement related to the *Dental Participation* and *EPSDT Participation* measures; and rates related to

Members With an Influenza Immunization measure indicators indicated opportunities for improvement in CYE 2014.

With regard to the DES/DDD rates, HSAG observed positive performance related to the *Annual Dental Visits—2–21 Years* measure in CYE 2013 and positive performance related to the *Children’s Access to PCPs* measure indicators for CYE 2013 and CYE 2014. However, the DES/DDD rates for *Adolescent Well-Care Visits; Dental Participation; EPSDT Participation; and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* indicated opportunities for improvement in CYE 2013 and CYE 2014. Further, rates reported for the *Annual Dental Visits—2–21 Years* and *Members With an Influenza Immunization* measures for CYE 2014 also indicated opportunities for improvement.

Recommendations

In light of the Contractors’ CYE 2013 and CYE 2014 performance, HSAG encourages AHCCCS and its Contractors to consider:

- Implementing targeted root cause analyses with detailed drill-down analyses for member and/or provider demographics to better identify subgroups within populations with disproportionately lower performance rates that adversely affected the overall rate. These types of analyses will allow for the development of population-specific interventions, addressing the members who will benefit most. These efforts should be focused on members included in the *Dental Participation, EPSDT Participation, and Members With an Influenza Immunization* measures for ALTCS EPD and *Adolescent Well-Care Visits, Dental Participation, EPSDT Participation, and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* for the DES/DDD as these rates suggest that strategic interventions are needed to improve members’ access to preventive services.
- Conducting interim performance measure calculations in addition to the formal annual evaluation could assist Contractors in identifying and eliminating barriers that contribute to decreases in performance. Quarterly performance measure reports may provide valuable insight into the effectiveness of current interventions, allowing interventions to be reassessed or repurposed for other low-performing measures in a timely manner.
- Enhancing partnerships between providers and community-based resources such as shelters, schools, and community health education programs, to manage and improve access to preventive services at the community level.

Performance Improvement Projects (PIPs)

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: October 1, 2015, through September 30, 2016, and October 1, 2016, through September 30, 2017. This annual report will include baseline measurement data and first year interventions only.

AHCCCS implemented the *E-Prescribing* PIP to improve preventable errors in communicating a medication between a prescriber and a pharmacy. Research found that clinicians make fewer errors when using an electronic system rather than handwritten prescriptions.¹⁻¹ AHCCCS found that sending electronic prescriptions can reduce mistakes related to medication types, dosages, and member information and that electronic prescribing assists pharmacies to identify potential problems related to medication management and potential reactions 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 (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 the number of prescriptions submitted electronically, followed by increased sustainment for one year.

Findings

This was the baseline reporting period for the *E-Prescribing* PIP; therefore, no comparable findings are noted. The Contractors implemented many solid interventions. For Indicator 1, the percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically, contractors' performance ranged from 36.00 percent for BHS to 58.40 percent for DES/DDD. For Indicator 2, the percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider sent electronically, contractor performance ranged from 20.20 percent for BHS to 41.30 percent for DES/DDD.

All Contractors participated in an e-prescribing workgroup (Workgroup) formed with other Arizona MCOs. The Workgroup developed two surveys. One 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.

Conclusions

Contractors implemented strong interventions in CYE 2015 for the *E-Prescribing* PIP. With the exception of BHS (with rates below the average for both Indicator 1 and Indicator 2), all Contractors were either close to (UHCCP and MCP) or substantially above (DES/DDD) AHCCCS aggregated rates for both indicators.

¹⁻¹ Electronic prescribing improves medication safety in community-based office practices. Kaushal R et al. 6, Alexandria: Springer, 2010, Journal of General Internal Medicine, Vol. 25, pp. 530-536.

Recommendations

The Contractors are encouraged to monitor the progress of the PIP interventions employed to increase provider prescribing electronically and prescriptions sent electronically and adjust interventions as needed to ensure that the rates increase by a statistically significant amount during the first remeasurement period. In addition, HSAG recommends that AHCCCS continue to encourage the collaboration among Contractors to improve the number of providers prescribing electronically and the number of prescriptions sent electronically.

Overall Findings, Conclusions, and Recommendations

ALTCS and DES/DDD Contractors are working toward improving the delivery of services and quality of care provided to their members. AHCCCS has a comprehensive system to monitor and improve the timeliness of, access to, and quality of care that Contractors provide to Medicaid members. In the focused OR, four Contractors were in full compliance for 61 percent of the 75 standards reviewed, with varied performance across six of the seven categories. No Contractors were fully compliant in all standards, and two remained noncompliant in several areas. Rates for AHCCCS-selected performance measures demonstrated marginal improvement and highlighted targeted improvement opportunities for the ALTCS Contractors. AHCCCS has selected for all lines of business a new PIP, *E-Prescribing*, which, in an effort to increase patient safety, measures the number of providers that write electronic prescriptions and the number of prescriptions submitted electronically.

Organizational Assessment and Structure Standards

AHCCCS conducted a comprehensive OR for each contractor during CYE 2014. Consequently, in CYE 2015, AHCCCS monitored the progress of the Contractors in implementing their CAPs for the recommendations from the 2014 OR. In addition, AHCCCS conducted a focused OR that targeted six categories of standards for review based on a combination of the Contractors' 2014 OR results. AHCCCS elected not to perform a CAP follow-up process for the CYE 2015 focused OR.

The Contractors were in full compliance for 61 percent of the 75 standards reviewed, with varied performance across six of the seven categories. Three Contractors were scored as fully compliant in the Case Management category. The General Administration and Claims and Information Systems results demonstrated the greatest opportunity for improvement. HSAG recommended that Contractors conduct internal reviews of operational systems to identify barriers that impact their compliance with AHCCCS standards.

Performance Measures

Overall, positive performance was observed related to the ALTCS EPD Contractors' initiation of home and community-based services in CYE 2013 and Contractors' documentation of advance directives in CYE 2014. Aggregate performance measure rates reported in CYE 2013 and CYE 2014 indicated opportunities for improvement for the ALTCS EPD Contractors with regard to participation in dental

services and comprehensive EPSDT services. Additionally, rates reported for documentation of influenza immunizations for adults indicated opportunities for improvement in CYE 2014.

For DES/DDD, HSAG observed overall positive performance related to the rate of children's dental visits in CYE 2013, and positive performance related to the access to primary care for children in CYE 2013 and CYE 2014. The DES/DDD rates for well-care and well-child visits for adolescents, and participation in dental services and comprehensive EPSDT services indicated opportunities for improvement in CYE 2013 and CYE 2014. Additionally, in CYE 2014, the rates of children's dental visits and documentation of influenza immunizations for adults indicated areas for potential performance improvement interventions.

Performance Improvement Projects

In CYE 2015, AHCCCS implemented for all lines of business a new PIP, *E-Prescribing*, which measures the number of providers that send prescriptions electronically and the number of prescriptions sent electronically. This PIP seeks to improve preventable errors in communicating a medication between a prescriber and a pharmacy, thereby increasing patient safety.

This was the baseline reporting period for the *E-Prescribing* PIP; therefore, no comparable findings were noted. The Contractors did, however, implement solid interventions. In addition, because this was the baseline measurement period, strong conclusions have not been identified regarding the strengths and opportunities for Contractor performance improvement. However, Contractors should continue to monitor and evaluate the effectiveness of interventions for this PIP.

Conclusions

In general, and as documented in detail in other sections of this report, ALTCS and DES/DDD Contractors made improvements in the timeliness of, access to, and quality of care they provide to Medicaid members. While several opportunities for improvement are highlighted throughout the report, the opportunities for improvement and the associated recommendations should not detract from the targeted progress made by each ALTCS Contractor.

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' QAPI strategy. The description of the QAPI strategy summarizes AHCCCS':

- Quality strategy goals and objectives.
- Operational performance standards used to evaluate Contractor performance in complying with Medicaid managed care act regulations and State contract requirements.
- Requirements and targets AHCCCS used to evaluate Contractor performance on AHCCCS-selected measures and to evaluate the validity of and improvements achieved through the Contractors' AHCCCS-required PIPs.

AHCCCS Medicaid Managed Care Program History

AHCCCS has operated throughout its 34-year history as a pioneer and recognized, respected leader in developing and managing innovative, quality, and cost-effective Medicaid managed care programs. AHCCCS' model for delivering services has always been one that emphasizes and promotes the goal of providing timely member access to quality healthcare and preventive services.

AHCCCS operates under a federal 1115 Research and Demonstration Waiver that allows for the operation of a total managed care model that mainstreams members and allows them to select their providers. AHCCCS was the first statewide Medicaid managed care system in the nation and has operated under its waiver since 1982 when it began its Acute Care program. In December 1988 AHCCCS added the 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. As part of the 2015 Budget Session, the Division of Behavioral Health Services (DBHS) merged with AHCCCS.

AHCCCS contracts with private and public MCOs to provide services to its members statewide. Within the AHCCCS program, the MCOs are called "Contractors."

AHCCCS' Strategic Plan

AHCCCS' Strategic Plan for State Fiscal Years 2015–2019 described the agency's vision, mission, and guiding principles:²⁻¹

- 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.
- Guiding Principles:
 - A Strategic Plan is the result of a collaborative process and reflects informed planning efforts by the Executive Management Team.
 - AHCCCS continues to pursue multiple long-term strategies already in place that can effectively bend the cost curve including system alignment and integration, payment modernization, tribal care coordination, program integrity, health information technology, and continuous quality improvement initiatives.
 - Success is only possible through the retention and recruitment of high quality staff.
 - Program integrity is an essential component of all operational departments and when supported by transparency, promotes efficiency and accountability in the management and delivery of services.
 - AHCCCS must continue to engage stakeholders regarding strategic opportunities.

The six focus areas of the strategic plan are: (1) delivery system alignment and integration, (2) payment modernization, (3) tribal care coordination initiative, (4) program integrity, (5) health information technology, and (6) quality assessment and performance improvement strategy.

AHCCCS Strategic Goals and related Strategies are as follows:

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

- Increase transparency by providing relevant financial and quality information.
- Implement and maintain shared savings requirements for all ALTCS and Acute Care Contractors excluding Children's Rehabilitative Services (CRS), Comprehensive Medical and Dental Program (CMDP), and the Regional Behavioral Health Authority (RBHA).
- Modernize hospital payments to better align incentives, increase efficiency and improve the quality of care provided to members.
- Establish robust Payment Modernization stakeholder input opportunities.

²⁻¹ *AHCCCS Strategic Plan 2015–2019*—December 2014. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan_15-19.pdf. Accessed on: Oct 17, 2016.

- Achieve the Program Integrity Plan goals that improve Third Party Liability (TPL), Coordination of Benefits (COB), and Fraud and Abuse programs.

AHCCCS must pursue continuous quality improvement.

- Continue to promote and evaluate access to care.
- Continue to improve health outcomes for the integrated populations (CRS and serious mental illness [SMI]).
- Achieve statistically significant improvements on Contractor PIPs.
- Achieve statistically significant improvements on quality performance measures.
- Leverage American Indian care management program to improve health outcomes.

AHCCCS must reduce the systematic fragmentation that exists in healthcare delivery to develop an integrated system of healthcare.

- Align and integrate the model for individuals with SMI and Dual-eligible members.
- Pursue Care Coordination opportunities in System.
- Leverage Health Integration Technology (HIT) investments to create more data flow in healthcare delivery system.
- Build analytics into actionable solutions.
- Build a web-based system (Health-e-Arizona Plus) in accordance with federal timelines and requirements that improve the accuracy and efficiency of the eligibility determination process for Medicaid and Children’s Health Insurance Program (CHIP).

AHCCCS must maintain core organizational capacity and workforce planning that effectively serves AHCCCS operations.

- Pursue continued deployment of electronic solutions to reduce healthcare administrative burden.
- Continue to manage workforce environment, promoting activities that support employee engagement and retention; and address potential gaps in the organization’s knowledge base due to retirements and other staff departures.
- Strengthen system-wide security and compliance with privacy regulations related to all information/data by evaluating, analyzing and addressing potential security risks.
- Maintain Information Technology (IT) network infrastructure, including server-based applications, ensuring business continuity.

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 438.200 and 438.202 implement Section 1932(c)(1) of the Medicaid managed care act, defining certain Medicaid state agency responsibilities. The regulations

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 must, in part:

- Conduct periodic reviews to examine the scope and content of its quality strategy and evaluate the strategy's effectiveness.
- Ensure compliance with standards established by the state that are consistent with federal Medicaid managed care regulations.
- Update the strategy periodically, as needed.
- Submit to CMS a copy of its initial strategy, a copy of the revised strategy whenever significant changes have occurred in the program, and regular reports describing the implementation and effectiveness of the strategy.

AHCCCS has had a formal QAPI plan in place since 1994, established and submitted an initial quality strategy to CMS in 2003, and has continued to update and submit revisions of the strategy as needed to CMS. AHCCCS' QAPI strategy was last revised in December 2014. AHCCCS administration oversees the overall effectiveness of its QAPI strategy with several divisions/offices within the agency sharing management responsibilities. For specific initiatives and issues, AHCCCS frequently involves other internal and/or external collaborations/participants.

Quality Strategy Scope, Goals, and Objectives

As mentioned earlier, AHCCCS' vision statement is, "Shaping tomorrow's managed healthcare from today's experience, quality, and innovation." Its mission statement is, "Reaching across Arizona to provide comprehensive, quality health care to those in need."

AHCCCS uses a workgroup model for considering and deciding whether to add new clinical or non-clinical projects for enhancing the well-being of its members. The first step is to review the current components of AHCCCS' quality initiatives and examine the various processes in place to develop, review, and revise quality measures. Following the review, the workgroup reviews AHCCCS' materials that define and illustrate the agency's focus on quality, its approach to quality improvement, and existing quality measurement initiatives and processes. AHCCCS is also diligent in identifying and incorporating opportunities to improve care coordination through designing new or enhancing current projects and programs that include more than one aspect of a member's healthcare needs.

The specific components of AHCCCS' Quality Strategy include, but are not limited to, activities such as:

- Facilitating stakeholder involvement through venues such as collaborative relationships with sister agencies, such as the Arizona Department of Health Services and the Arizona Department of Economic Security; task forces, such as the Fetal Alcohol Spectrum Disorder Task Force; and

agencies dedicated to specific issues, such as the Behavioral Health Children’s Executive Committee.

- Developing and accessing the quality and appropriateness of member care and services, including identifying priority areas for improvement; establishing realistic outcome-based performance measures; identifying, collecting, and assessing relevant data; providing incentives for excellence; imposing sanctions for poor performance, and sharing best practices.
- Including medical quality assessment and quality improvement requirements in AHCCCS contracts (e.g., including all federally required elements in contracts and monitoring related performance).
- Regularly monitoring and evaluating Contractor compliance and performance by conducting desk- and on-site operational reviews; reviewing required Contractor deliverables; and reviewing, analyzing, and validating required Contractor performance measures and PIP results.
- Maintaining an information system that supports initial and ongoing operations and review of the established quality strategy through the use of an automated statewide managed care data system that supports the processing, reporting, research, and project needs of AHCCCS and the Contractors.
- Reviewing, revising, and beginning new projects in any given area of the quality strategy, such as identifying needs for new projects or initiatives based on information from performance results, stakeholder input, and new mandates.
- Involving the public, such as the State Medicaid Advisory Committee, physicians, and others associated with the medical community at large, and other State agencies.
- Frequently evaluating the quality strategy to ensure that it remains aligned with new federal and State regulations/mandates, programs, funding, technologies, and opportunities for improvement.

Operational Performance Standards

At least every three years, AHCCCS reviews Contractor performance in complying with standards in a number of performance areas to ensure Contractor compliance with Medicaid managed care act requirements and AHCCCS contract standards. AHCCCS conducts ORs and reviews Contractor deliverables to meet the requirements of the Medicaid managed care regulations (42 CFR 438.364). AHCCCS also conducts the reviews to determine the extent to which each Contractor complied with other federal and State regulations as well as AHCCCS contract requirements and policies. As part of the ORs, AHCCCS staff review Contractor progress in implementing recommendations made during prior ORs and determine each Contractor’s compliance with its own policies and procedures.

Developing and Assessing the Quality and Appropriateness of Care and Services for Members

AHCCCS assures a continual focus on optimizing members’ health and healthcare outcomes, and maintains a major focus on ongoing development and continual refinement of quality initiatives.

AHCCCS operates from a well-established objective and systematic process in identifying priority areas for improvement and selecting new Contractor-required performance measures and PIPs. The process

involves a review of internal and external data sources. AHCCCS also considers the prevalence of a particular condition, the population affected, and the resources required by both AHCCCS and the Contractors to conduct studies and drive improvement. AHCCCS also:

- Considers whether the areas represent CMS' and/or State leadership priorities and whether they can be combined with existing initiatives, preventing duplication of efforts.
- Ensures that initiatives are actionable and result in quality improvement, member satisfaction, and system efficiencies.
- Solicits Contractor input when prioritizing areas for targeting improvement resources.

Performance Measure Requirements and Targets

AHCCCS has been a leader in developing, implementing, and holding Contractors accountable to performance measurements. AHCCCS' consistent approach for performance expectations has resulted in performance measures with rates closer to the NCQA HEDIS national Medicaid mean. AHCCCS has made the decision to transition to measures found in the CMS Core Measure Sets that provide a better opportunity to shift the systems toward indicators of health outcomes, access to care, and member satisfaction.

For all lines of business, AHCCCS developed new performance measures that became effective October 1, 2014, which aligned with the start of a new contract period. This allowed AHCCCS to align with the CMS measure sets for the Children's Health Insurance Program Reauthorization Act (CHIPRA) Core Measure Set, the Adult Core Measure Set, and Meaningful Use.

It is AHCCCS' goal to continue to develop and implement additional core measures as the data become available. Initial measures were chosen based on a number of criteria that included the greatest need for members, system ability to impact/improve results, alignment with national measure sets, and comparability across lines of business. AHCCCS anticipates that transitioning the measure sets will support the adoption of electronic health records and the use of the health information exchange, resulting in efficiencies and data/information that will transform care practices, improve individual member outcomes and population health management, improve member satisfaction, and reduce costs.

