Arizona Health Care Cost Containment System

AHCCCS

2015–16 External Quality Review Annual Report

for

Acute Care and DES/CMDP

January 2017

HSAG HEALTH SERVICES ADVISORY GROUP

Contents

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 its 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 Contractor performance and, as applicable, recommendations to improve the Contractor's 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 and optional 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 EQRO 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 Contractor's 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.

In addition to children and adults enrolled in AHCCCS' Acute Care Medicaid managed care program, children enrolled in KidsCare, Arizona's Children's Health Insurance Program (CHIP), also receive services through the same managed care Contractors. While this report incorporates performance among Contractors serving KidsCare members, nationwide economic conditions resulted in AHCCCS' decision to freeze enrollment in the KidsCare program effective January 1, 2010. As a result of this enrollment freeze, children who aged out of KidsCare were not replaced by newly eligible members. In April 2012, CMS approved AHCCCS' waiver amendment, which included funding for the KidsCare II program; however, this program expired in January 2014. Fewer than 1,000 members remain enrolled in the KidsCare program.

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 AHCCCS contract requirements and the applicable federal 42 CFR 438 requirements for each activity. Additional 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 the Acute Care program (i.e., Acute Care Contractors and the Arizona Department of Economic Security/Comprehensive Medical and Dental Plan [DES/CMDP] Contractor).
- Section 5—An overview of the Contractors' best and emerging practices.
- Section 6 (Organizational Assessment and Structure Performance)—A presentation of findings for Contractors in complying with select AHCCCS contract requirements and, as applicable, HSAG's recommendations to improve Contractors' 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 contract year ending (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 Acute Care and DES/CMDP Contractor and HSAG's associated findings and recommendations for CYE 2013 and 2014.

- Section 8 (Performance Improvement Project Performance)—A presentation of Contractor-specific PIP results and 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.

Overview of the 2015–2016 External Review

During the time period of the review, AHCCCS contracted with the Contractors listed below to provide services to members enrolled in the AHCCCS Acute Care Medicaid managed care program.

The Contractors and associated abbreviations used throughout this report are listed below:

- Care1st Health Plan Arizona, Inc. (Care1st)
- Health Choice Arizona (HCA)
- Health Net Access (Health Net)
- Maricopa Health Plan (MHP)
- Mercy Care Plan (MCP)
- Phoenix Health Plan, LLC (PHP)
- University Family Care (UFC)
- UnitedHealthcare Community Plan (UHCCP)
- Department of Economic Security/Comprehensive Medical and Dental Program (DES/CMDP)

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

AHCCCS conducted a comprehensive operational review (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.

For the focused OR, AHCCCS reviewed Contractors' performance for nine Acute Care Contractors and DES/CMDP. AHCCCS reviewed the Acute Care Contractors' and DES/CMDP's performance on 151 compliance standards in six categories. Please note that some of the compliance standards reviewed were the same among Contractors. Based on AHCCCS' review findings and assessment of the degree to which the Contractor complied with the standards, AHCCCS assigned the applicable compliance designation to the Contractor's performance:

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

Findings

Under Section 6 ("Organizational Assessment and Structure Performance") of this report, HSAG includes details for each Contractor's performance in the particular categories and standards measured in the focused OR. Based on the data, and considering that each of the six categories contained numerous standards that varied among Contractors, conducting a uniform comparative analysis was not possible. However, HSAG did conduct an analysis of outcome of performance for each Contractor.

The following summarizes outcomes of the reviews conducted by AHCCCS related to the nine Contractors' performance:

Care1st was fully compliant for all standards reviewed in the Maternal and Child Health and the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT); Medical Management; and Quality Management categories. HCA was fully compliant for the one standard reviewed for Medical Management. For Claims and Information Systems (three standards total) HCA received one *Full Compliance*, one *Partial Compliance*, and one *Noncompliance* score for each standard. For Maternal and Child Health and EPSDT, HCA received a *Partial Compliance* score.