AHCCCS has undergone extensive planning efforts, including barrier and risk identification, in its effort to implement the performance measure transition. To assist in the transition and to reduce risks that AHCCCS identified, AHCCCS contracted with HSAG to perform the measurement calculations for the CYE 2014 measurement period. Contractors will be given data for planning and implementation efforts. Workgroups, new reporting mechanisms, increased opportunities for technical assistance, and a more transparent reporting process are all efforts to assist the plans prior to the end of the measurement period, allowing them to make the necessary adjustments and payment reform initiatives that align with the performance measure thresholds. Finally, AHCCCS has contracted with a vendor that is capable and interested in partnering to develop and implement measures from the CMS Core and other measures sets in addition to maintaining the traditional HEDIS measures.

Performance Improvement Project Requirements and Targets

AHCCCS' QAPI strategy described the agency's requirements and processes to ensure that Contractors conduct PIPs, which the QAPI defined as "a planned process of data gathering, evaluation, and analysis to design and implement interventions or activities that are anticipated to have a positive outcome"—i.e., to improve the quality of care and service delivery. AHCCCS encourages its Contractors to conduct PIPs for topics that they select (e.g., increasing screening of blood lead levels for children, improving timeliness of prenatal care). However, AHCCCS also selects PIPs that the Contractors must conduct.

For the AHCCCS-mandated PIPs, AHCCCS and the Contractors measure performance for at least two years after the Contractor reports baseline rates and implements interventions to show not only improvement, but also sustained improvement, as required by the Medicaid managed care regulations. AHCCCS requires Contractors to demonstrate improvement, and then sustain the improvement over at least one subsequent remeasurement cycle. AHCCCS requires Contractors to submit reports evaluating their data and interventions and propose new or revised interventions, if necessary.

3. 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 ALTCS and DES/DDD Contractors as noted below:

- Validate Contractors’ PIP—Validation performed by AHCCCS.
- Validate Contractor performance measures—Validation performed by AHCCCS. CYE 2013 and 2014 performance measurement rates as well as associated findings and recommendations are included in this annual EQR technical report.
- Review Contractor performance in complying with the AHCCCS contract requirements and the federal Medicaid managed care regulations cited at 42 CFR 438.358—Review performed by AHCCCS.

AHCCCS contracted with HSAG to aggregate and analyze the data AHCCCS obtained from conducting the three mandatory activities for its ALTCS and DES/DDD Contractors and to prepare this CMS-required 2015–2016 external quality review annual report of findings and recommendations.

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 system capabilities).
- Analyze and report results, including providing conclusions and recommendations based on optional activities that AHCCCS conducted.

Technical Reporting to Assess Progress in Meeting Quality Goals and Objectives

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 also transparent with performance results, posting to its website both provider performance reports and the required quarterly reports it submits to CMS. AHCCCS also 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. HSAG provides meaningful and actionable recommendations for improving performance, for example, AHCCCS' programs, processes, policies, and procedures; data completeness and accuracy; monitoring of its Contractors' programs and performance; and the Contractors' oversight and monitoring of their providers, delegates, and vendors.

AHCCCS uses the information to assess the effectiveness of its current goals and related strategies and to provide a road map for potential changes and new goals and strategies.

AHCCCS Quality Initiatives

AHCCCS continued to demonstrate innovative, collaborative approaches to managing costs while improving the quality of systems, care, and services. Its documentation, including the Quarterly Quality Assurance/Monitoring Activity Reports, the 2015–2019 Strategic Plan, and the October 2012 Quality Assessment and Performance Improvement (QAPI) Strategy, demonstrated 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 member health outcomes.

HSAG continues to attribute much of AHCCCS’ success in driving quality improvement to having embraced the importance of these actions:

- Collaborating across departments within AHCCCS.
- Fostering and strengthening partnerships with its sister State agencies, contracted managed care organizations (i.e., Contractors) and their providers, community organizations and key stakeholders.
- Launching strong, compelling advocacy for sustaining the Medicaid managed care program, services, financing, and covered populations.
- Efficiently managing revenue and expenditures.
- Incorporating input obtained through its collaborative approach and actions in identifying priority areas for quality improvement and developing new initiatives.

Some of the key accomplishments AHCCCS highlighted in its quality plan include the following:

- Significant progress pursuing long-term strategies to bend the healthcare cost curve while improving quality outcomes and care coordination, including strategies such as:
 - Continued emphasis on care coordination and other opportunities to keep costs down.
 - System alignment and integration for three unique populations (seriously mentally ill, children’s rehabilitation services, and dual-eligible members).
- Payment modernization— Conducted demonstrations with Contractors and providers in support of payment models designed to improve alignment with incentives.
- Exchange—Addressed Medicaid coordination, including extensive analysis of its Information Technology (IT) infrastructure and efforts to move toward developing a state exchange and Medicaid expansion.
- Following CMS approval for the Medicaid Health Integration Technology (HIT) Plan, continued processing payments to eligible hospitals and providers and continued to serve on the Health-e Connection Board and the Health Information Network of Arizona Board. AHCCCS also entered into an agreement with the Health Information Network of Arizona (HINAz) to begin using its Health Information Exchange (HIE) services.

- Healthcare reform modernization—Participated with other state government agencies in developing the necessary infrastructure to manage a State Insurance Exchange while also pursuing opportunities to ensure coordination of care between the Medicaid program and those Contractors that participate in the exchange in order to manage utilization and transition of care.
- Worked collaboratively with the Arizona Association of Health Plans (AzAHP) representing the organizations that contract with AHCCCS to create a new Credentialing Alliance (CA) aimed at making the credentialing and recredentialing process easier for providers through eliminating duplication of efforts and reducing administrative burden. Prior to establishing the CA, providers had to apply for credentials with each Contractor, whereas with the CA, providers need only apply for credentialing/recredentialing once and their status is accepted by all AHCCCS' Contractors.

Selecting and Initiating New Quality Improvement Initiatives

AHCCCS further enhanced its quality and performance improvement approach in working with Contractors by selecting and initiating new quality improvement initiatives. 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 effect 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.

Collaboratives/Initiatives

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

- The Arizona Partnership for Immunization (TAPI): AHCCCS Quality Management staff regularly attend TAPI Steering Committee meetings and subcommittee meetings related to community awareness, provider issues, and adult immunizations. TAPI regularly communicates immunization trends and best practices to AHCCCS and its Contractors.
- Arizona Diabetes Steering Committee (Steering Committee): The Steering Committee is responsible for increasing adherence to evidence-based guidelines, guiding efforts to improve State policy, and implementing the Chronic Disease Self-Management Program. AHCCCS is a member of the Steering Committee and the Diabetes Coalition and works to align Medicaid policy with statewide efforts.
- Arizona Health-e Connection/Arizona Regional Extension Center: Arizona Health-e Connection (AzHeC) is a public-private community agency geared toward promotion of and provider support for EHR integration into the healthcare system. AzHeC is a key partner with AHCCCS in promoting the use of health information technology, as well as Arizona's HIE. As a subset of AzHeC, the Arizona Regional Extension Center provides technical assistance and support to Medicare- and Medicaid-eligible professionals working to adopt, implement, or upgrade an EHR in their practices and/or to achieve Meaningful Use in order to receive monetary payments through State (Medicaid) and national (Medicare) EHR incentive programs. The long-term goal is to be able to use this technology for quality improvement purposes and to improve outcomes for AHCCCS members. One of the first steps in using EHRs is with the Childhood Obesity Learning Collaborative, wherein federally qualified health center EHR data will be used to collect information for the initiative.
- Health Information Network of Arizona (HINAz): AzHeC is the umbrella company for the HINAz, which is responsible for building the state's largest electronic HIE site. HINAz partners with a multitude of community partners and stakeholders, including AHCCCS, in order to make the HIE a successful reality. To date, approximately 35 health systems (representing 55 percent of covered lives in Arizona) have signed agreements with HINAz to share health information in the HIE. Additionally, HINAz has formed a partnership opportunity with the Behavioral Health Information Network of Arizona to ensure coordination of care among physical and behavioral health providers. A fully operating HIE opened in April 2015, with many planned enhancements scheduled through 2016.
- Arizona Department of Health Services (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 (WIC) promotion and obesity issues. The nutrition coordinators present the most up-to-date information at the AHCCCS Contractor quarterly meetings.
- Arizona and Maricopa County Asthma Coalitions: AHCCCS is collaborating with ADHS, DES, community agencies, and organizations to identify and provide to Contractors quality improvement resources that can be used to support optimal health outcomes among members with asthma and other respiratory diseases.
- ADHS Bureau of Tobacco and Chronic Disease: In collaboration with ADHS, AHCCCS continued monitoring the utilization of and access to smoking cessation drugs and nicotine replacement therapy programs. AHCCCS members are encouraged to participate in ADHS' Tobacco Education and Prevention Program (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 seriously mentally ill (SMI) population, connecting members to smoking cessation and nicotine replacement programs.

- **Injury Prevention Advisory Council (IPAC):** Arizona’s injury statistics exceed the national average. In response, ADHS entered into a cooperative agreement with the Centers for Disease Control (CDC) in September 2000 to develop a systematic injury surveillance and control process. ADHS formed an internal work group called the Council with representatives from the divisions of Public Health Services, Assurance and Licensure Services, and Behavioral Health Services. An AHCCCS representative also participates in the Council to provide opportunities to implement change and interventions in the Medicaid program to prevent injuries. The Council, with input from leaders in the field of injury control, met to develop the Arizona Injury Surveillance and Prevention Plan, 2001–2005, 2006–2010, and 2012–2016. Along with development of the plan, the Council provides recommendations to ADHS on injury priorities, reviews progress in implementation, assists in problem solving, participates in revision and evaluation of the plan, and acts as a liaison between external agencies and ADHS.
- **Interventions for Members with Alzheimer or Memory Issues:** AHCCCS initiated discussions with the ADHS Bureau of Tobacco and Chronic Disease related to intervention strategies for members diagnosed with Alzheimer’s or memory issues and those at-risk for Alzheimer’s Disease. AHCCCS will implement requirements for its Contractors to use education and outreach material provided by ADHS to inform members about evidence based prevention and treatment options for individuals diagnosed or at-risk for the conditions. In addition, AHCCCS will share information about upcoming ADHS-sponsored educational and continuing medical education events for providers.
- **Emergency Medical Services (EMS) Treat and Refer Initiative:** AHCCCS began the process of studying treatment deferrals with City of Mesa EMS teams. EMS took members to the emergency department for treatment because AHCCCS had no other mechanism for payment when EMS teams were called to transport members. AHCCCS and the Mesa EMS team explored a broad-based approach to EMS care. AHCCCS is currently working on opening code sets to allow EMS teams to treat and release members as appropriate and bill for those evaluations versus billing for transport and creating an emergency department fee for the member. It is expected that EMS teams will use their training to complete a thorough assessment of the member and make the best decision for the member’s care, while limiting unnecessary treatment for the member. Members that need emergent services will be expeditiously transported; however, if there is not an emergency situation, the EMS teams can make recommendations for home care and timely follow-up with primary care physicians (PCPs).
- **ICD-10 Implementation:** While ICD-10 implementation was a national requirement, AHCCCS conducted extensive testing leading up to the implementation, resulting in a seamless transition. AHCCCS and Contractor technical teams worked closely together to ensure that the implementation was ready, further highlighting the benefit of having strong relationships with Contractors.
- **Value-Based Purchasing (VBP) Initiatives:** AHCCCS is promoting a number of VBP initiatives for both providers and Contractors. Implementation of initiatives are now contractually mandated, with requirements increasing each year. Additionally, AHCCCS leverages VBP strategies with the

Contractors on certain performance measures, strengthening the focus on initiatives that AHCCCS deems most meaningful to the populations served.

Continuing or New AHCCCS Actions and Collaborative Initiatives to Improve Performance for the ALTCS EPD and DES/DDD Contractors

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

- **Agency with Choice:** AHCCCS has developed and implemented a member-directed option, Agency with Choice. This option is available to ALTCS members who prefer to reside in their own homes. The member and provider agency enter a formal partnership agreement that allows the provider agency to act as the legal employer of a Direct Care Worker, with the member serving as the day-to-day managing employer. During CYE 2012, to progress with the implementation of the Agency with Choice member-directed option, AHCCCS worked in collaboration with a Development and Implementation Council comprised of ALTCS members, providers, community stakeholders, and Contractors—the primary function being to provide input on programmatic changes that AHCCCS needed to make in order to implement the Agency with Choice member-directed option. In CYE 2013, the primary focus was on supporting Contractors to educate members/IRs about the available service model options, including member-directed options. In CYE 2014, AHCCCS prioritized the development of tools for the purpose of assessing members’ support needs for directing their care under this option. AHCCCS planned to work in collaboration with Contractors to implement the use of these specific tools in CYE 2015, but implementation was postponed to CYE 2016 to align with other program development activities. Currently, AHCCCS is planning to develop and implement a case manager refresher training program to ensure that case managers are able to support members making informed choices about the member-directed option as well as a provider assessment tool to help providers and Contractors assess whether or not the provider agency is fulfilling its roles and responsibilities. AHCCCS is also developing performance indicators for Contractors.
- **Direct Care Workforce Development:** In March 2004, the former Governor formed the Citizens’ Workgroup on the Long Term Care Workforce (LTC Workgroup). The purpose of the LTC Workgroup was to study the issue of the direct care workforce and provide recommendations regarding potential strategies to improve the workforce. Significant activities have occurred throughout the years. In CY 2015, AHCCCS created online computer-based training (CBT) modules to support users in learning how to set up accounts and enter and access data within the online database. The CBT modules are an effective technical assistance tool for users. Additionally, AHCCCS and the Contractors formally incorporated utilization of the online database into monitoring and auditing tools for both direct care service agencies and approved direct care worker training and testing programs.
- **Arizona Dementia Coalition:** AHCCCS collaborates with this partnership composed of thought leaders in the treatment of dementia. The group discusses barriers to and interventions for reducing the use of antipsychotics in nursing homes. Fifty nursing homes across the State have agreed to

participate in this work. AHCCCS and its Contractors provide de-identified data related to this initiative and work with stakeholders to develop effective interventions.

- **Testing Experience and Functional Tools (TEFT) Experience of Care Survey for ALTCS Populations:** As one of nine states participating in the TEFT grant from CMS, Arizona participated in the first round Experience of Care Survey being tested as a member satisfaction tool. Arizona believes that this innovative tool will provide valuable insight on member perspectives for those receiving home- and community-based services. AHCCCS will conduct a second-round survey in 2017.

5. Contractor Best and Emerging Practices

HSAG, through its review of AHCCCS and Contractor documentation, had the opportunity to identify noteworthy practices in place during the period covered by this report. The following are examples that highlight approaches and practices that HSAG generally considered best and/or promising practices. This list should not be considered all-inclusive.

Bridgeway Health Solutions (BHS)

- **BHS's Member Advisory Council (Council):** The Council was implemented during 2007 to participate in providing input on policy and programs and to promote a collaborative effort to enhance the service delivery system in local communities while maintaining a member focus. The purpose of the Council is to help facilitate the quality and effectiveness of medical, behavioral, skilled nursing facility, and home and community-based services (HCBS) delivered to BHS's members, and provide a forum for providers and members as well as their families and/or guardians to have a "meaningful voice" in the development of BHS's delivery model. The Council is a service-based council that reports through the Quality Management/Performance Improvement Committee and meets quarterly.
- **Coordination with PCPs and Dentists:** Providers who appear to have a trend of noncompliant members are educated regarding required elements, targeted for other education and partnering efforts to increase compliance, and re-evaluated in six months. The Quality Management (QM) Department conducts medical record reviews of a statistically valid random sample of EPSDT-eligible members' records to ensure that dentists provide all age-appropriate, AHCCCS-required elements during dental visits. The Maternal Child Health (MCH) coordinator also reviews dental information received from providers on a case-to-case basis to ensure that appropriate screenings and services are conducted.
- **Member Coordination with Community Agencies:** When an indication for follow-up or coordination of care with a community agency is noted, personal outreach to each member is instigated by the case manager or MCH coordinator. BHS has initiated relationships with experienced local community agencies and resources in order to reduce barriers to healthcare for members. These community-based agencies/resources assist to provide good health outcomes.

Mercy Care Plan (MCP)

- **Medical Record Review (MRR):** It is MCP's policy to monitor the quality and effectiveness of preventive care and treatment provided to MCP members by participating (contracted) physicians and other healthcare professionals through MRRs. Member medical records are evaluated for accuracy and completeness of documentation regarding the member's health status, health needs, and health services provided for the member and any resulting changes over time. MCP confirms that the record is kept up to date, well organized and comprehensive, inclusive of information

obtained from consultations and referrals and/or other healthcare professionals and providers, and has sufficient detail to promote effective patient care and quality review. MCP confirms that the physician or other healthcare professional within the group reviews diagnostic information and reports resulting from referrals, consultations, hospitalizations, and emergency/urgent care. The MRR verifies that the physician or other healthcare professional within the group provides and coordinates care with behavioral healthcare professionals, if applicable. This component is reviewed using evaluation criteria specific to the diagnosis and treatment of anxiety, depression, and attention deficit hyperactivity disorder (ADHD).

- **Mercy Care Plan (MCP) Integrated Care Management (ICM) Program:** The purpose of the ICM program is to help members diagnosed with targeted chronic illnesses or conditions to better manage their illness or condition. ICM services are offered with the intent of reducing the frequency and severity of exacerbations, promoting more efficient use of healthcare resources, and achieving optimal health outcomes. The ICM program assists practitioners and providers in managing members diagnosed with targeted chronic illnesses like asthma, diabetes, chronic obstructive pulmonary disease, heart failure, and depression. These targeted illnesses—that frequently result in exacerbations and hospitalizations, require high usage of certain resources, and incur in high costs—have been shown to respond to coordinated management strategies.

UnitedHealthcare LTC (UHCCP)

- **Practitioner Accessibility and Availability Monitoring:** Practitioner access and availability monitoring is conducted periodically to measure performance against established standards for reasonable geographic location of practitioners, number of practitioners, appointment availability, provision for emergency care, and after-hours service. Monitoring activities include provider surveys, on-site visits, evaluation of member satisfaction, evaluation of complaints, geo-access surveys, and the number of closed primary physician panels. Specific deficiencies are addressed with a corrective action plan, and follow-up activity is conducted to reassess compliance.
- **The Clinical Practice Consultant (CPC) Program:** The CPC program, under QM, serves as an individual point of contact for provider offices in support of member access to care and assists in the management of clinical requirements that are part of the Healthcare Effectiveness Data and Information Set (HEDIS[®])⁵⁻¹ and the AHCCCS clinical performance measures. The CPC program partners with providers in the management of their member panel by completing on-site visits. The CPC staff meet with providers regularly to discuss expectations about the delivery of preventive services to members. The focus is on the quality metrics important for the individual. In addition, the CPC staff work with providers to ensure that all appropriate services are billed, to ensure that all care is captured in the claims system.
- **The Accountable Care Community (ACC) Model:** The ACC model envisioned by UHCCP requires an alignment with measurable goals to improve care. This approach strives to provide primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and

⁵⁻¹ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

culturally effective. Cross-functional teams drive accountable care community integration at the practice level and in support of “Communities of Care”—extending beyond the organization and the accountable care community practice to include the hospital clinical teams and other partners in care (behavioral health services). This creates an ACC driven by a common goal: to improve patient care. UHCCP accountable care consultants are assigned by practice and engage in active collaboration with practice clinical leaders to significantly improve the delivery of high-quality care and service to members. The goal is to improve use of evidence-based care and reduce inappropriate emergency room (ER) use and admissions by providing practices with real-time actionable data on access to care, ER utilization, admissions, discharges, care opportunities, and timely PCP follow-up.

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

- **Consumer/Family Grievances Tracking:** Consumer/family grievance tracking is accomplished through the Consumer Resolution Tracking System (CRTS). Monthly Data from the Consumer Resolution System is tracked and trended; statistics are produced, evaluated and shared with program management staff to identify solutions to various issues and/or systemic concerns. Within 30 days of identifying a systemic concern, DES/DDD will develop an action plan to correct the systemic issue. From date of completed corrective action, monthly data will be provided to DES/DDD management so that they can determine the success of the action plan.
- **Calls with Children’s Rehabilitative Services (CRS):** Every two weeks, the Behavioral Health Unit (BHU)—including the behavioral health manager, behavioral health coordinator, behavior analyst, district behavioral health specialists, and the medical director (when available)—participate in telephone calls (called DDD rounds) with UHCCP-CRS staff to discuss complex members’ needs, barrier resolution, and service delivery options to better coordinate the care and treatment provided to these members. The district behavioral health specialists are encouraged to forward names of members for discussion in addition to those identified by the BHU and UHCCP-CRS. With the implementation of the High-Need, High-Cost (HNHC) program, the BHU will be using one of these monthly calls to staff the jointly-served members in this program.

6. Organizational Assessment and Structure Performance

According to 42 CFR 438.358, which describes activities related to external quality reviews, a state Medicaid agency, its agent that is not an MCO or PIHP, or an EQRO must conduct a review within a three-year period to determine MCO and PIHP compliance with state standards. In accordance with 42 CFR 438.204(g), these standards must be as stringent as the federal Medicaid managed care standards described at 42 CFR 438 that address requirements related to access, structure and operations, and measurement and improvement. 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' performance in complying with federal and AHCCCS requirements. As permitted by 42 CFR 438.258(a), AHCCCS elected to conduct the functions associated with the Medicaid managed care act mandatory compliance review activity. In accordance with, and satisfying, the requirements of 42 CFR 438.364(a) (1-5), AHCCCS then contracted with HSAG as an EQRO, to use the information AHCCCS obtained from its compliance review activities to prepare this 2015–2016 annual external quality review report.

CYE 2013 commenced a new, three-year cycle of ORs; and AHCCCS conducted a comprehensive OR for the ALTCS and DES/DDD Contractors during CYE 2014. During CYE 2015, AHCCCS monitored Contractors' progress implementing CAPs for the recommendations from the 2014 OR. In addition, AHCCCS conducted a focused OR that targeted specific standards for review based on a combination of the Contractors' 2014 OR results. AHCCCS elected not to perform a CAP follow-up process for the CYE 2015 focused OR; however, AHCCCS made clear to the Contractors the expectation that any issues identified be addressed and corrected. AHCCCS will follow up at the next full OR.

The results of the focused OR are described in this section of the annual EQR report. Two contractors (MCP and UHCCP) offering more than one line of business received an OR during CYE 2015 for each line of business; however, only results pertaining to ALTCS standards are presented here.

Conducting the Review

For the CYE 2015 focused OR, AHCCCS reviewed specific standards in various categories for each Contractor. Standards reviewed varied by Contractor. Details regarding the standards reviewed for each Contractor are included in the findings.

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 Statute, the Arizona Administrative Code (AAC), and Medicaid managed care regulations (42 CFR Part 438).
- Increase AHCCCS' knowledge of the Contractor's operational encounter processing procedures.
- Provide technical assistance and identify areas where the Contractor can improve, as well as areas of noteworthy performance and accomplishments.
- Review the Contractor's progress in implementing recommendations 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 monitors 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.⁶⁻¹

AHCCCS conducted a focused review of Contractor performance in meeting standards. AHCCCS provided the Contractors with: (1) a detailed description of the contract requirements and expectations for each of the standards that AHCCCS reviewed, and (2) a list of documents and information that was to be available to AHCCCS for its review during the OR process.

AHCCCS' methodology for conducting the OR included the following:

- Activities that AHCCCS conducted to assess the Contractors' performance, including:
 - Reviewing documents and deliverables the Contractors were required to submit to AHCCCS.
 - Conducting interviews with key Contractor administrative and program staff. Compliance reviews generally require three to four days, depending on the extent of the review.
- Activities AHCCCS conducted following the review, including:
- Documenting and compiling the results of its reviews, preparing the draft reports of findings, and issuing the draft reports to the Contractors for their review and comment. In the report, each standard

⁶⁻¹ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQRO Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQRO)*, Version 2.0, September 2012. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>. Accessed on: June 28, 2016.

and substandard was individually listed with the applicable performance designation based on AHCCCS' review findings and assessment of the degree to which the Contractor was in compliance with the standards. Performance designations were as follows:

- Full compliance (FC): 90 percent to 100 percent compliant
- Substantial compliance (SC): 75 percent to 89 percent compliant
- Partial compliance (PC): 50 percent to 74 percent compliant
- Noncompliance (NC): 0 percent to 49 percent compliant
- Compiling a report to send to Contractors that included, when applicable, AHCCCS recommendations, which began with one of the following three phrases:
 - *The Contractor must* This statement indicates a critical noncompliant area that must be corrected as soon as possible to be in compliance with the AHCCCS contract.
 - *The Contractor should* This statement indicates a noncompliant area that must be corrected to be in compliance 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.
- Reviewing and responding to any Contractor challenges to AHCCCS' draft report findings and, as applicable based on AHCCCS' review of the challenges, revising the draft report.
- Issuing the final report to the Contractor describing the findings, scores, and required CAPs for each standard that AHCCCS reviewed.

AHCCCS' review team members included employees of the Division of Health Care Management (DHCM) in medical and case management, operations, and clinical quality management units.

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 the Contractors. HSAG then analyzed the data by performance category (e.g., Quality Management).

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

Contractor-Specific Results

For CYE 2015 AHCCCS conducted a focused OR that targeted specific categories of OR standards for each Contractor. Within these standard categories, AHCCCS chose specific sub-standards for review. Contractor specific results are presented below.

Bridgeway Health Solutions (BHS)

BHS has contracted with AHCCCS since 2006 for the ALTCS population.

Findings

For CYE 2015 AHCCCS conducted a focused OR that targeted four categories of OR standards. Within these standard categories, AHCCCS chose specific sub-standards to be reviewed. Table 6-1 presents the overall compliance results and results for each standard reviewed.

Table 6-1—Category of Standards and Compliance Scores for BHS

Category of Standards	Total No. of Standards	Full Compliance	Substantial Compliance	Partial Compliance	Non-compliance
Claims and Information Systems	5	0	0	1	4
Maternal and Child Health and EPSDT	7	6	1	0	0
Case Management	1	1	0	0	0
Quality Management	1	1	0	0	0
Totals	14	8	1	1	4
% Totals		57%	7%	7%	29%

Table 6-1 illustrates the following compliance results for the 14 standards reviewed for the BHS focused OR:

- Claims and Information Systems: For the five standards reviewed, the BHS received one *Partial Compliance* score and four *Noncompliance* scores.
- Maternal and Child Health and EPSDT: *Full Compliance* for six standards reviewed and *Substantial Compliance* for one standard reviewed.
- Case Management: *Full Compliance* for the one standard reviewed.
- Quality Management: *Full Compliance* for the one standard reviewed.

Strengths

For this focused review AHCCCS reviewed a total of 14 standards in four categories. BHS was fully compliant in the one standard reviewed for Case Management and the one standard reviewed for Quality Management.

Opportunities for Improvement and Recommendations

The results of the focused OR demonstrated opportunities for improvement as BHS was less than fully compliant in the five standards reviewed for Claims and Information Systems and the seven standards reviewed for Maternal and Child Health and EPSDT. In the report generated from BHS' OR, AHCCCS included recommendations for BHS, which necessitated submitting CAPs. AHCCCS included the following recommendations in the final OR report to BHS.

Claims and Information Systems:

- For all remits issued by the Contractor directly or through its Subcontractors, the remits must include an adequate description of all denials and adjustments; the amount billed; the amount paid; the correct application of Coordination of Benefits and copays; provider rights for claim disputes; and instruction for the submission of claim disputes or corrected claims.
- The Contractor must pay applicable interest on all claims, including overturned claims disputes.
- The Contractor must ensure that it processes and pays all overturned claims disputes in a manner consistent with the decision within 15 days of the decision.
- The Contractor must appropriately apply provider demographic information such as category of service data.
- The Contractor's policy should address auditing for accuracy of payment and ensure that 100 percent of providers' contracts are audited within five years. In absence of a signed contract, the Contractor should reimburse according to the AHCCCS Fee for Service Rate Schedule.

Maternal and Child Health and EPSDT:

- The Contractor must have a process to educate providers about AzeIP, including the need for providers to request authorization from the Contractor to provide medically necessary services.

Summary

BHS was fully compliant with all standards reviewed for both Case Management and Quality Management (two standards total). For Maternal and Child Health and EPSDT (seven standards total) BHS received *Full Compliance* for six standards and *Substantial Compliance* for one standard. For Claims and Information Systems (five standards total) BHS received *Partial Compliance* and *Noncompliance* scores only. BHS has submitted corrective action plans to AHCCCS for these standards, which will be reevaluated for compliance at the next OR.

Mercy Care Plan (MCP)

MCP has contracted with AHCCCS since 2000 for the ALTCS population. AHCCCS conducted the focused OR in CYE 2015, concurrent with the focused OR for MCP’s Acute Care line of business.

Findings

For CYE 2015 AHCCCS conducted a focused OR that targeted three categories of OR standards. Within these standard categories, AHCCCS chose specific sub-standards to be reviewed. Table 6-2 presents the overall compliance results and results for each standard reviewed.

Table 6-2—Category of Standards and Compliance Scores for MCP

Category of Standards	Total No. of Standards	Full Compliance	Substantial Compliance	Partial Compliance	Non-compliance
Claims and Information Systems	4	3	0	1	0
Maternal and Child Health and EPSDT	4	4	0	0	0
Case Management	1	1	0	0	0
Totals	9	8	0	1	0
% Totals		89%	0%	11%	0%

Table 6-2 illustrates the following compliance results for the nine standards reviewed for the MCP focused OR:

- Claims and Information Systems: For the four standards reviewed, MCP received three *Full Compliance* scores and one *Partial Compliance* score.
- Maternal and Child Health and EPSDT: *Full Compliance* for the four standards reviewed.
- Case Management: *Full Compliance* for the one standard reviewed.

Strengths

For this focused review AHCCCS reviewed a total of nine standards in three categories. MCP was fully compliant in the four standards reviewed for Maternal and Child Health and EPSDT and the one standard reviewed for Case Management.

Opportunities for Improvement and Recommendations

The results of the focused OR demonstrated opportunities for improvement as MCP was less than fully compliant in the four standards reviewed for Claims and Information Systems. In the report generated

from MCP’s OR, AHCCCS included recommendations for MCP, which necessitated submitting CAPs. AHCCCS included the following recommendation in the final OR report to MCP.

Claims and Information Systems:

- The Contractor must ensure that it accurately pays applicable interest on overturned claim disputes.

Summary

MCP was fully compliant for all standards reviewed for both Maternal and Child Health and EPSDT (five standards) and Case Management (one standard). For Claims and Information Systems (four standards total), MCP was fully compliant three standards reviewed and partially compliant one standard reviewed. MCP has submitted corrective action plans to AHCCCS for these standards, which will be reevaluated for compliance at the next OR.

UnitedHealthcare Community Plan-LTC (UHCCP-LTC)

UHCCP-LTC has contracted with AHCCCS since 1989 for the ALTCS population, though the Contractor was previously referred to as Evercare Select. AHCCCS conducted the OR in CYE 2015, concurrent with the OR for UHCCP’s Acute Care and Children’s Rehabilitative Services lines of business.

Findings

For CYE 2015 AHCCCS conducted a focused OR that targeted one category of OR standards. Table 6-3 presents the compliance standard and compliance score results reviewed for UHCCP-LTC.

Table 6-3—Category of Standards and Compliance Scores for UHCCP-LTC

Category of Standards	Total No. of Standards	Full Compliance	Substantial Compliance	Partial Compliance	Non-compliance
Case Management	1	0	1	0	0
Totals	1	0	1	0	0
% Totals		0%	100%	0%	0%

Table 6-3 illustrates the following compliance result for the one standard reviewed for the UHCCP-LTC focused OR:

- Case Management: *Substantial Compliance* for the one standard reviewed.

Strengths

UHCCP-LTC was not in full compliance with the one category reviewed; however, it is a strength that UHCCP-LTC had just one standard out of compliance for the focused OR.

Opportunities for Improvement and Recommendations

Results of the focused OR demonstrated opportunities for improvement as UHCCP-LTC was less than fully compliant in the one standard reviewed for Case Management. In the report generated from UHCCP-LTC's OR, AHCCCS included recommendations for UHCCP-LTC, which necessitated submitting CAPs. AHCCCS included the following recommendations in the final OR report to UHCCP-LTC.

Case Management

- In addition to the CAP, the Contractor was also required to submit a Caseload Report for July 2015 (when 10 case managers are expected to be assigned full caseloads), by August 10, 2015 to demonstrate compliance with the Weighted Caseload Standards.

Summary

For this focused OR, AHCCCS reviewed one standard within one category. UHCCP-LTC was substantially compliant for the standard reviewed for Case Management. UHCCP-LTC has submitted a CAP to AHCCCS for this standard, which will be reevaluated for compliance at the next OR.

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

CYE 2013 began a three-year cycle of ORs and, within this cycle, AHCCCS conducted an OR for DES/DDD early in CYE 2014. The results of the CYE 2014 OR were reported in the CYE 2013 external quality review report. AHCCCS' subsequent OR-related activities during CYE 2014 were limited to oversight of the 72 CAPs resulting from the CYE 2014 OR findings.

Findings

For CYE 2015 AHCCCS conducted a focused OR that targeted seven categories of OR standards. Within these standard categories, AHCCCS chose specific sub-standards to be reviewed. Table 6-4 presents overall compliance results and results for each standard reviewed.

Table 6-4—Category of Standards and Compliance Scores for DES/DDD

Category of Standards	Total No. of Standards	Full Compliance	Substantial Compliance	Partial Compliance	Non-compliance
Case Management	2	2	0	0	0
Claims and Information Systems	6	1	1	2	2
General Administration	9	3	0	2	4
Maternal and Child Health and EPSDT	8	6	1	1	0
Medical Management	12	8	0	3	1
Member Information	8	5	0	0	3
Quality Management	6	5	0	1	0
Totals	51	30	2	9	10
% Totals		58%	3.9%	17%	19%

Table 6-4 illustrates the following compliance results for the 51 standards reviewed for the DES/DDD focused OR:

- Case Management: DES/DDD received *Full Compliance* scores for the two standards reviewed.
- Claims and Information Systems: For the six standards reviewed, DES/DDD received one *Full Compliance* score, one *Substantial Compliance* score, two *Partial Compliance* scores, and two *Noncompliance* scores.
- General Administration: For the nine standards reviewed, DES/DDD received three *Full Compliance* scores, two *Partial Compliance* scores, and four *Noncompliance* scores.
- Maternal and Child Health and EPSDT: For the eight standards reviewed, DES/DDD received six *Full Compliance* scores, one *Substantial Compliance* score, and one *Partial Compliance* score.
- Medical Management: For the 12 standards reviewed, DES/DDD received eight *Full Compliance* scores, three *Partial Compliance* scores, and one *Noncompliance* score.
- Member Information: For the eight standards reviewed, DES/DDD received five *Full Compliance* scores and three *Noncompliance* scores.
- Quality Management: For the six standards reviewed, DES/DDD received five *Full Compliance* scores and one *Partial Compliance* score.

Strengths

For this focused review AHCCCS reviewed a total of 51 standards in seven categories. DES/DDD was fully compliant in the two standards reviewed for Case Management.

Opportunities for Improvement and Recommendations

The results of the focused OR demonstrated opportunities for improvement as DES/DDD was less than fully compliant in the 51 standards reviewed for the focused OR. In the report generated from DES/DDD's OR, AHCCCS included recommendations for DES/DDD, which necessitated submitting CAPs. AHCCCS included the following recommendations in the final OR report to DES/DDD.

Claims and Information Systems

- The Contractor remits for its American Indian Health Program (AIHP) must include complete descriptions of all denials and adjustments, correct language for resubmission of claims, complete instructions for the submission of claims disputes, appropriate headers on every page, and reasons for all denials and adjustments. For its ALTCS program claims, the remits must include the amount billed and the complete language for claims disputes.
- The Contractor must ensure that its claim payment system edits for primary insurance coverage are based on AHCCCS-supplied third party liability (TPL) information.
- The Contractor must ensure that it pays 10 percent per annum (calculated daily) on all non-hospital claims paid more than 45 days after the date of receipt of the clean submission; pays interest on all claim disputes as appropriate, based on the date of the receipt of the original clean submission; pays interest on clean claims for licensed skilled nursing facilities, assisted living ALTCS or home and community based providers for authorized services provided to members that are not paid within 30 calendar days after the claim is received, at the rate of one percent per month from the date the claim is submitted; and pays interest at the rate of one percent per month for each month or portion of a month following the 60th day of receipt of the clean claim for all hospital claims until the date of payment.
- The Contractor must ensure that its claims system links all adjusted claims with the original claim.