Health Net was fully compliant for all standards reviewed for Maternal and Child Health and EPSDT (14 standards) and Quality Management (nine standards). For the four standards reviewed for Claims and Information Systems, Health Net received one *Full Compliance* score and three *Noncompliance* scores. For the nine standards reviewed for General Administration, Health Net received seven *Full Compliance* scores, one *Substantial Compliance* score, and one *Noncompliance* score. For the 17 standards reviewed for Grievance System, Health Net received 15 *Full Compliance* scores, one *Substantial Compliance* score, and one *Partial Compliance* score. For the eight standards reviewed for Medical Management, Health Net received five *Full Compliance* scores, two *Substantial Compliance* scores, and one *Noncompliance* score. MHP was fully compliant for all standards reviewed for Claims

and Information Systems (six standards), Grievance System (three standards), Maternal and Child Health and EPSDT (four standards), Medical Management (one standard), and Quality Management (three standards). For Claims and Information Systems (six standards total) MHP received five *Full Compliance* scores and one *Partial Compliance* score. MCP was fully compliant for all standards reviewed for both Maternal and Child Health and EPSDT (one standard) and Medical Management (one standard). For Claims and Information Systems (four standards total), MCP received one *Partial Compliance* score, one *Substantial Compliance* score, and two *Noncompliance* scores.

PHP was fully compliant for all standards reviewed in the Maternal and Child Health and EPSDT, Medical Management, and Quality Management categories.

UHCCP was fully compliant for all standards reviewed for both Maternal and Child Health and EPSDT (five standards) and Medical Management (one standard). For Claims and Information Systems (three standards total), UHCCP received one *Partial Compliance* score and two *Noncompliance* scores.

UFC was fully compliant for all standards reviewed for all categories of standards (Maternal and Child Health and EPSDT, Medical Management, and Quality Management) with the exceptions of Claims and Information Systems and Grievance System. For Claims and Information Systems (six standards total) UFC received three *Full Compliance* scores, one *Substantial Compliance* score, and two *Partial Compliance* scores. For the Grievance System (three standards total), UFC received two *Full Compliance* scores and one *Substantial Compliance* score.

DES/CMDP was fully compliant for all standards reviewed for Maternal and Child Health and EPSDT (three standards). For the three standards reviewed for Claims and Information Systems, CMDP received one *Partial Compliance* score and two *Noncompliance* scores. For the four standards reviewed for Medical Management, CMDP received two *Full Compliance* scores and two *Substantial Compliance* scores. For the six standards reviewed for Quality Management, CMDP received one *Full Compliance* score, one *Substantial Compliance* score, one *Partial Compliance* score, two *Noncompliance* scores, and one standard was not applicable.

Conclusions

The AHCCCS' CYE 2015 Acute Care and DES/CMDP OR had positive results overall. All Contractors scored fully compliant in at least one category, and two Contractors scored 100 percent compliant through all categories. Three contractors scored less than 50 percent compliant. However, no contractors had more than 50 percent of the standards scored as noncompliant.

Maternal and Child Health and EPSDT standards were a strength across Acute Care and DES/CMDP Contractors. All but one of the Contractors were in full compliance with this standard, and that Contractor scored as partially compliant. In addition, the Medical Management categories were identified as strengths for the majority of Acute Care and DES/CMDP Contractors. The standard that resulted in the highest number of noncompliant scores was Claims and Information Systems.

Recommendations

Based on AHCCCS' review of the Acute Care and DES/CMDP 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, that they are in 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 procedures.
- Contractors should apply lessons learned from improving performance for 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 one additional performance measure in CYE 2013 and six additional performance measures in CYE 2014 that were reported by the Acute Care Contractors, AHCCCS selected the same measures for reporting by the DES/CMDP Contractor as for the eight Acute Care Contractors.

Results presented are for the CYE 2013 and CYE 2014 measurement periods. For CYE 2013, AHCCCS selected 11 performance measures for the Acute Care Contractors and 10 performance measures for DES/CMDP. For CYE 2014, AHCCCS selected 28 measures for the Acute Care Contractors and 22 measures for DES/CMDP. Only 11 measures for the Acute Care Contractors and 10 measures for DES/CMDP had reportable rates for both CYE 2013 and CYE 2014.

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.