General Administration

- The Contractor must provide required new employee orientation and ongoing training for existing staff as required, based on changes to the AHCCCS program or the federal requirements. The Contractor must demonstrate how these training requirements are also passed down to its Subcontractors.
- The Contractor must have a corporate compliance officer who is an on-site official reporting directly to the Contractor's top management and who has the authority to access records and make independent referrals to the AHCCCS, Office of the Inspector General (OIG). The Contractor must also have a Compliance Committee that is accountable to the Contractor's top management and including all required representation.

- The Contractor must develop a process to immediately notify AHCCCS OIG in writing upon discovery of suspected fraud and abuse.
- The Contractor's process for training new hires and annually training existing staff must include all topics required under this standard.
- The Contractor must finalize and implement its policies related to regular auditing of the claims payments and health information system for potential fraud, and its post processing/retrospective review of claims. These audits must include documentation of the audit findings and deficiencies, and include corrective action, where appropriate.
- The Contractor must collect the required information related to its managing employees and determine whether or not any have been convicted of a criminal offense related to that person's involvement in any Medicare, Medicaid, or Title XX Service program by periodically screening the List of Excluded Individuals and Entities (LEIE) and the System of Award Management (SAM) databases.

Maternal and Child Health and EPSDT

- The Contractor must develop and implement a process that will demonstrate its monitoring of Subcontractors in coordination with the Arizona Early Intervention Program (AzEIP) and using AHCCCS/AzEIP procedure.
- The Contractor must ensure it conducts follow-up to ensure timely and appropriate treatment is received.

Medical Management

- The Contractor must document the outcome of retrospective reviews and the rationale for decisions made by appropriate clinical staff and report the results to the Medical Management (MM) Committee.
- The Contractor must develop and implement a chronic care/disease management program based on high utilization, high risk, high volume, or high cost. Likewise, the Contractor must develop measurable outcomes and planned interventions based on evidence-based guidelines for its disease management plan. The Contractor must document in the MM Committee meeting minutes the discussion of the outcomes and revisions to the program based on recommendations of the MM Committee.
- The Contractor must develop and implement policies and procedures associated with the drug utilization review (DUR) program that addresses the criteria for coverage decisions and medical necessity based on scientific evidence and standards of practice. Respectively, the Contractor must define and implement methods to educate prescribers on utilization pattern problems, including a summary of interventions used and effects on quality of care.
- The Contractor should expand the *Behavioral Health Encounter/Utilization Data Application* document into a formal policy that illustrates how the Contractor collaborates with the Regional Behavioral Health Authorities (RBHAs) to analyze blind spot data, outlines criteria for identifying

super utilizers, develops care plans with mutual goals, implements interventions to effect change, and reports outcomes.

Member Information

- The Contractor must have approved policies for new member Information packets that include AHCCCS' standards for content and distribution.
- The Contractor, at least 30 days before any effective date of change, must have approved policies for notifications to affected members concerning material changes to network and operations.
- The Contractor, prior to assigning new members, must have approved policies for monitoring and assessing PCP capacity.

Quality Management

- The Contractor, to ensure appropriate and consistent data collection, must implement an interrater reliability process if more than one person is collecting and entering data.

Summary

For this focused OR AHCCCS reviewed a total of 51 standards within seven categories. DES/DDD was fully compliant for all standards reviewed for Case Management (two standards). For the six standards reviewed for Claims and Information Systems, DES/DDD received one *Full Compliance* score, one *Substantial Compliance* score, two *Partial Compliance* scores, and two *Noncompliance* scores. For the nine standards reviewed for General Administration, DES/DDD received three *Full Compliance* scores, two *Partial Compliance* scores, and four *Noncompliance* scores. For the eight standards reviewed for Maternal and Child Health and EPSDT, the Contractor DES/DDD received six *Full Compliance* scores, one *Substantial Compliance* score, and one *Partial Compliance* score. For the 12 standards reviewed for Medical Management, DES/DDD received eight *Full Compliance* scores, three *Partial Compliance* scores, and one *Noncompliance* score. For the eight standards reviewed for Member Information, DES/DDD received five *Full Compliance* scores and three *Noncompliance* scores. For the six standards reviewed for Quality Management, DES/DDD received five *Full Compliance* scores and one *Partial Compliance* score. DES/DDD has submitted corrective action plans to AHCCCS for these standards, which will be reevaluated for compliance at the next OR.

Overall Results for ALTCS EPD Contractors

Findings

AHCCCS conducted a focused OR for the four Contractors for CYE 2015. The seven categories and numerous standards reviewed varied among Contractors, disallowing a uniform comparative analysis. However, HSAG was able to review and compare outcomes and recommendations for purposes of this report. In the seven categories evaluated during the focused OR, AHCCCS reviewed one category (Case Management) for all Contractors. AHCCCS reviewed all seven categories for DES/DDD. AHCCCS

reviewed three of four of the Contractors for Claims and Information Systems and Maternal and Child Health and EPSDT and two of four of the Contractors for Quality Management.

The Contractors' strongest performance was for the standards associated with Case Management. AHCCCS scored all Contractors fully compliant for all related standards in this category excepting UHCCP, receiving a *Substantial Compliance* score. Overall outcomes from the scoring tools indicate high performance in the Maternal and Child Health and EPSDT category as the majority of Contractors in this category scored as fully compliant.

Based on AHCCCS' review, the outcomes for the Claims and Information Systems category identified vulnerable areas that allow opportunities for improvement. For instance, AHCCCS scored BHS as non-compliant in four standards and partially compliant in one standard of five total. In addition, although MCP received three *Full Compliance* scores, the Contractor received one *Partial Compliance* score. In the same category, of six standards total, DES/DDD received scores of two *Noncompliance*, two *Partial Compliance*, one *Substantial Compliance*, and one *Full Compliance*.

In the Claims and Information Systems category, two (BHS and MCP) of the three Contractors reviewed had deficiencies related to the payment of applicable interest on all claims, including overturned claim disputes. No other commonalities in recommendations for AHCCCS were noted.

In the Maternal and Child Health and EPSDT category, two Contractors (BHS and DES/DDD) experienced challenges demonstrating a process to educate providers and monitor Subcontractors using the AHCCCS/AzEIP procedure. AHCCCS reviewed seven categories for one Contractor (DES/DDD). Although DES/DDD was fully compliant in one category (Case Management), outcomes identified challenges in the remaining six categories. In fact, AHCCCS scored *Noncompliance* in two standards in the Claims and Information Systems category, *Noncompliance* in four standards in General Administration, *Noncompliance* in one standard in Medical Management, and *Noncompliance* in three standards in Member Information.

Strengths

All Contractors, with the exception of UHCCP-LTC, had one category (Case Management) in which all related standards were scored as fully compliant. Overall, MCP had 89 percent of reviewed standards in full compliance. Two of four Contractors (BHS and MCP) had at least two categories in which all related standards were scored as fully compliant. One Contractor, MCP, had no standards scored as noncompliant and eight of the nine standards scored as fully compliant.

Opportunities for Improvement and Recommendations

All Contractors made progress in meeting the standards; however, opportunities for improvement do exist. BHS was fully compliant in only 57 percent of standards reviewed, with the highest percentage (80 percent) of noncompliance in the Claims and Information Systems. DES/DDD was noncompliant in 19 percent of standards reviewed, with 44 percent of the standards noncompliant in the General Administration area. Results from these three categories suggest targeted opportunities for improvement.

Based on AHCCCS' review of ALTCS EPD Contractor's performance in CYE 2015 and the associated opportunities for improvement identified as a result of the focused OR, HSAG recommends the following:

- Contractors should conduct internal reviews of operational systems to identify barriers that impact their compliance with AHCCCS standards, State rules, and federal regulations. Specifically, Contractors should cross-reference existing policies and procedures 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 assess current monitoring programs and activities to identify strengths and vulnerable areas. When deficiencies are noted, the Contractors should develop mechanisms to address such areas and enhance the existing processes.
- Contractors should apply lessons learned from improving performance for one category of standards to other categories. Specifically, Contractors should assess previous CAPs completed from earlier ORs to determine best practices specific to their organization to identify and correct deficient standards and monitor subsequent compliance.

Summary

All four Contractors were in full compliance for 61 percent of the 75 standards reviewed, with varied performance across six of the seven categories. Three Contractors were scored as fully compliant in the Case Management category. The General Administration and Claims and Information Systems showed the most opportunities for improvement. HSAG recommends that Contractors conduct internal reviews of operational systems to identify barriers and issues that may impact their compliance with AHCCCS standards.

7. Performance Measure Performance

In accordance with 42 CFR 438.240(b), AHCCCS requires Contractors to have a QAPI program that includes measuring and submitting AHCCCS data related to Contractor performance. Validating MCO and PIHP performance measures is one of the three mandatory EQR activities described at 42 CFR 438.358(b)(2). The requirement at 438.358(a) allows states, their agents that are not MCOs or PIHPs, or an EQRO to conduct the mandatory activities. MCOs/PIHPs can report performance results to a state (as required by the state), or the state can 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 438.258(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 AHCCCS obtained from its performance measure calculation and its data validation activities to prepare this 2015–2016 annual report.

Conducting the Review

AHCCCS calculates and reports rates for a variety of Contractor-specific and statewide aggregate performance measures to address different quality initiatives. AHCCCS collected data and reported Contractor performance for a set of performance measures selected by AHCCCS for both the CYE 2013 and CYE 2014 measurement periods. AHCCCS calculated and reported rates for the following AHCCCS-selected measures for the EPD Contractors for CYE 2013:

- *Initiation of Home and Community-Based Services (HCBS)*
- *Early Periodic Screening, Diagnostic and Treatment (EPSDT) Participation*
- *Dental Participation*

For DES/DDD in CYE 2013, AHCCCS calculated and reported performance for the following AHCCCS-required measures:

- *Adolescent Well-Care Visits*
- *Annual Dental Visits—2–21 Years*
- *Children's Access to Primary Care Providers (PCPs)—12–24 Months, 25 Months–6 Years, 7–11 Years, 12–19 Years, and Total*
- *Dental Participation*
- *EPSDT Participation*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

AHCCCS calculated and reported rates for the following AHCCCS-selected measures for the EPD Contractors for CYE 2014:

- *7 Day Follow-Up After Hospitalization for Mental Illness*
- *30 Day Follow-Up After Hospitalization for Mental Illness*
- *Advance Directives*
- *Ambulatory Care—ED Visits—Total per 1,000 Member Months*
- *Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate*
- *Dental Participation*
- *Diabetes Short-Term Complications Admission Rate*
- *EPSDT Participation*
- *Heart Failure Admission Rate*
- *Members With an Influenza Immunization—50–64 Years of Age and 65 Years of Age and Older*
- *Inpatient Utilization—General Hospital/Acute Care per 1,000 Member Months—Total Inpatient, Maternity, Surgery, and Medicine*
- *Plan All-Cause Readmissions—18–64 Years of Age, 65+ Years of Age, and Total*

For DES/DDD, AHCCCS calculated and reported performance for the following AHCCCS-required measures for CYE 2014:

- *Adolescent Well-Care Visits*
- *Ambulatory Care—ED Visits—Total per 1,000 Member Months*
- *Annual Dental Visits—2–21 Years*
- *Asthma in Younger Adults Admission Rate*
- *Children’s Access to Primary Care Providers (PCPs)—12–24 Months, 25 Months–6 Years, 7–11 Years, 12–19 Years, and Total*
- *Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate*
- *Dental Participation*
- *Diabetes Short-Term Complications Admission Rate*
- *EPSDT Participation*
- *Heart Failure Admission Rate*
- *Members With an Influenza Immunization—50–64 Years of Age and 65 Years of Age and Older*
- *Inpatient Utilization—General Hospital/Acute Care per 1,000 Member Months—Total Inpatient, Maternity, Surgery, and Medicine*
- *Plan All-Cause Readmissions—18–64 Years of Age, 65+ Years of Age, and Total*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Using AHCCCS' results and statistical analysis of Contractors' performance rates, HSAG organized, aggregated, and analyzed the performance data. From its analysis, HSAG was able to draw conclusions about Contractor-specific and statewide aggregate performance related to the quality and timeliness of care and services as well as access to care and services the Contractors provided to AHCCCS members for CYE 2013 and CYE 2014.

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.
- Performed encounter data validation according to industry standards.

HSAG designed a summary tool to organize and represent the information and data AHCCCS provided for three ALTCS EPD Contractors and for DES/DDD for performance with respect to each AHCCCS-selected measure. The summary tool focused on HSAG's objectives for aggregating and analyzing the data, which were to:

- Determine Contractor performance on each of the AHCCCS-selected measures.
- Compare Contractor performance to AHCCCS' minimum performance standard (MPS) for each measure.
- Provide data from analyzing the performance results that would allow HSAG to draw conclusions about the quality and timeliness of and access to care and services furnished by individual Contractors and statewide by all Contractors.
- Aggregate and assess the AHCCCS-required Contractor CAPs to provide an overall evaluation of performance for each Contractor and statewide for all Contractors.

Methodology for Conducting the Review

For both review periods (i.e., CYE 2013 and CYE 2014) AHCCCS conducted the following activities:

- Collected Contractor encounter data associated with each State-selected measure and from member medical and/or case management records.
- Calculated, for each measure, Contractor-specific performance rates and statewide aggregate rates for all Contractors.
- Reported Contractor performance results by individual Contractor and in aggregate statewide.
- Compared Contractor performance rates with standards defined by AHCCCS' contract.

CAPs are key components of the AHCCCS Quality Strategy and general quality improvement processes serving as foundational elements to improve performance rates below contractual minimum performance standards. At the time of the production of this report, AHCCCS elected to forgo CAPs for CYE 2013 due to Contractor challenges and had not yet formally placed CAPs on Contractors for CYE 2014 data. As a result, no CAP data are included in the report for this year.

AHCCCS calculated the Contractors' performance rates for AHCCCS-selected measures using a combination of the following types of data:

- Administrative data collected from the automated managed care data system known as the Prepaid Medicaid Management Information System (PMMIS). AHCCCS selected sample members and services meeting numerator criteria from the recipient and encounter subsystems of PMMIS.
- Data the Contractors collected from medical and/or case management records and data/information from supporting documentation.

With the exception of the *Dental Participation*, *EPSDT Participation*, and *Initiation of Home and Community-Based Services (HCBS)* measures, performance measures used the Healthcare Effectiveness Data and Information Set (HEDIS[®])⁷⁻¹ or a HEDIS-like methodology for rate calculation. The HEDIS administrative methodology used for data collection in the current measurement did not differ from the methodology used for the previous measurement period. NCQA updates its methodology annually to add new codes to better identify the eligible population and/or services being measured or to delete codes that have been retired from standardized coding sets used by providers. Examples include Current Procedural Terminology (CPT) and International Classification of Diseases (ICD) coding.

For CYE 2013, the performance measure related to the timeliness of members' HCBS initiation is derived from AHCCCS contract standards. In addition to assessing the timeliness of services to members, this measure helps determine individual Contractors' compliance with AHCCCS' medical policy. Encounter data were sampled from AHCCCS' PMMIS for members newly placed in an HCBS setting other than an assisted living facility. Numerator data were based first on administrative data, and AHCCCS used medical records to confirm instances of sampled members without evidence of timely HCBS service initiation in the encounter data. Members were excluded from the sample in certain situations (e.g., the member was receiving hospice services or was hospitalized within 30 days of HCBS enrollment).⁷⁻²

⁷⁻¹ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

⁷⁻² Arizona Long Term Care System (ALTCS) Initiation of Home and Community Based Services for Elderly and Physically Disabled Members. June 2012. Pages 3–4. Available at: <https://www.azahcccs.gov/resources/Downloads/PerformanceMeasures/ALTCSHCBS2012.pdf>. Accessed on January 5, 2017.

The *EPSDT Participation* and *Dental Participation* measures were calculated by AHCCCS based only on administrative data. For these measures, AHCCCS followed a methodology that CMS had developed for the EPSDT Form 416 report and that all state Medicaid agencies must submit annually to CMS.⁷⁻³

AHCCCS analyzed Contractor-specific and statewide aggregate performance results for each measure to determine:

- If Contractor performance rates met or exceeded AHCCCS' MPS.
- The direction of any change in rates from previous measurement periods and whether or not the change was statistically significant.

Using the performance rates calculated by AHCCCS and the statistical analysis conducted by AHCCCS for each Contractor, HSAG organized, aggregated, and analyzed the data to draw conclusions about Contractor performance in providing accessible, timely, and quality care and services to AHCCCS members. When applicable, HSAG formulated and presented recommendations to improve Contractor performance rates.

Note: AHCCCS reports performance measure rates as percentages with one decimal place. While AHCCCS follows mathematical rules in rounding values to obtain a single decimal place, an exception is made when the rounded value results in a different, generally higher, integer percentage. For cases in which rounding would change the integer portion of the percentage, the results are truncated after the first decimal place. As an example of this rule, a calculated rate of 74.37 percent would be reported as 74.4 percent. However, a calculated rate of 74.99 percent would be reported as 74.9 percent because rounding would change the value to 75.0 percent. As a result of this reporting practice, calculations using accepted rounding rules may not align with the performance measure rates reported by AHCCCS.

The following sections describe HSAG's findings, conclusions, and recommendations for each Contractor as well as statewide comparative results for all Contractors for CYE 2013 and CYE 2014.

ALTCS EPD Contractor-Specific Results—CYE 2013

AHCCCS provided data to HSAG on the CYE 2013 performance measure rates for three ALTCS EPD Contractors and for DES/DDD. The three ALTCS EPD Contractors were Bridgeway Health Solutions (BHS), Mercy Care Plan (MCP), and UnitedHealthcare Community Plan (UHCCP). The measures reported in CYE 2013 have been reported since CYE 2009, and comparative data for the two most recent measurement periods are reported here. The performance measures reported for the ALTCS EPD Contractors and DES/DDD are listed in the "Conducting the Review" section above. No CAPs data are included for any Contractors in the report this year.