Findings

Table 1-1 presents aggregate performance measure rates for all Acute Care and DES/CMDP 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 1-1—Performance Measurement Review for Acute Care and DES/CMDP Contractors

Performance Measure	CYE 2012 Performance	CYE 2013 Performance	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Adolescent Well-Care Visits	38.0%	40.5%	6.5%	***p*<0.001**	42.0%
Annual Dental Visits—2–21 Years	61.8%	61.1%	-1.2%	***p*<0.001**	57.0%
Children's Access to Primary Care Practitioners (PCPs)	89.0%	90.9%	2.3%	***p*<0.001**	**
12–24 Months	97.0%	97.7%	0.7%	***p*<0.001**	93.0%
25 Months–6 Years	87.7%	89.9%	2.6%	***p*<0.001**	83.0%
7–11 Years	90.0%	91.9%	2.1%	***p*<0.001**	83.0%
12–19 Years	87.7%	89.8%	2.4%	***p*<0.001**	81.0%
Dental Participation	43.8%	45.3%	3.3%	***p*<0.001**	46.0%
EPSDT Participation	65.6%	62.4%	-4.9%	***p*<0.001**	68.0%
Well-Child Visits in the First 15 Months of Life—6+ Visits[B]	67.8%	70.6%	4.0%	***p*<0.001**	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.8%	66.7%	-0.2%	*p*=0.584	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] CMDP was not included in the aggregate rate for this measure.

** 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.

Table 1-1 shows that the aggregate rates for the *Children's Access to PCPs* indicators as well as *Annual Dental Visits—2–21 Years; Well-Child Visits in the First 15 Months of Life—6+ Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures each met the corresponding established AHCCCS MPS for CYE 2013. Additionally, of the measures that met the AHCCCS MPS for CYE 2013 all but two showed statistically significant improvement from CYE 2012. Conversely, the aggregate rates for *Adolescent Well-Care Visits, Dental Participation*, and *EPSDT Participation* failed

to meet the CYE 2013 AHCCCS MPS values; and the *EPSDT Participation* rate declined from CYE 2012 to CYE 2013.

Table 1-2 presents aggregate performance measure rates for all Acute Care and DES/CMDP 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 1-2—Performance Measurement Review for Acute Care and DES/CMDP Contractors

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Adolescent Well-Care Visits	40.5%	41.1%	1.5%	***p*=0.001**	41.0%
Ambulatory Care—Emergency Department Visits—Total per 1,000 Member Months	—	56	—	—	—
Annual Dental Visits—2–21 Years	61.1%	63.8%	4.4%	***p*<0.001**	60.0%
Asthma in Younger Adults Admission Rate[B]	—	104.2	—	—	—
Children's Access to Primary Care Practitioners (PCPs)	90.9%	90.7%	-0.3%	***p*<0.001**	**
12–24 Months	97.7%	97.2%	-0.6%	***p*<0.001**	93.0%
25 Months–6 Years	89.9%	88.6%	-1.5%	***p*<0.001**	84.0%
7–11 Years	91.9%	92.5%	0.6%	***p*<0.001**	83.0%
12–19 Years	89.8%	90.2%	0.5%	***p*=0.002**	82.0%
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate[B]	—	875.7	—	—	—
Dental Participation	45.3%	43.4%	-4.2%	***p*<0.001**	46.0%
Developmental Screening in the First Three Years of Life	—	11.4%	—	—	—
1 Year	—	10.2%	—	—	—

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
2 Years	—	15.1%	—	—	—
3 Years	—	10.0%	—	—	—
Diabetes Short-Term Complications Admission Rate[B]	—	225.0	—	—	—
EPSDT Participation	62.4%	53.8%	-13.9%	***p*<0.001**	68.0%
Heart Failure Admission Rate[B]	—	290.9	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Total Inpatient Discharges per 1,000 Member Months	—	8	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Maternity Discharges per 1,000 Member Months	—	4	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Surgery Discharges per 1,000 Member Months	—	2	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Medicine Discharges per 1,000 Member Months	—	4	—	—	—
Plan All-Cause Readmissions[C]	—	13.6%	—	—	<11.5%
18–64 Years of Age[C]	—	14.4%	—	—	—
65+ Years of Age[C]	—	10.3%	—	—	—
Use of Appropriate Medications for People With Asthma[B]	—	80.6%	—	—	86.0%
Well-Child Visits in the First 15 Months of Life—6+ Visits[B]	70.6%	71.4%	1.2%	*p*=0.061	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.7%	65.1%	-2.4%	***p*<0.001**	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] CMDP was not included in the aggregate rate for this measure.

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
[C] 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 (PCPs) measure were established for each age group rather than, as in previous years, for the aggregate. Aggregated data are presented for informational purposes.					