⁷⁻³ Technical Specifications—EPSDT Annual Participation Rate. Available at:
https://www.azahcccs.gov/resources/Downloads/PerformanceMeasures/ALTCS_CMS416EPSDTCoding_1-2011.pdf.
Accessed on December 2, 2016.

Bridgeway Health Solutions (BHS)

BHS has contracted with AHCCCS since 2006 for the ALTCS EPD population.

Findings

Table 7-1 presents the performance measure rates for BHS. The table displays the following information for each measure: CYE 2012 performance, CYE 2013 performance, the relative percentage change between the CYE 2012 and CYE 2013 rates, the statistical significance of the relative percentage change, and AHCCCS' CYE 2013 MPS.

Table 7-1—Performance Measurement Review for BHS

Performance Measure	CYE 2012 Performance	CYE 2013 Performance	Relative Percentage Change	Significance Level ^A (<i>p</i> value)	Minimum Performance Standard
<i>Dental Participation</i>	11.0%	19.1%	74.3%	<i>p</i> =0.153	46.0%
<i>EPSDT Participation</i>	43.8%	39.5%	-9.7%	<i>p</i> =0.606	68.0%
<i>Initiation of HCBS^B</i>	93.3%	94.8%	1.6%	<i>p</i> =0.650	92.0%

^A Significance levels (*p* values) noted in the table were calculated by AHCCCS and HSAG and demonstrate the statistical significance between performance during the previous measurement period and performance during the current measurement period. Statistical significance is traditionally reached when the *p* value is ≤ 0.05. Rates in bold font indicate statistically significant values.

^B HCBS = Home and Community-Based Services

CAPs

No CAPs data are included in the report for this year.

Strengths

BHS' performance for the *Initiation of HCBS* measure was a demonstrated strength for the Contractor, as this measure continued to meet the AHCCCS MPS for the third consecutive year since CYE 2011 and exceeded the CYE 2012 rate by 1.6 percentage points.

Opportunities for Improvement and Recommendations

HSAG recommends that BHS monitor the *EPSDT Participation* measure rate given its decline in performance in CYE 2013 and focus efforts on identifying improvement strategies to raise *EPSDT Participation* rates. Although the *Dental Participation* measure rate increased, the rate was well below the AHCCCS MPS. BHS should continue the interventions that were successful in raising the *Dental Participation* measure rate and apply these interventions after the CYE 2013 measurement period.

Summary

BHS’ *Initiation of HCBS* rate increased slightly and exceeded the AHCCCS MPS in CYE 2013. BHS’ *Dental Participation* rate also increased, by a relative 74.3 percent, but the measure did not meet the CYE 2013 AHCCCS MPS. The *EPSDT Participation* rate demonstrated a decrease and did not meet the CYE 2013 AHCCCS MPS. No measure increases or decreases were statistically significant.

Mercy Care Plan (MCP)

MCP has contracted with AHCCCS since 2000 for the ALTCS EPD population.

Findings

Table 7-2 presents the performance measure rates for MCP. The table displays the following information for each measure: CYE 2012 performance, CYE 2013 performance, the relative percentage change between the CYE 2012 and CYE 2013 rates, the statistical significance of the relative percentage change, and AHCCCS’ CYE 2013 MPS.

Table 7-2—Performance Measurement Review for MCP

Performance Measure	CYE 2012 Performance	CYE 2013 Performance	Relative Percentage Change	Significance Level ^A (<i>p</i> value)	Minimum Performance Standard
<i>Dental Participation</i>	34.9%	37.3%	6.9%	<i>p</i> =0.516	46.0%
<i>EPSDT Participation</i>	32.7%	31.1%	-4.8%	<i>p</i> =0.677	68.0%
<i>Initiation of HCBS</i> ^B	100.0%	98.5%	-1.5%	<i>p</i> =0.402	92.0%

^A Significance levels (*p* values) noted in the table were calculated by AHCCCS and HSAG and demonstrate the statistical significance between performance during the previous measurement period and performance during the current measurement period. Statistical significance is traditionally reached when the *p* value is ≤ 0.05. Rates in bold font indicate statistically significant values.

^B HCBS = Home and Community-Based Services

CAPs

No CAPs data are included in the report for this year.

Strengths

MCP’s rate for the *Initiation of HCBS* measure continued to show the greatest strength as this measure continued to exceed the AHCCCS MPS.

Opportunities for Improvement and Recommendations

MCP’s reported rate for the *EPSDT Participation* measure showed a decline from the previous year, resulting in a failure to meet the MPS for the third consecutive year since CYE 2011. HSAG recommends that MCP monitor the *EPSDT Participation* measure rate, given its decline in performance in CYE 2013, and focus efforts on identifying improvement strategies to raise the *EPSDT Participation* rate. Although the rate for *Dental Participation* increased between CYE 2012 and CYE 2013, the measure fell below the AHCCCS MPS. MCP should continue interventions to raise this rate after the CYE 2013 measurement period.

Summary

One measure, *Initiation of HCBS*, continued to show strong performance during CYE 2013 by exceeding the AHCCCS MPS, despite showing a slight relative decrease from CYE 2012. The other two performance measures, *EPSDT Participation* and *Dental Participation*, did not display statistically significant increases or decreases; and both fell below their respective CYE 2013 AHCCCS MPS.

UnitedHealthcare Community Plan (UHCCP)

UHCCP has contracted with AHCCCS since 1989.

Findings

Table 7-3 presents the performance measure rates for UHCCP. The table displays the following information for each measure: CYE 2012 performance, CYE 2013 performance, the relative percent change between the CYE 2012 and CYE 2013 rates, the statistical significance of the relative percentage change, and AHCCCS’ CYE 2013 MPS.

Table 7-3—Performance Measurement Review for UHCCP

Performance Measure	CYE 2012 Performance	CYE 2013 Performance	Relative Percentage Change	Significance Level ^A (<i>p</i> value)	Minimum Performance Standard
<i>Dental Participation</i>	9.8%	12.8%	31.0%	<i>p</i> =0.487	46.0%
<i>EPSDT Participation</i>	23.1%	16.7%	-27.8%	<i>p</i> =0.271	68.0%
<i>Initiation of HCBS</i> ^B	95.7%	95.7%	-0.1%	<i>p</i> =0.981	92.0%
^A Significance levels (<i>p</i> values) noted in the table were calculated by AHCCCS and HSAG and demonstrate the statistical significance between performance during the previous measurement period and performance during the current measurement period. Statistical significance is traditionally reached when the <i>p</i> value is ≤ 0.05. Rates in bold font indicate statistically significant values.					
^B HCBS = Home and Community-Based Services					

CAPs

No CAPs data are included in the report for this year.

Strengths

UHCCP's performance for the *Initiation of HCBS* measure was a demonstrated strength for the Contractor as this measure continued to exceed the AHCCCS MPS.

Opportunities for Improvement and Recommendations

While the change was not statistically significant, the percentage decrease in the rate for the *EPSDT Participation* measure, combined with the notable failure to meet the MPS for a third consecutive year since CYE 2011, indicated this measure a potential area for improvement. HSAG recommends that UHCCP monitor the *EPSDT Participation* measure rate, given its decline in performance in CYE 2013, and focus efforts on identifying improvement strategies to raise the *EPSDT Participation* rate. Additionally, although the rate for *Dental Participation* increased between CYE 2012 and CYE 2013, the measure fell well below the AHCCCS MPS. MCP should continue interventions to raise this rate after the CYE 2013 measurement period.

Summary

One measure, *Initiation of HCBS*, continued to show strong performance during CYE 2013 by remaining constant at 95.7 percent and exceeding the AHCCCS MPS. Additionally, UHCCP's *EPSDT Participation* rate showed a relative percentage change decrease of over 27 percentage points, after displaying a dramatic increase between CYE 2011 and CYE 2012, and continued to fall below the AHCCCS MPS. *Dental Participation* showed a rate increase, but also fell below the AHCCCS MPS. The changes for *EPSDT Participation* and *Dental Participation* were not statistically significant.

Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD) Results—CYE 2013

DES/DDD has contracted with AHCCCS since 1989.

Findings

Table 7-4 presents the performance measure rates for DES/DDD. The table displays the following information for each measure: CYE 2012 performance, CYE 2013 performance, the relative percentage change between the CYE 2012 and CYE 2013 rates, the statistical significance of the relative percentage change, and AHCCCS' CYE 2013 MPS.

Table 7-4—Performance Measurement Review for DES/DDD

Performance Measure	CYE 2012 Performance	CYE 2013 Performance	Relative Percentage Change	Significance Level ^A (p value)	Minimum Performance Standard
<i>Adolescent Well-Care Visits</i>	35.4%	35.1%	-1.1%	<i>p</i> =0.655	40.0%
<i>Annual Dental Visits—2–21 Years</i>	47.7%	49.4%	3.5%	<i>p</i>=0.004	49.0%
<i>Children’s Access to Primary Care Practitioners (PCPs)</i>	86.5%	87.7%	1.5%	<i>p</i>=0.002	**
<i>12–24 Months</i>	93.7%	99.0%	5.6%	<i>p</i> =0.054	85.0%
<i>25 Months–6 Years</i>	86.3%	88.1%	2.1%	<i>p</i>=0.028	80.0%
<i>7–11 Years</i>	88.0%	89.5%	1.7%	<i>p</i>=0.031	80.0%
<i>12–19 Years</i>	85.2%	86.0%	0.9%	<i>p</i> =0.254	80.0%
<i>Dental Participation</i>	36.9%	40.8%	10.5%	<i>p</i><0.001	46.0%
<i>EPSDT Participation</i>	48.1%	42.9%	-10.8%	<i>p</i><0.001	68.0%
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	51.5%	48.8%	-5.2%	<i>p</i>=0.038	52.0%
^A Significance levels (<i>p</i> values) noted in the table were calculated by AHCCCS and HSAG and demonstrate the statistical significance between performance during the previous measurement period and performance during the current measurement period. Statistical significance is traditionally reached when the <i>p</i> value is ≤ 0.05. Rates in bold font indicate statistically significant values.					
** The minimum performance standards for the <i>Children’s Access to Primary Care Practitioners (PCPs)</i> measure were established for each age group rather than, as in previous years, for the aggregate. Aggregated data are presented for informational purposes.					

CAPs

No CAPs data are included in the report for this year.

Strengths

The rates for the *Children’s Access to PCPs* measures and *Annual Dental Visits—2–21 Years* are noted as strengths for the Contractor because performance for all five measures improved and the *Children’s Access to PCPs* indicators continued to meet their respective AHCCCS MPS levels for a third consecutive year since CYE 2011.

Opportunities for Improvement and Recommendations

The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, *Adolescent Well-Care Visits*, and *EPSDT Participation* measures declined from the previous measurement period, with the rates for

Adolescent Well-Care Visits and *EPSDT Participation* declining for a third consecutive year since CYE 2011. All three measures fell below the AHCCCS MPS targets; and the declines for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *EPSDT Participation* were statistically significant. HSAG recommends that the Contractor monitor these measure rates and focus efforts on identifying strategies that could be leveraged to improve all rates related to children and adolescents receiving preventive care and screenings, which will allow progress toward meeting the AHCCCS MPS targets.

Summary

DES/DDD’s performance during CYE 2013 demonstrated mixed results when compared to CYE 2012. Five measures displayed statistically significant increases: *Children’s Access to PCPs—Total*, *Children’s Access to PCPs—25 Months–6 Years*, *Children’s Access to PCPs—7–11 Years*, *Annual Dental Visits—2–21 Years*, and *Dental Participation*. Of these five measures, three measures exceeded their MPS targets in CYE 2013 and one measure did not have an MPS. Two measures, *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *EPSDT Participation*, showed statistically significant decreases from the previous measurement period and failed to meet their respective AHCCCS MPS levels.

Comparative Results for ALTCS EPD Contractors—CYE 2013

Findings

Table 7-5 presents aggregate performance measure rates for all ALTCS EPD Contractors that had comparable data between CYE 2012 and CYE 2013. The table displays the following information for each measure: CYE 2012 performance, CYE 2013 performance, the relative percentage change between the CYE 2012 and CYE 2013 rates, the statistical significance of the relative percentage change, and AHCCCS’ CYE 2013 MPS.

Table 7-5—Performance Measurement Review for ALTCS EPD Contractors

Performance Measure	CYE 2012 Performance	CYE 2013 Performance	Relative Percentage Change	Significance Level ^A (p value)	Minimum Performance Standard
<i>Dental Participation</i>	26.6%	29.1%	9.8%	<i>p=0.351</i>	46.0%
<i>EPSDT Participation</i>	32.3%	29.6%	-8.3%	<i>p=0.371</i>	68.0%
<i>Initiation of HCBS^B</i>	96.3%	95.9%	-0.4%	<i>p=0.797</i>	92.0%

^A Significance levels (p values) noted in the table were calculated by AHCCCS and HSAG and demonstrate the statistical significance between performance during the previous measurement period and performance during the current measurement period. Statistical significance is traditionally reached when the p value is ≤ 0.05. Rates in bold font indicate statistically significant values.

^B HCBS = Home and Community-Based Services

CAPs

No CAPs data are included in the report for this year.

Strengths

One measure, *Initiation of HCBS*, met its AHCCCS MPS for a third consecutive year since CYE 2011, despite showing a slight decrease for this measure in CYE 2013.

Opportunities for Improvement and Recommendations

During CYE 2013, all ALTCS EPD Contractors and DES/DDD had opportunities for improvement because all failed to meet the AHCCCS MPS for at least one measure. Overall, the *EPSDT Participation* measure presented the greatest opportunity for improvement; neither any EPD Contractors nor DES/DDD achieved the MPS, and all Contractors showed declines in rates.

Summary

Aggregate rates for two performance measures declined among all three ALTCS EPD Contractors. However, none of these decreases were statistically significant. The Contractors continued to show potential for the second year reporting the *Dental Participation* measure as the aggregate rate improved between CYE 2012 and CYE 2013.

In addition to the decline in the rate, *EPSDT Participation* failed to meet the CYE 2013 AHCCCS MPS. The rate for the *Initiation of HCBS* measure met the AHCCCS MPS during CYE 2013, despite a small decrease.

Overall Recommendations

Please refer to the CYE 2014 comparative results section of this report for recommendations based on the most recently reported data.

ALTCS EPD Contractor-Specific Results—CYE 2014

There were no Contractor changes during CYE 2014. Several new measures were reported in CYE 2014; therefore, comparative data for the two most recent measurement periods are reported only for those measures reported in CYE 2013. The CYE 2014 performance measures reported for the ALTCS EPD Contractors and DES/DDD are listed in the “Conducting the Review” section preceding. As CYE 2014 performance measure results are still under review by AHCCCS and its Contractors, all CYE 2014 performance measure results provided in this report should be considered preliminary and are subject to

change prior to finalization. As previously noted, no CAPs data are included for any Contractors in the report this year.

Bridgeway Health Solutions (BHS)

BHS has contracted with AHCCCS since 2006 for the ALTCS EPD population.

Findings

Table 7-6 presents performance measure rates for BHS. The table displays the following information for each measure: CYE 2013 performance, CYE 2014 performance, the relative percentage change between the CYE 2013 and CYE 2014 rates, the statistical significance of the relative percentage change, and AHCCCS' CYE 2014 MPS.

Table 7-6—Performance Measurement Review for BHS

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level ^A (p value)	Minimum Performance Standard
<i>7 Day Follow-Up After Hospitalization for Mental Illness</i>	—	18.6%	—	—	—
<i>30 Day Follow-Up After Hospitalization for Mental Illness</i>	—	25.6%	—	—	—
<i>Advance Directives</i>	—	68.9%	—	—	55.0%
<i>Ambulatory Care—ED Visits—Total per 1,000 Member Months</i>	—	64	—	—	—
<i>Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate</i>	—	1371.6	—	—	—
<i>Dental Participation</i>	19.1%	34.1%	78.6%	p=0.025	46.0%
<i>Diabetes Short-Term Complications Admission Rate</i>	—	154.4	—	—	—
<i>EPSDT Participation</i>	39.5%	43.4%	9.8%	p=0.615	68.0%
<i>Heart Failure Admission Rate</i>	—	1081.1	—	—	—
<i>Members With an Influenza Immunization—50–64 Years of Age</i>	—	53.2%	—	—	55.0%
<i>Members With an Influenza Immunization—65 Years of Age and Older</i>	—	56.1%	—	—	60.0%
<i>Inpatient Utilization—General Hospital/Acute Care—Total Inpatient Discharges per 1,000 Member Months</i>	—	36	—	—	—

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level ^A (p value)	Minimum Performance Standard
<i>Inpatient Utilization—General Hospital/Acute Care—Maternity Discharges per 1,000 Member Months</i>	—	0	—	—	—
<i>Inpatient Utilization—General Hospital/Acute Care—Surgery Discharges per 1,000 Member Months</i>	—	11	—	—	—
<i>Inpatient Utilization—General Hospital/Acute Care—Medicine Discharges per 1,000 Member Months</i>	—	25	—	—	—
<i>Plan All-Cause Readmissions^B</i>	—	14.0%	—	—	—
<i>18–64 Years of Age^B</i>	—	18.5%	—	—	—
<i>65+ Years of Age^B</i>	—	11.4%	—	—	—
^A Significance levels (p values) noted in the table were calculated by AHCCCS and HSAG and demonstrate the statistical significance between performance during the previous measurement period and performance during the current measurement period. Statistical significance is traditionally reached when the p value is ≤ 0.05. Rates in bold font indicate statistically significant values.					
^B A lower rate for this measure indicates better performance.					
— CYE 2014 is a baseline reporting year for this measure; therefore, CYE 2013 Performance, Relative Percentage Change, and Significance Level are not displayed. Additionally, this measure may not yet have a CYE 2014 AHCCCS Minimum Performance Standard established.					
* CYE 2014 performance measure results are still under review by AHCCCS and its Contractors; therefore, all performance measure results provided in this report should be considered preliminary and are subject to change prior to finalization.					

CAPs

No CAPs data are included in the report for this year.

Strengths

BHS exceeded the AHCCCS MPS for one of the five measures with MPS targets in CYE 2014, *Advance Directives*. For the two measures reported in both CYE 2013 and CYE 2014 (*Dental Participation* and *EPSDT Participation*), both measures showed an increase in performance, with *Dental Participation* showing a statistically significant increase.

Opportunities for Improvement and Recommendations

The rates for *Dental Participation*, *EPSDT Participation*, *Members With an Influenza Immunization—50–64 Years of Age*, and *Members With an Influenza Immunization—65 Years of Age and Older* fell below the AHCCCS MPS. HSAG recommends that the Contractor monitor these measure rates and focus efforts on identifying strategies that could be leveraged to improve all rates related to preventive care and screenings, which will allow the Contractor to progress toward meeting the AHCCCS MPS targets.

Summary

With respect to the AHCCCS MPS targets, BHS’ *Dental Participation* rate increased dramatically, by a relative 78.6 percent; but the measure did not meet the CYE 2014 AHCCCS MPS. The *EPSDT Participation* rate demonstrated an increase, but did not meet the CYE 2014 AHCCCS MPS. BHS’ *Advance Directives* exceeded the AHCCCS MPS in CYE 2014, while the other two measures with an MPS, *Members With an Influenza Immunization—50–64 Years of Age* and *Members With an Influenza Immunization—65 Years of Age and Older*, did not meet the CYE 2014 AHCCCS MPS target, but were within 5 percentage points.

Mercy Care Plan (MCP)

MCP has contracted with AHCCCS since 2000 for the ALTCS EPD population.

Findings

Table 7-7 presents the performance measure rates for MCP. The table displays the following information for each measure: CYE 2013 performance, CYE 2014 performance, the relative percentage change between the CYE 2013 and CYE 2014 rates, the statistical significance of the relative percentage change, and AHCCCS’ CYE 2014 MPS.

Table 7-7—Performance Measurement Review for MCP

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level ^A (p value)	Minimum Performance Standard
<i>7 Day Follow-Up After Hospitalization for Mental Illness</i>	—	19.1%	—	—	—
<i>30 Day Follow-Up After Hospitalization for Mental Illness</i>	—	37.1%	—	—	—
<i>Advance Directives</i>	—	69.7%	—	—	55.0%
<i>Ambulatory Care—ED Visits—Total per 1,000 Member Months</i>	—	68	—	—	—
<i>Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate</i>	—	1647.1	—	—	—
<i>Dental Participation</i>	37.3%	44.8%	20.0%	<i>p</i> =0.067	46.0%
<i>Diabetes Short-Term Complications Admission Rate</i>	—	152.9	—	—	—
<i>EPSDT Participation</i>	31.1%	41.5%	33.3%	<i>p</i>=0.011	68.0%
<i>Heart Failure Admission Rate</i>	—	1528.9	—	—	—
<i>Members With an Influenza Immunization—50–64 Years of Age</i>	—	65.2%	—	—	55.0%

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level ^A (p value)	Minimum Performance Standard
<i>Members With an Influenza Immunization—65 Years of Age and Older</i>	—	66.8%	—	—	60.0%
<i>Inpatient Utilization—General Hospital/Acute Care—Total Inpatient Discharges per 1,000 Member Months</i>	—	46	—	—	—
<i>Inpatient Utilization—General Hospital/Acute Care—Maternity Discharges per 1,000 Member Months</i>	—	0	—	—	—
<i>Inpatient Utilization—General Hospital/Acute Care—Surgery Discharges per 1,000 Member Months</i>	—	16	—	—	—
<i>Inpatient Utilization—General Hospital/Acute Care—Medicine Discharges per 1,000 Member Month</i>	—	29	—	—	—
<i>Plan All-Cause Readmissions^B</i>	—	16.9%	—	—	—
<i>18–64 Years of Age^B</i>	—	21.2%	—	—	—
<i>65+ Years of Age^B</i>	—	13.6%	—	—	—
^A Significance levels (p values) noted in the table were calculated by AHCCCS and HSAG and demonstrate the statistical significance between performance during the previous measurement period and performance during the current measurement period. Statistical significance is traditionally reached when the p value is ≤ 0.05. Rates in bold font indicate statistically significant values.					
^B A lower rate for this measure indicates better performance.					
— CYE 2014 is a baseline reporting year for this measure; therefore, CYE 2013 Performance, Relative Percentage Change, and Significance Level are not displayed. Additionally, this measure may not yet have a CYE 2014 AHCCCS Minimum Performance Standard established.					
* CYE 2014 performance measure results are still under review by AHCCCS and its Contractors; therefore, all performance measure results provided in this report should be considered preliminary and are subject to change prior to finalization.					

CAPs

No CAPs data are included in the report for this year.

Strengths

MCP exceeded the AHCCCS MPS for three of the five measures with MPS targets in CYE 2014, *Advance Directives*, *Members With an Influenza Immunization—50–64 Years of Age*, and *Members With an Influenza Immunization—65 Years of Age and Older*. For the two measures reported in both CYE 2013 and CYE 2014 (*Dental Participation* and *EPSDT Participation*), both measures showed an increase in performance, with *EPSDT Participation* showing a statistically significant increase.

Opportunities for Improvement and Recommendations

MCP’s reported rates for *Dental Participation* and *EPSDT Participation* failed to meet the MPS targets for the fourth consecutive year since CYE 2011; thus, these measures have been identified as opportunities for improvement. HSAG recommends that the Contractor monitor these measure rates and focus efforts on identifying strategies that could be leveraged to improve all rates related to preventive care and screenings, which will allow the Contractor to progress toward meeting the AHCCCS MPS targets.

Summary

With respect to the AHCCCS MPS targets, MCP’s *EPSDT Participation* rate increased by a relative 33.3 percent, but did not meet the CYE 2014 AHCCCS MPS. The *Dental Participation* rate also demonstrated an increase, but failed to meet the CYE 2014 AHCCCS MPS. MCP’s *Advance Directives*, *Members With an Influenza Immunization—50–64 Years of Age*, and *Members With an Influenza Immunization—65 Years of Age and Older* exceeded the AHCCCS MPS in CYE 2014.

UnitedHealthcare Community Plan (UHCCP)

UHCCP has contracted with AHCCCS since 1989.

Findings

Table 7-8 presents the performance measure rates for UHCCP. The table displays the following information for each measure: CYE 2013 performance, CYE 2014 performance, the relative percentage change between the CYE 2013 and CYE 2014 rates, the statistical significance of the relative percentage change, and AHCCCS’ CYE 2014 MPS.

Table 7-8—Performance Measurement Review for UHCCP

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level ^A (p value)	Minimum Performance Standard
<i>7 Day Follow-Up After Hospitalization for Mental Illness</i>	—	14.3%	—	—	—
<i>30 Day Follow-Up After Hospitalization for Mental Illness</i>	—	28.6%	—	—	—
<i>Advance Directives</i>	—	46.3%	—	—	55.0%
<i>Ambulatory Care—ED Visits—Total per 1,000 Member Months</i>	—	55	—	—	—
<i>Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate</i>	—	885.1	—	—	—
<i>Dental Participation</i>	12.8%	3.0%	-76.4%	p=0.011	46.0%

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level ^A (p value)	Minimum Performance Standard
<i>Diabetes Short-Term Complications Admission Rate^B</i>	—	205.2	—	—	—
<i>EPSDT Participation</i>	16.7%	25.8%	54.6%	<i>p=0.122</i>	68.0%
<i>Heart Failure Admission Rate</i>	—	706.7	—	—	—
<i>Members With an Influenza Immunization—50–64 Years of Age</i>	—	43.5%	—	—	55.0%
<i>Members With an Influenza Immunization—65 Years of Age and Older</i>	—	33.5%	—	—	60.0%
<i>Inpatient Utilization—General Hospital/Acute Care—Total Inpatient Discharges per 1,000 Member Months</i>	—	14	—	—	—
<i>Inpatient Utilization—General Hospital/Acute Care—Maternity Discharges per 1,000 Member Months</i>	—	0	—	—	—
<i>Inpatient Utilization—General Hospital/Acute Care—Surgery Discharges per 1,000 Member Months</i>	—	5	—	—	—
<i>Inpatient Utilization—General Hospital/Acute Care—Medicine Discharges per 1,000 Member Months</i>	—	9	—	—	—
<i>Plan All-Cause Readmissions^B</i>	—	10.8%	—	—	—
<i>18–64 Years of Age^B</i>	—	15.4%	—	—	—
<i>65+ Years of Age^B</i>	—	5.7%	—	—	—
^A Significance levels (p values) noted in the table were calculated by AHCCCS and HSAG and demonstrate the statistical significance between performance during the previous measurement period and performance during the current measurement period. Statistical significance is traditionally reached when the p value is ≤ 0.05. Rates in bold font indicate statistically significant values.					
^B A lower rate for this measure indicates better performance.					
— CYE 2014 is a baseline reporting year for this measure; therefore, CYE 2013 Performance, Relative Percentage Change, and Significance Level are not displayed. Additionally, this measure may not yet have a CYE 2014 AHCCCS Minimum Performance Standard established.					
* CYE 2014 performance measure results are still under review by AHCCCS and its Contractors; therefore, all performance measure results provided in this report should be considered preliminary and are subject to change prior to finalization.					

CAPs

No CAPs data are included in the report for this year.

Strengths

UHCCP’s measure rate for *EPSDT Participation* improved during CYE 2014.

Opportunities for Improvement and Recommendations

UHCCP’s rate for *EPSDT Participation* improved during CYE 2014; however, the measure fell below the AHCCCS MPS. UHCCP’s reported rate for *Dental Participation* showed a statistically significant decline from CYE 2013, suggesting that an opportunity for improvement exists. HSAG recommends that the Contractor focus on interventions to improve the rate for this measure (highlighting the importance of preventive dental care) and analyze strategies that could be linked to increased rates of dental participation.

Summary

One measure, *EPSDT Participation*, improved during CYE 2014, with a relative 54.6 percent increase; but the measure did not meet the CYE 2014 AHCCCS MPS. UHCCP’s *Dental Participation* rate showed a significant relative percentage decrease of over 76 percent and continued to fall below the AHCCCS MPS. Two other measures, *Members With an Influenza Immunization—50–64 Years of Age* and *Members With an Influenza Immunization—65 Years of Age and Older*, fell below the AHCCCS MPS.

DES/DDD Results—CYE 2014

DES/DDD has contracted with AHCCCS since 1989.

Findings

Table 7-9 presents the performance measure rates for DES/DDD. The table displays the following information for each measure: CYE 2013 performance, CYE 2014 performance, the relative percentage change between the CYE 2013 and CYE 2014 rates, the statistical significance of the relative percentage change, and AHCCCS’ CYE 2014 MPS.

Table 7-9—Performance Measurement Review for DES/DDD

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level ^A (p value)	Minimum Performance Standard
<i>Adolescent Well-Care Visits</i>	35.1%	35.8%	2.1%	<i>p</i> =0.365	41.0%
<i>Ambulatory Care—ED Visits—Total per 1,000 Member Months</i>	—	41	—	—	—
<i>Annual Dental Visits—2–21 Years</i>	49.4%	52.9%	7.1%	<i>p</i><0.001	60.0%
<i>Asthma in Younger Adults Admission Rate</i>	—	70.3	—	—	—
<i>Children’s Access to Primary Care Practitioners (PCPs)</i>	87.7%	88.1%	0.4%	<i>p</i> =0.343	**

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level ^A (p value)	Minimum Performance Standard
<i>12–24 Months</i>	99.0%	93.4%	-5.6%	<i>p=0.090</i>	93.0%
<i>25 Months–6 Years</i>	88.1%	86.6%	-1.8%	<i>p=0.064</i>	84.0%
<i>7–11 Years</i>	89.5%	90.1%	0.8%	<i>p=0.294</i>	83.0%
<i>12–19 Years</i>	86.0%	87.3%	1.6%	<i>p=0.032</i>	82.0%
<i>Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate</i>	—	99.5	—	—	—
<i>Dental Participation</i>	40.8%	43.5%	6.6%	<i>p<0.001</i>	46.0%
<i>Diabetes Short-Term Complications Admission Rate</i>	—	63.7	—	—	—
<i>EPSDT Participation</i>	42.9%	36.6%	-14.7%	<i>p<0.001</i>	68.0%
<i>Heart Failure Admission Rate</i>	—	47.8	—	—	—
<i>Members With an Influenza Immunization—50–64 Years of Age</i>	—	45.8%	—	—	75.0%
<i>Members With an Influenza Immunization—65 Years of Age and Older</i>	—	46.0%	—	—	75.0%
<i>Inpatient Utilization—General Hospital/Acute Care—Total Inpatient Discharges per 1,000 Member Months</i>	—	8	—	—	—
<i>Inpatient Utilization—General Hospital/Acute Care—Maternity Discharges per 1,000 Member Months</i>	—	0	—	—	—
<i>Inpatient Utilization—General Hospital/Acute Care—Surgery Discharges per 1,000 Member Months</i>	—	3	—	—	—
<i>Inpatient Utilization—General Hospital/Acute Care—Medicine Discharges per 1,000 Member Months</i>	—	6	—	—	—
<i>Plan All-Cause Readmissions^B</i>	—	11.5%	—	—	—
<i>18–64 Years of Age^B</i>	—	11.7%	—	—	—
<i>65+ Years of Age^B</i>	—	10.1%	—	—	—
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	48.8%	47.9%	-1.6%	<i>p=0.545</i>	66.0%

^A Significance levels (p values) noted in the table were calculated by AHCCCS and HSAG and demonstrate the statistical significance between performance during the previous measurement period and performance during the current measurement period. Statistical significance is traditionally reached when the p value is ≤ 0.05. Rates in bold font indicate statistically significant values.

^B A lower rate for this measure indicates better performance.

— CYE 2014 is a baseline reporting year for this measure; therefore, CYE 2013 Performance, Relative Percentage Change, and Significance Level are not displayed. Additionally, this measure may not yet have a CYE 2014 AHCCCS Minimum Performance Standard established.

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level ^A (p value)	Minimum Performance Standard
* CYE 2014 performance measure results are still under review by AHCCCS and its Contractors; therefore, all performance measure results provided in this report should be considered preliminary and are subject to change prior to finalization.					
** The minimum performance standards for the Children’s Access to Primary Care Practitioners (PCPs) measure were established for each age group rather than, as in previous years, for the aggregate. Aggregated data are presented for informational purposes.					

CAPs

No CAPs data are included in the report for this year.

Strengths

DES/DDD continued to exceed the AHCCCS MPS targets for four of the nine performance measures with rates reported for CYE 2013 and CYE 2014 that had an MPS. The rates for the *Children’s Access to PCPs* measures are noted as strengths for the Contractor, since performance for all four measure indicators improved and continued to meet their respective AHCCCS MPS levels for a fourth consecutive year since CYE 2011.

Opportunities for Improvement and Recommendations

The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *EPSDT Participation* measures declined from the previous measurement period, with the rates for *EPSDT Participation* declining for a fourth consecutive year since CYE 2011. Both measure rates fell below the AHCCCS MPS targets, and the declines for *EPSDT Participation* were statistically significant. HSAG recommends that the Contractor monitor these measure rates and focus efforts on identifying strategies that could be leveraged to improve all rates related to children and adolescents receiving preventive care and screenings, which will allow the Contractor to progress toward meeting the AHCCCS MPS targets.

Summary

DES/DDD’s performance during CYE 2014 demonstrated mixed results when compared to CYE 2013. Three measures displayed statistically significant increases: *Annual Dental Visits—2–21 Years*, *Children’s Access to PCPs—12–19 Years*, and *Dental Participation*. Of these three measures, one measure, *Children’s Access to PCPs—12–19 Years*, exceeded its MPS in CYE 2014. One DES/DDD *EPSDT Participation* rate showed a statistically significant decline from the previous measurement period and failed to meet the respective AHCCCS MPS.

Comparative Results for ALTCS EPD Contractors—CYE 2014

Findings

Table 7-10 presents aggregate performance measure rates for all ALTCS EPD Contractors with comparable data between CYE 2013 and CYE 2014. The table displays the following information for each measure: CYE 2013 performance, CYE 2014 performance, the relative percentage change between the CYE 2013 and CYE 2014 rates, the statistical significance of the relative percentage change, and AHCCCS' CYE 2014 MPS.

Table 7-10—Performance Measurement Review for ALTCS EPD Contractors

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level ^A (p value)	Minimum Performance Standard
<i>7 Day Follow-Up After Hospitalization for Mental Illness</i>	—	17.9%	—	—	—
<i>30 Day Follow-Up After Hospitalization for Mental Illness</i>	—	32.3%	—	—	—
<i>Advance Directives</i>	—	61.6%	—	—	55.0%
<i>Ambulatory Care—ED Visits—Total per 1,000 Member Months</i>	—	63	—	—	—
<i>Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate</i>	—	1329.9	—	—	—
<i>Dental Participation</i>	29.1%	33.4%	14.6%	<i>p</i> =0.153	46.0%
<i>Diabetes Short-Term Complications Admission Rate</i>	—	170.6	—	—	—
<i>EPSDT Participation</i>	29.6%	38.3%	29.3%	<i>p</i>=0.006	68.0%
<i>Heart Failure Admission Rate</i>	—	1156.5	—	—	—
<i>Members With an Influenza Immunization—50–64 Years of Age</i>	—	54.2%	—	—	55.0%
<i>Members With an Influenza Immunization—65 Years of Age and Older</i>	—	52.2%	—	—	60.0%
<i>Inpatient Utilization—General Hospital/Acute Care—Total Inpatient Discharges per 1,000 Member Months</i>	—	33	—	—	—
<i>Inpatient Utilization—General Hospital/Acute Care—Maternity Discharges per 1,000 Member Months</i>	—	0	—	—	—

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level ^A (p value)	Minimum Performance Standard
<i>Inpatient Utilization—General Hospital/Acute Care—Surgery Discharges per 1,000 Member Months</i>	—	12	—	—	—
<i>Inpatient Utilization—General Hospital/Acute Care—Medicine Discharges per 1,000 Member Months</i>	—	21	—	—	—
<i>Plan All-Cause Readmissions^B</i>	—	15.5%	—	—	—
<i>18–64 Years of Age^B</i>	—	19.8%	—	—	—
<i>65+ Years of Age^B</i>	—	12.2%	—	—	—
^A Significance levels (p values) noted in the table were calculated by AHCCCS and HSAG and demonstrate the statistical significance between performance during the previous measurement period and performance during the current measurement period. Statistical significance is traditionally reached when the p value is ≤ 0.05. Rates in bold font indicate statistically significant values.					
^B A lower rate for this measure indicates better performance.					
— CYE 2014 is a baseline reporting year for this measure; therefore, CYE 2013 Performance, Relative Percentage Change, and Significance Level are not displayed. Additionally, this measure may not yet have a CYE 2014 AHCCCS Minimum Performance Standard established.					
* CYE 2014 performance measure results are still under review by AHCCCS and its Contractors; therefore, all performance measure results provided in this report should be considered preliminary and are subject to change prior to finalization.					