Table 1-2 shows that the aggregate rates for *Adolescent Well-Care Visits*, *Annual Dental Visits—2–21 Years*, all *Children's Access to PCPs* indicators, and *Well-Child Visits in the First 15 Months of Life—6+ Visits* each met the corresponding established AHCCCS MPS for CYE 2014. Additionally, of the measures that met the MPS, four rates showed statistically significant improvement from CYE 2013. Conversely, the aggregate rates for *Dental Participation; EPSDT Participation*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* failed to meet the CYE 2014 AHCCCS MPS values, and the measure rates declined from CYE 2013 to CYE 2014 for the measures with reported rates for both years. Two first-year measures, *Plan All-Cause Readmissions—Total* and *Use of Appropriate Medications for People With Asthma*, also had aggregate rates that failed to meet the established MPS.

Conclusions

Based on HSAG's review of the aggregate Acute Care and DES/CMDP rates, positive performance was observed related to the *Children's Access to PCPs* indicators *as well as Annual Dental Visits—2–21 Years*; *Well-Child Visits in the First 15 Months of Life—6+ Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures in CYE 2013. Positive performance was observed in all *Children's Access to PCPs* indicators as well as *Adolescent Well-Care Visits*, *Annual Dental Visits—2–21 Years*, and *Well-Child Visits in the First 15 Months of Life—6+ Visits* measures in CYE 2014. Conversely, the aggregate Acute Care and DES/CMDP rates indicated opportunities for improvement related to the *Dental Participation* and *EPSDT Participation* measures both in CYE 2013 and CYE 2014. Additionally, for Acute Care Contractors, rates related to *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure indicators indicated opportunities for improvement in CYE 2014.

Recommendations

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

- Implement 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

from the intervention. These efforts should be focused on members included in the *Dental Participation* and *EPSDT Participation* as these rates suggest that strategic interventions are needed to improve members' access to preventive services.

- Conduct interim performance measure calculations, in addition to the formal annual evaluation, that could assist the 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.
- Enhance 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 indicated 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 electronic prescription electronically, contractors' performance ranged from 47.31 percent for CMDP to 61.22 percent for

[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.

UHCCP. For Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider sent electronically, contractor performance ranged from 41.30 percent for Health Net to 55.19 percent for UFC.

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. Other than a few outliers for each indicator, the Contractors were close to the AHCCCS aggregate rates. All Contractors reported involvement in the Workgroup; and it is anticipated that the collective efforts of AHCCCS and the Contractors, all of which have collaborated in several interventions, should produce significant increases in both indicators in CYE 2016.

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

Acute Care and DES/CMDP 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. Results from the focused OR demonstrated improvement in nearly all areas included in the review. Rates for AHCCCS-selected performance measures such as *Adolescent Well-Care Visits*, *Annual Dental Visits—2–21 Years*, and *Well-Child Visits in the First 15 Months of Life—6+ Visits* demonstrated improvement from previous years and targeted improvement opportunities were highlighted for other measures for the Acute Care and DES/CMDP 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.

In CYE 2015 the Acute Care and DES/CMDP Contractors had positive results overall. All Contractors scored fully compliant in at least one category, and two Contractors (Care1st and PHP) scored 100 percent compliant through all categories. Maternal and Child Health and EPSDT standards were a strength across Acute Care and DES/CMDP Contractors, with almost 100 percent of Contractors in full compliance, while Claims and Information Systems was the standard that resulted in the highest number of noncompliant scores.

Performance Measures

Overall, positive performance was observed related to the Acute Care and DES/CMDP Contractors' adolescent members who received comprehensive well-care visits in CYE 2013 and members ages 2 to 21 who received annual dental visits in CYE 2014. Aggregate performance measure rates reported in CYE 2013 and CYE 2014 indicated opportunities for improvement for the Acute Care and DES/CMDP Contractors with regard to member participation in dental services and offering of comprehensive EPSDT services.

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 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, Acute Care and DES/CMDP 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 Acute Care and DES/CMDP Contractors.

2. Background

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' Quality Assessment and Performance Improvement (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 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 Arizona Long Term Care System (ALTCS) program for individuals with developmental disabilities, and then expanded the program in January 1989 to include the elderly and physically disabled (EPD) populations. In October 1990 AHCCCS began coverage of comprehensive behavioral health services for seriously emotionally disabled (SED) children younger than 18 years of age who required residential care. Through further expansion, AHCCCS added comprehensive behavioral health coverage for all Medicaid-eligible individuals.