CAPs

No CAPs data are included in the report for this year.

Strengths

Of the five measures with AHCCCS MPSs reported in CYE 2014, one measure, *Advance Directives*, met its AHCCCS MPS for its first year of reporting. MCP exhibited the greatest strength in CYE 2014 for the performance measures. MCP met the AHCCCS MPS for *Advance Directives*, *Members With an Influenza Immunization—50–64 Years of Age*, and *Members With an Influenza Immunization—65 Years of Age and Older* in its first year of reporting.

Opportunities for Improvement and Recommendations

During CYE 2014, all ALTCS EPD Contractors and DES/DDD had opportunities for improvement because all failed to meet the AHCCCS MPS for at least one measure. Overall, the *EPSDT Participation* measure presented the greatest opportunity for improvement; neither any EPD Contractors nor DES/DDD achieved the MPS.

Contractors should continue to monitor the *EPSDT Participation* measure rate given the challenges with meeting the AHCCCS MPS in CYE 2014 and focus efforts on identifying improvement strategies to raise *EPSDT Participation* rates. Contractors should also investigate other root cause factors impacting

the rate of EPSDT screenings, including whether or not appropriate screenings are distributed differently among members of different age groups or geographic areas. Given the ongoing challenge of all Contractors to meet the AHCCCS MPS for the *EPSDT Participation* measure, Contractors should consider implementing improvement strategies that aim to ensure that communications with members are clear about the services available to the members as well as when those services should be used (i.e., what types of preventive screenings should be done and when they should be done). Furthermore, Contractors should ensure that care managers understand the importance and necessity of EPSDT screenings in order to effectively engage members and then schedule the appropriate preventive appointments, including providing assistance with transportation services when appropriate.

Summary

Table 7-10 shows an increase in aggregate rates for two performance measures among all three ALTCS EPD Contractors. One measure rate, *EPSDT Participation*, had a statistically significant increase but did not meet the AHCCCS MPS for CYE 2014. For the first year of reporting the *Advance Directives* measure, the Contractors showed strong performance by meeting the AHCCCS MPS for CYE 2014.

Overall Recommendations

In light of the Contractors' CYE 2014 performance, HSAG encourages AHCCCS and Contractors to consider:

- Implementing targeted root cause analyses with detailed drill-down analyses for member and/or provider demographics to better identify subgroups within populations with disproportionately lower performance rates that adversely affected the overall rate. These types of analyses will allow for the development of population-specific interventions, addressing the members who will benefit most. These efforts should be focused on members included in the *Dental Participation* and *EPSDT Participation* measures as these rates suggest that strategic interventions are needed to improve members' access to preventive services.
- Conducting interim performance measure calculations in addition to the formal annual evaluation could assist Contractors in identifying and eliminating barriers that contribute to decreases in performance. Quarterly performance measure reports may provide valuable insight into the effectiveness of current interventions, allowing interventions to be reassessed or repurposed for other low-performing measures in a timely manner.
- Enhancing partnerships between providers and community-based resources such as shelters, schools, and community health education programs, to manage and improve access to preventive services at the community level.

8. Performance Improvement Project Performance

In accordance with 42 CFR 438.240(d), and as required by AHCCCS, Contractors must have a QAPI program that (1) includes ongoing programs of PIPs designed to achieve favorable effects on health outcomes and member satisfaction, and (2) focuses on clinical and/or nonclinical areas that involve the following:

- Measuring performance using objective quality indicators
- Implementing system interventions to achieve improvement in quality
- Evaluating the effectiveness of interventions
- Planning and initiating activities for increasing and sustaining improvement

42 CFR 438.240(d) also requires each PIP to be completed in a reasonable period to allow information on the success of PIPs in the aggregate to produce new information on quality of care each year.

One of the three EQR-related activities mandated by the federal Medicaid managed care requirements and described at 42 CFR 438.358(b)(1) is the annual validation of MCO and PIHP PIPs that are required by a state and are underway during the preceding 12 months. The requirement at 42 CFR 438.358(a) allows a state, its agent that is not an MCO or PIHP, or an EQRO to conduct the mandatory and optional EQR-related activities.

Conducting the Review

AHCCCS requires Contractors to participate in AHCCCS-selected PIPs. The mandated PIP topics:

- Are selected through the analysis of internal and external data and trends and through Contractor input.
- Take into account comprehensive aspects of enrollee needs, care, and services for a broad spectrum of members.

AHCCCS performs data collection and analysis for baseline and successive measurements and reports the performance results of mandated PIPs for each Contractor and across Contractors.

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, October 1, 2015, through September 30, 2016; and October 1, 2016, through September 30, 2017. This annual report will include baseline measurement data and baseline interventions only.

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 a prescriber and a 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 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 to increase 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 increased sustainment for one year.

Objectives for Conducting the Review

In its objectives for evaluating Contractor PIPs, AHCCCS:

- Ensures that each Contractor had an ongoing performance improvement program of projects that focused on clinical and/or nonclinical areas for the services it furnished to members.
- Ensures that each Contractor measured performance using objective and quantifiable quality indicators.
- Ensures that each Contractor implemented systemwide interventions to achieve improvement in quality.
- Evaluates the effectiveness of each Contractor's interventions.
- Ensures that each Contractor planned and initiated activities to increase or sustain its improvement.
- Ensures that each Contractor reported to the State data/information it collected for each project in a reasonable period to allow timely information on the status of PIPs.
- Calculates and validates the PIP results from the Contractor data/information.
- Reviews the impact and effectiveness of each Contractor's performance improvement program.
- Requires each Contractor to have an ongoing process to evaluate the impact and effectiveness of its performance improvement program.

AHCCCS requested that HSAG design a summary tool to organize and represent the information and data AHCCCS provided for the Contractors' performance on the AHCCCS-selected PIP. The summary tool focused on HSAG's objectives for aggregating and analyzing the data, which were to:

- Determine Contractor performance on the AHCCCS-selected PIP.

⁸⁻¹ Electronic prescribing improves medication safety in community-based office practices. Kaushal R, et al. 6, Alexandria: Springer, 2010, Journal of General Internal Medicine, Vol. 25, pp. 530-536.

- Provide data from analyzing the PIP results that would allow HSAG to draw conclusions about the quality and timeliness of, and access to, care and services furnished by individual Contractors and statewide comparatively across Contractors.
- Aggregate and assess the AHCCCS-required Contractor CAPs to provide an overall evaluation of performance for each Contractor and statewide comparatively across Contractors.

Methodology for Conducting the Review

AHCCCS developed a methodology to measure performance in a standardized way across Contractors for each mandated PIP and followed quality control processes to ensure the collection of valid and reliable data. The study indicators AHCCCS selected for each PIP were based on current clinical knowledge or health services research. The methodology stated the study question, the population(s) included, any sampling methods, and methods to collect the data. AHCCCS collected the data from the encounter subsystem of its Prepaid Medical Management Information System (PMMIS). To ensure the reliability of the data, AHCCCS conducted data validation studies to evaluate the completeness, accuracy, and timeliness of the data. AHCCCS may also request that Contractors collect additional data. In these cases, AHCCCS requires the Contractors to submit documentation to verify that indicator criteria were met.

Following data collection and encounter validation, AHCCCS reported Contractor results and provided an analysis and discussion of possible interventions. Contractors may conduct additional data analyses and performance improvement interventions. After a year of intervention, the first remeasurement of performance will be conducted in the third year of the PIP. AHCCCS requires Contractors to evaluate the effectiveness of their interventions and report to AHCCCS the results of their evaluation and any new or revised interventions. Contractors whose performance does not demonstrate improvement from baseline to remeasurement will be required to report to AHCCCS their proposed actions to revise, replace, and/or initiate new interventions.

To determine if improved Contractor performance is sustained, AHCCCS will conduct a second remeasurement. If Contractors do not sustain their performance, they will be required to report to AHCCCS their planned changes to interventions.

If results of the second remeasurement demonstrate that a Contractor's performance improved and the improvement was sustained, AHCCCS will consider the PIP closed for that Contractor. If the Contractor's performance was not improved or the improvement was not sustained, the PIP will remain open and continue for another remeasurement cycle. When a PIP is considered closed for a Contractor, the Contractor's final report and any follow-up or ongoing activities are due 180 days after the end of the project (typically the end of the contract year). AHCCCS uses a standardized format for documenting PIP activities (i.e., Performance Improvement Project Reporting Format). AHCCCS encourages Contractors to use the PIP reporting format to document their analyses of baseline and remeasurement results, implementation of interventions, and assessment of improvement.

AHCCCS conducted its review and assessment of Contractor performance using the applicable criteria found in CMS' PIP protocol.⁸⁻² The protocol included 10 distinct steps:

- Review the selected study topic(s).
- Review the study question(s).
- Review the identified study populations.
- Review the selected study indicators.
- Review the sampling methods (if sampling was used).
- Review the Contractor's data collection procedures.
- Review the data analysis and the interpretation of the study's results.
- Assess the Contractor's improvement strategies.
- Assess the likelihood that reported improvement is real improvement.
- Assess whether or not the Contractor has sustained its documented improvement.

The methodology for evaluating each of the 10 steps is covered in detail in the CMS protocol, including acceptable examples of each step.

As noted above, not all steps were applicable to AHCCCS' evaluation of the Contractors' performance because AHCCCS:

- Selected the study topics, questions, indicators, and populations.
- Defined sampling methods, if applicable.
- Collected all or part of the data.
- Calculated Contractor performance rates.

Throughout the process, AHCCCS maintained confidentiality in compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements. Member-specific data files were maintained on a secure, password-protected computer. Only AHCCCS employees who analyzed the data had access to the database, and all employees were required to sign confidentiality agreements. Only the minimum amount of necessary information to complete the project was collected. Upon completion of each study, all information was removed from the AHCCCS computer and placed on a compact disc to be stored in a secure location.

Based on its analysis of the data, HSAG drew conclusions about Contractor-specific and statewide performance in providing accessible, timely, and quality care and services to AHCCCS members. When applicable, HSAG formulated and presented recommendations to improve Contractor performance.

⁸⁻² Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>. Accessed on: January 5, 2017.

For the 2015–2016 annual report, the following sections have been updated to include Contractor-specific activities and interventions during CYE 2015 (October 1, 2014, through September 30, 2015) as submitted to AHCCCS.

The following sections describe HSAG’s findings, conclusions, and recommendations for each Contractor as well as statewide comparative results for the ALTCS Contractors and DES/DDD.

Contractor-Specific Results

AHCCCS provided HSAG with its CYE 2015 Contractor PIP results for three ALTCS Contractors and DES/DDD. The three ALTCS EPD Contractors for which data were provided were BHS, MCP, and UHCCP-LTC. The PIP conducted during CYE 2015 for the ALTCS Contractors and DES/DDD was *E-Prescribing*, which focused on increasing both the number of providers ordering prescriptions electronically and increasing the percentage of prescriptions submitted electronically rather than via paper or other method in order to improve patient safety.

During CYE 2015, the *E-Prescribing* PIP was in the baseline measurement phase. Baseline data were used to assist AHCCCS Contractors in identifying and/or implementing strategies to increase the number of providers ordering prescriptions electronically and to increase the percentage of prescriptions submitted electronically. It is expected that Contractor, provider and member education efforts during this intervention period will result in a greater percentage of AHCCCS members being prescribed prescriptions electronically.

This section includes Contractors’ PIP remeasurement results as submitted to AHCCCS by the Contractors along with specific activities and interventions during the baseline measurement period from October 1, 2013, through September 30, 2014, and CYE 2015. Though the results were not validated by AHCCCS, an assessment of Contractors’ strengths was performed.

Bridgeway Health Solutions (BHS)

Findings

Table 8-1 presents the baseline results for the *E-Prescribing* PIP for BHS’ members, including those members from 0–64 years of age and those members 65 years of age and over.

Table 8-1—BHS E-Prescribing*

PIP Measure	Baseline Period Oct. 1, 2013, to Sept. 30, 2014	Remeasurement Period 1 Oct. 1, 2015, to Sept. 30, 2016	Remeasurement Period 2 Oct. 1, 2016, to Sept. 30, 2017	Relative Percentage Change From Baseline	AHCCCS Aggregate Rate
Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically.	36.47%	NA	NA	NA	43.80%
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider sent electronically.	21.31%	NA	NA	NA	23.70%

*Percentages are a combination of members 0–64 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 36.47 percent of BHS’ providers prescribed at least one prescription electronically and that 21.31 percent of prescriptions were sent by an AHCCCS-contracted provider electronically. The AHCCCS aggregate rate for providers prescribing electronically all ages combined is 43.80 percent and the AHCCCS aggregate rate for prescriptions prescribed electronically for all ages is 23.70 percent. BHS’ baseline rate for all ages for providers prescribing electronically is 36.47 percent, or 7.33 percent below the aggregate rate. BHS’ baseline rate for prescriptions prescribed electronically for all ages 21.31 percent, or 2.39 percent under the AHCCCS aggregate rate.

BHS completed the following quantitative analyses:

- BHS surveyed the top 15 providers by prescription volume to determine if they used EHRs and could send electronic prescriptions. BHS determined that six of 15 providers had EHRs. Of the nine that did not identify as having used EHRs, six providers were unable to be reached, one was acquiring a new system, and two were hospitalists and did not own EHRs. The six providers not able to be contacted were mobile and worked in nursing facilities or assisted living facilities.
- BHS participated in a midyear review of results conducted by the Arizona Health Plan Association’s e-prescribing workgroup (Workgroup) to determine if outreach efforts improved baseline e-prescribing results. As the BHS rate for e-prescribing was below the State aggregate rate, BHS completed an analysis and determined that the electronic prescribing rate for LTC providers working in healthcare facilities was 4.00 percent while the rate for providers with offices was 51.30 percent.

- BHS determined that, based on results of the sample, providers working in facilities rely on the facilities' medical records to allow them to prescribe electronically. However, only one facility with ability to prescribe electronically was identified in the BHS network. Most of the nursing homes and assisted living facilities (ALFs) received prescriptions telephonically from the provider, transcribed them into their EHR, and manually faxed a computer-generated document to the pharmacy.
- BHS found that mobile providers that see LTC members in the members' homes experienced connectivity issues or no access to a mobile e-prescribing program and are required to submit by phone the prescriptions to the pharmacy.

BHS initiated the following interventions to improve both the rate of providers ordering prescriptions electronically and the rate of prescriptions sent electronically:

- Participated in the completion of two surveys as part of the Workgroup formed with other AHCCCS Contractors. One survey asked providers to identify contributing factors to e-prescribing rates in order to identify best practices or barriers, while another asked Arizona EHR vendors to determine system capabilities for e-prescribing controlled substances.
- Educated prescribers on the advantages of e-prescribing and offered assistance in connecting with e-prescribing vendors.
- Reviewed data to determine if e-prescribing was more difficult among the LTC population.
- Met with corporate leadership of several skilled nursing facilities (SNFs) and ALFs to discuss current status of e-prescribing and future plans and educated them on the benefits of e-prescribing and the State's initiative.
- Offered assistance to the SNFs and ALFs to help them institute e-prescribing in their facilities.
- Created pay for performance (P4P) contracts that included benchmarks on e-prescribing as part of the incentive contract.
- Scheduled an LTC e-prescribing focus group to engage all stakeholders including representatives from facilities, provider groups, LTC pharmacy owners, health plans, Arizona Health Care Association (AHCA), and AHCCCS to collaborate on ideas and efforts to bring e-prescribing to LTC in Arizona.

Strengths

BHS has completed additional analyses to determine why BHS rates are below the State aggregate rates. The analyses have yielded useful data that enabled BHS to formulate strong interventions to improve the indicators. In addition to meeting with facilities and providers to assist them in implementing e-prescribing, BHS has included a P4P incentive in the contracts to motivate providers and facilities to improve performance.

Opportunities for Improvement and Recommendations

BHS has an opportunity for improvement for both the rate of providers prescribing prescriptions electronically and the rate of prescriptions sent electronically indicators. HSAG recommends that BHS

continue to monitor the outcomes associated with the reported interventions. In addition, HSAG recommends that AHCCCS continue the collaboration among Contractors to improve these indicators.

Summary

BHS’ baseline rate for the *E-Prescribing* PIP Indicator 1 (the percentage of AHCCCS-contracted providers who prescribed at least one electronic prescription) was 36.47 percent and for Indicator 2 (the percentage of prescriptions prescribed by an AHCCCS-contracted provider sent electronically) was 21.31 percent. Both indicators are below the AHCCCS aggregate rate. BHS is encouraged to monitor the progress of the PIP interventions employed to increase provider prescribing electronically and prescriptions sent electronically and adjust interventions as needed to ensure that the rates increase by a statistically significant amount during the first remeasurement period.

Mercy Care Plan (MCP)

Findings

Table 8-2 presents the baseline results for the *E-Prescribing* PIP for MCP’s members, including those members from 0–64 years of age and those members 65 years of age and over.

Table 8-2—MCP E-Prescribing*

PIP Measure	Baseline Period Oct. 1, 2013, to Sept. 30, 2014	Remeasurement Period 1 Oct. 1, 2015, to Sept. 30, 2016	Remeasurement Period 2 Oct. 1, 2016, to Sept. 30, 2017	Relative Percentage Change From Baseline	AHCCCS Aggregate Rate
Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically.	46.83%	NA	NA	NA	43.80%
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider sent electronically.	24.02%	NA	NA	NA	23.70%

*Percentages are a combination of members 0–64 years of age and 65 years of age and over.

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-2 shows that 46.83 percent of MCP's providers prescribed at least one prescription electronically and that 24.02 percent of prescriptions were sent by an AHCCCS-contracted provider electronically. The AHCCCS aggregate rate for providers prescribing electronically all ages combined is 43.80 percent, and the AHCCCS aggregate rate for prescriptions prescribed electronically for all ages is 23.70 percent. MCP's baseline rate for all ages for providers prescribing electronically is 46.83 percent, or 3.03 percent above the aggregate rate. MCP's baseline rate for prescriptions prescribed electronically for all ages is 24.02 percent, or 0.33 percent above the AHCCCS aggregate rate.

MCP initiated the following interventions to improve both the rate of providers prescribing prescriptions electronically and the rate of prescriptions sent electronically:

- Completed data mining, including data extracts by pharmacy and by prescriber, which were merged into a software tool that allows for data analysis and target identification.
- Participated in the completion of two surveys as part of the Workgroup formed with other Arizona MCOs. One survey asked providers to identify contributing factors to e-prescribing rates in order to identify best practices or barriers, while another asked Arizona EHR vendors to determine system capabilities for e-prescribing controlled substances.
- Developed, along with other members of the Arizona Association of Health Plans, a fact sheet for providers on the topic of E-Prescribing Controlled Substances (EPCS).
- Conducted on-site visits and distribution of the EPCS fact sheet; visits conducted by an MCP medical director and provider relations staff.
- Targeted review/outreach to larger practices to show variances across providers.
- Incentivized e-prescribing with patient-centered medical homes (PCMH) and Arizona Care Network (ACN). Contractors include improvements in e-prescribing as that will be one performance measure for 2015, with targets and rewards varying by practice based on baseline and actual practice performance.

Strengths

MCP has already exceeded the AHCCCS aggregate rate for both the rate of providers prescribing prescriptions electronically (by 3.03 percent) and the rate of prescriptions sent electronically (by 0.33 percent). The plan has solid interventions to improve the indicators, including four additional interventions under consideration that will require technical and financial support.

Opportunities for Improvement and Recommendations

Although MCP has exceeded the AHCCCS aggregate rate, MCP has an opportunity to sustain the improvement for both the rate of providers prescribing prescriptions electronically and the rate of prescriptions sent electronically indicators. HSAG recommends that MCP continue to monitor outcomes associated with the reported interventions. In addition, HSAG recommends that AHCCCS continue the collaboration among Contractors to improve these indicators.

Summary

MCP’s baseline rate for the *E-Prescribing* PIP Indicator 1 (the percentage of AHCCCS-contracted providers who prescribed at least one prescription electronically) was 46.83 percent and for Indicator 2 (the percentage of prescriptions prescribed by an AHCCCS-contracted provider sent electronically) was 24.02 percent. Both indicators are above the AHCCCS aggregate rate. MCP is encouraged to monitor the progress of the PIP interventions employed to increase provider prescribing electronically and prescriptions sent electronically and adjust interventions as needed to ensure that the rates increase by a statistically significant amount during the first remeasurement period.

UnitedHealthcare Community Plan-LTC (UHCCP-LTC)

Findings

Table 8-3 presents the baseline results for the *E-Prescribing* PIP for UHCCP-LTC’s members, including those members from 0–64 years of age and those members 65 years of age and over.

Table 8-3—UHCCP-LTC E-Prescribing*

PIP Measure	Baseline Period Oct. 1, 2013, to Sept. 30, 2014	Remeasurement Period 1 Oct. 1, 2015, to Sept. 30, 2016	Remeasurement Period 2 Oct. 1, 2016, to Sept. 30, 2017	Relative Percentage Change From Baseline	AHCCCS Aggregate Rate
Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically.	46.88%	NA	NA	NA	43.80%
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider sent electronically.	27.40%	NA	NA	NA	23.70%

*Percentages are a combination of members 0–64 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 46.88 percent of UHCCP-LTC’s providers prescribed at least one prescription electronically and that 27.40 percent of prescriptions were sent by an AHCCCS-contracted provider electronically. The AHCCCS aggregate rate for providers prescribing electronically all ages combined is 43.80 percent, and the AHCCCS aggregate rate for prescriptions prescribed electronically for all ages is 23.70 percent.

UHCCP-LTC's baseline rate for all ages for providers prescribing electronically is 46.88 percent, or 3.08 percent above the aggregate rate. UHCCP-LTC's baseline rate for prescriptions prescribed electronically for all ages is 27.40 percent, or 3.70 percent above the AHCCCS aggregate rate.

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

- Produced a report that ranked providers with the greatest volume of prescriptions and the lowest e-prescribing rates for intervention.
- Incorporated e-prescribing into provider forums and engagement meetings.
- Participated in the completion of two surveys as part of the Workgroup formed with other Arizona MCOs. One survey asked providers to identify contributing factors to e-prescribing rates in order to identify best practices or barriers, while another asked Arizona EHR vendors to determine system capabilities for e-prescribing controlled substances.

Strengths

UHCCP-LTC has already exceeded the AHCCCS aggregate rate for both the rate of providers prescribing prescriptions electronically (by 3.08 percent) and the rate of prescriptions sent electronically (by 3.70 percent). UHCCP-LTC has produced a report that ranks providers as to volume of electronic prescriptions and has incorporated the *E-Prescribing* PIP into provider forums and engagement meetings.

Opportunities for Improvement and Recommendations

Although UHCCP-LTC has exceeded the AHCCCS aggregate rate, UHCCP-LTC has an opportunity to sustain the improvement for both the rate of providers prescribing prescriptions electronically and the rate of prescriptions sent electronically indicators. HSAG recommends that UHCCP-LTC continue to monitor outcomes associated with the reported interventions. In addition, HSAG recommends that AHCCCS continue the collaboration among contractors to improve these indicators.

Summary

UHCCP-LTC's baseline rate for the *E-Prescribing* PIP Indicator 1 (the percentage of AHCCCS-contracted providers who prescribed at least one prescription electronically) was 46.88 percent and for Indicator 2 (the percentage of prescriptions prescribed by an AHCCCS-contracted provider sent electronically) was 27.40 percent. Both indicators are above the AHCCCS aggregate rate. UHCCP-LTC is encouraged to monitor the progress of the PIP interventions employed to increase provider prescribing electronically and prescriptions sent electronically and adjust interventions as needed to ensure that the rates increase by a statistically significant amount during the first remeasurement period.

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

Findings

Table 8-4 presents the baseline results for the *E-Prescribing* PIP for DES/DDD members, including those members from 0–64 years of age and those members 65 years of age and over.

Table 8-4—DES/DDD E-Prescribing*

PIP Measure	Baseline Period Oct. 1, 2013, to Sept. 30, 2014	Remeasurement Period 1 Oct. 1, 2015, to Sept. 30, 2016	Remeasurement Period 2 Oct. 1, 2016, to Sept. 30, 2017	Relative Percentage Change From Baseline
Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically.	57.18%	NA	NA	NA
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider sent electronically.	44.63%	NA	NA	NA

*Percentages are a combination of members 0–64 years of age and 65 years of age and over.

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-4 shows that 57.18 percent of DES/DDD providers prescribed at least one prescription electronically and that 44.63 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically.

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

- Educated members about e-prescribing in the member newsletter in Spanish and English. Some DES/DDD contracted health plans have begun member education.
- Participated in the completion of two surveys as part of the Workgroup formed with other Arizona MCOs. One survey asked providers to identify contributing factors to e-prescribing rates in order to identify best practices or barriers, while another asked Arizona EHR vendors to determine system capabilities for e-prescribing controlled substances.
- Provided education (regarding the benefits of e-prescribing) to residential and home-based services providers at the quarterly provider meetings around the State.
- Worked with contracted health plans to target high-volume providers for education surrounding e-prescribing. Incorporated e-prescribing education and information at provider forums and

engagement meetings as well as in provider newsletters and other communications. All three contracted health plans committed to this education, and DES/DDD continues to monitor compliance.

- Incorporated e-prescribing into PCMH and quality improvement partnership agreements.
- Reported rankings of provider e-prescribing rates.
- Incorporated e-prescribing as a measure under ACN targets for 2015 with rewards and incentives based on actual practice performance.
- Began quarterly data sharing for e-prescribing rates to practices.

Strengths

DES/DDD has already exceeded the AHCCCS aggregate rate for both the rate of providers prescribing prescriptions electronically (by 13.38 percent) and the rate of prescriptions sent electronically (by 20.93 percent). DES/DDD has implemented positive interventions to increase the rates for e-prescribing. DES/DDD has worked with its contracted health plans to provide education to members and providers. High-volume providers have been targeted for e-prescribing education. DES/DDD has incorporated e-prescribing into PCMH and quality improvement partnership agreements. The agency has reported e-prescribing rate rankings for providers and begun to share quarterly data on rates to providers. Finally, the agency has incorporated e-prescribing as a measure under ACN targets for 2015, with rewards and incentives based on actual practice performance.

Opportunities for Improvement and Recommendations

Although DES/DDD has significantly exceeded the AHCCCS aggregate rate, DES/DDD has an opportunity to sustain the improvement for both the rate of providers prescribing prescriptions electronically and the rate of prescriptions sent electronically indicators. HSAG recommends that DES/DDD continue to monitor the outcomes associated with the reported interventions with all contracted health plans. In addition, HSAG recommends that AHCCCS continue the collaboration among Contractors to improve these indicators.

Summary

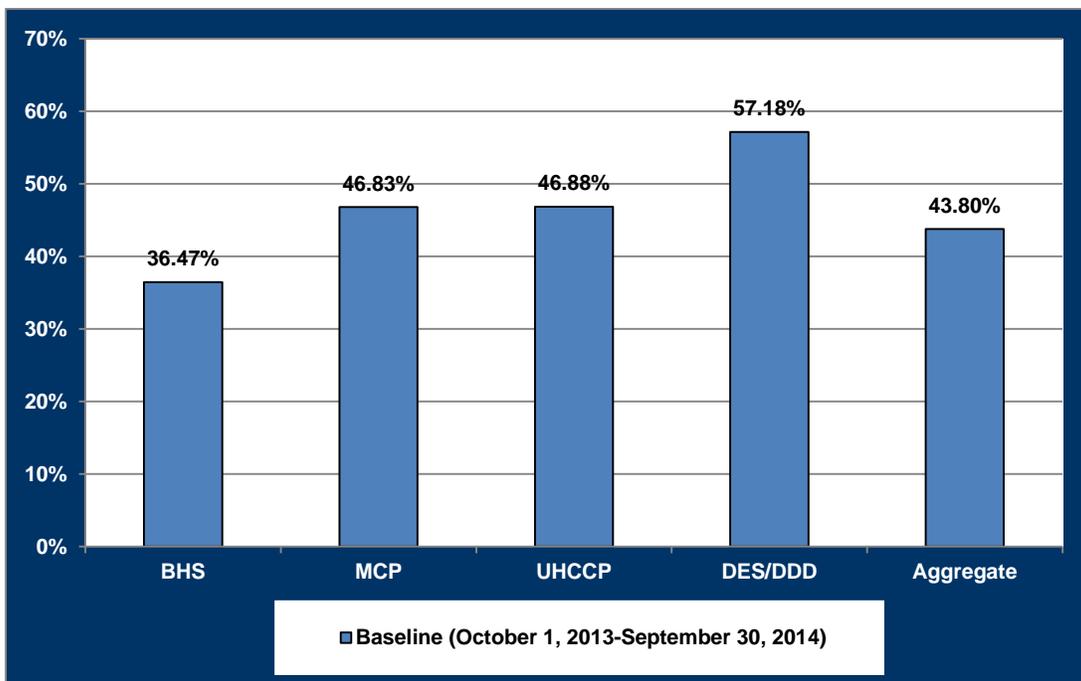
DES/DDD baseline rate for the *E-Prescribing* PIP Indicator 1 (the percentage of AHCCCS-contracted providers who prescribed at least one prescription electronically) was 57.18 percent and for Indicator 2 (the percentage of prescriptions ordered by an AHCCCS-contracted provider sent electronically) was 44.63 percent. Both indicators are above the AHCCCS aggregate rate. DES/DDD is encouraged to monitor the progress of the PIP interventions employed to increase provider prescribing electronically and prescriptions sent electronically and adjust interventions as needed to ensure that the rates increase by a statistically significant amount during the first remeasurement period.

Comparative Results for ALTCS EPD Contractors

Findings

Figure 8-1 presents the results for the *E-Prescribing PIP* Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically for the four ALTCS EPD and DES/DDD Contractors and among all Contractors combined. (Aggregate rate does not include DES/DDD data.)

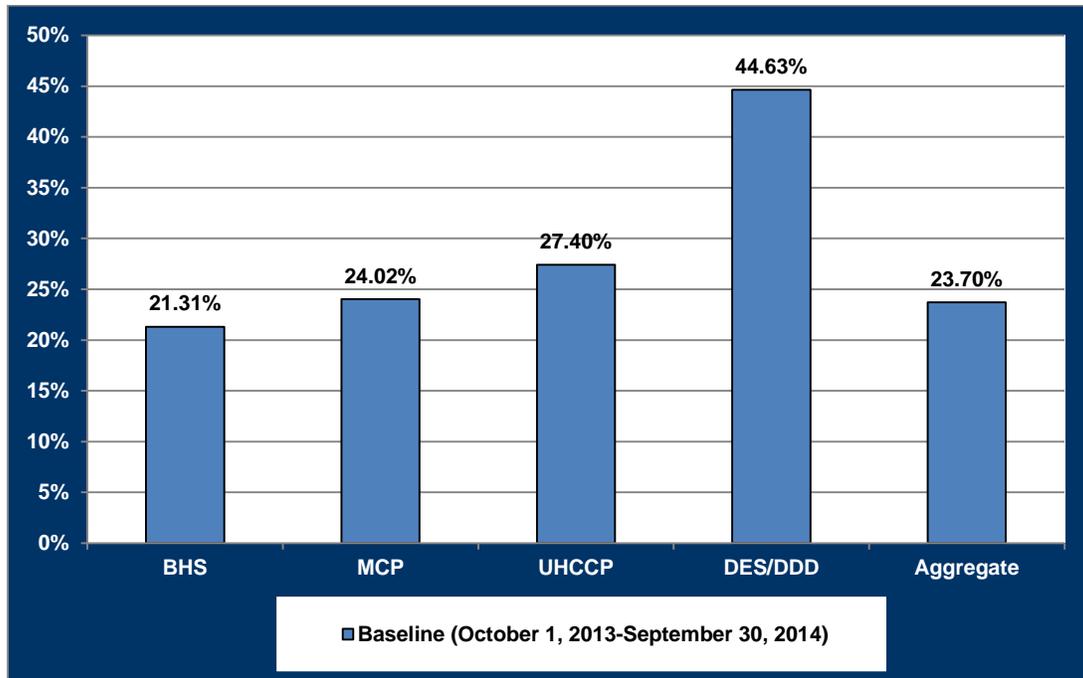
Figure 8-1—Performance Improvement Projects—*E-Prescribing*: Indicator 1: The percentage of providers who prescribed at least one prescription electronically—All ALTCS and DES/DDD Contractors*



*Percentage totals have been rounded. Aggregate rate does not include DES/DDD data.

Figure 8-1 shows that three Contractors (MCP, UHCCP-LTC, and DES/DDD) reported a higher percentage of providers using e-prescribing during the baseline measurement period than the AHCCCS aggregate rate of 43.80 percent. One Contractor, BHS, reported rates lower than the AHCCCS aggregate rate. At 36.47 percent, BHS was 7.33 percent below the AHCCCS aggregate rate, thereby having the greatest opportunity for improvement among the Contractors. At 57.18 percent, DES/DDD had the highest baseline rate for this PIP, followed by UHCCP-LTC and MCP respectively.

Figure 8-2—Performance Improvement Projects—E-Prescribing: Indicator 2: The percentage of prescriptions sent electronically—All EPD and DES/DDD Contractors*



*Percentage totals have been rounded. Aggregate rate does not include DES/DDD data.

Figure 8-2 shows that three Contractors (MCP, UHCCP-LTC, and DES/DDD) reported a higher percentage of prescriptions sent electronically during the baseline measurement period than the AHCCCS aggregate rate of 23.70 percent. One Contractor, BHS, reported rates lower than the AHCCCS aggregate rate. At 21.31 percent, BHS was 2.39 percent below the AHCCCS aggregate rate, thereby having the greatest opportunity for improvement among the Contractors. At 44.63 percent, DES/DDD had the highest baseline rate for this PIP, followed by UHCCP-LTC and MCP respectively.

Strengths

All Contractors participated in the completion of two surveys as part of the Workgroup formed with other AHCCCS Contractors. The surveys asked providers to identify contributing factors to e-prescribing rates to highlight best practices or barriers and requested that Arizona EHR vendors determine system capabilities for e-prescribing controlled substances. In addition, all Contractors provided education to providers, where several Contractors included facilities and members in their education interventions. Several plans targeted high-volume prescribers and provided incentives to encourage e-prescribing. Three Contractors were above the AHCCCS aggregate rate for both indicators.

Opportunities for Improvement and Recommendations

BHS demonstrated the greatest opportunity for improvement (i.e., the lowest rate of providers using e-prescribing) as the Contractor’s rate was 7.33 percentage points lower than the AHCCCS aggregate rate

for Indicator 1 and 2.39 percent lower than the AHCCCS aggregate rate for Indicator 2. This was a baseline measurement year; therefore, no previous performance data existed with which to compare Contractors' performance. The Contractors are encouraged to monitor the progress of the PIP interventions employed to increase provider prescribing electronically and prescriptions sent electronically and adjust interventions as needed to ensure that the rates increase by a statistically significant amount during the first remeasurement period. HSAG recommends that AHCCCS continue the collaboration among Contractors to improve these indicators.

Summary

This was the baseline reporting period for the *E-Prescribing* PIP. Contractors' performance ranged from 36.47 percent for BHS to 57.18 percent for DES/DDD for Indicator 1, compared to the AHCCCS aggregate rate of 43.80 percent. For Indicator 2, Contractors' performance ranged from 21.31 percent for BHS to 44.63 percent for DES/DDD, compared to the AHCCCS aggregate rate of 23.70 percent. This is the baseline year; therefore, comparisons cannot be made between rates for each indicator. HSAG recommends that Contractors continually monitor PIP rates prior to the first remeasurement of the PIP to determine whether or not interventions are successful.