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 health care…from today's experience, quality, and innovation.
- AHCCCS Mission: Reaching across Arizona to provide comprehensive quality health care 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*: http://www.azahcccs.gov/reporting/PoliciesPlans/strategicplan.aspx. 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 information 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 Acute Care and DES/CMDP Contractors:

- Validate Contractor 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 Acute Care and DES/CMDP 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 systems capabilities).
- Analyze and report results, including providing conclusions and recommendations based on optional activities that AHCCCS conducted.

AHCCCS has numerous sophisticated processes for monitoring both the Contractor 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, for 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 strategic goals and related strategies and to provide a roadmap for potential changes and new goals and strategies.

AHCCCS Quality Initiatives

AHCCCS continued to demonstrate innovative, collaborative approaches to managing costs while improving quality of systems, care, and services. Its documentation, including the Quarterly Quality Assurance/Monitoring Activity Reports, 2015–2019 Strategic Plan, and October 2012 Quality Assessment and Performance Improvement (QAPI) Strategy, provided compelling evidence of AHCCCS' vision and leadership in identifying and proactively pursuing opportunities to improve access to, and the quality and timeliness of, care and services; and 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, and 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.
- Using 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:

- Made significant progress in pursuing long-term strategies to bend the healthcare cost curve while improving quality outcomes and care coordination, including such strategies 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 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 burdens. 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.)

- Value-Based Purchasing (VBP) Initiatives: AHCCCS is promoting a number of VBP initiatives for both providers and Contractors. Implementation of initiatives is 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.
- 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.
- Arizona Department of Health Services (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 program. 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 primary care physicians. Additional efforts have been focused on the integrated seriously mentally ill (SMI) population to connect them to smoking cessation and nicotine replacement programs.
- 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 of Alzheimer's Disease. AHCCCS will implement requirements for its Contractors to use education and outreach material provided by ADHS to inform its 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.
- The Arizona Partnership for Immunization (TAPI): AHCCCS Quality Management staff attend TAPI Steering Committee meetings and subcommittee meetings for community awareness, provider issues, and adult immunizations. TAPI regularly communicates immunization trends and best practices with 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 occurs with the Childhood Obesity Learning Collaborative, wherein federally qualified health center EHR data will be used to collect information for the initiative.

- 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. HINAz continued to onboard Contractors and hospitals. A fully operating HIE opened in April 2015, with many planned enhancements scheduled through 2016.
- ADHS Bureau of the United States Department of Agriculture (USDA) Nutrition Programs: AHCCCS works with ADHS Bureau of USDA Nutrition Programs on many initiatives ranging from Contractor education to Women, Infants and Children promotion, and obesity issues. The nutrition coordinators present the most up-to-date information at the AHCCCS Contractor quarterly meetings.
- Arizona and Maricopa County Asthma Coalitions: AHCCCS is collaborating with ADHS, the DES, community agencies, and organizations to identify and provide quality improvement resources to Contractors 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 program. AHCCCS members are encouraged to participate in ADHS' TEPP smoking cessation support programs such as "ASHLine" and/or counseling in addition to seeking assistance from their PCPs. Additional efforts have been focused on the integrated SMI population in connecting members to smoking cessation and nicotine replacement programs.
- 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 IPAC with representatives from the divisions of Public Health Services, Assurance and Licensure Services, and Behavioral Health Services. An AHCCCS representative also participates in IPAC to provide opportunities to implement change and interventions in the Medicaid program to prevent injuries. IPAC, 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 IPAC 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.
- 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.

- ADHS Office of Environmental Health–Targeted Lead Screening: CMS has approved AHCCCS to implement a targeted approach to lead screening based on data obtained and analyzed by ADHS. The targeted policy is based on a three-pronged approach that takes into account high-risk zip codes, AHCCCS enrollment, and individual risk assessment. The AHCCCS policy change effective April 2015 required all children living in a high-risk zip code, as identified by the ADHS *Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning*, to have a blood lead test at 12 and 24 months of age. Children between 36 and 72 months of age are required to receive a screening blood lead test if they were not previously screened for lead poisoning. Children living outside targeted high-risk zip codes are required to receive an individual risk assessment according to the AHCCCS periodicity schedule (when the child is 6, 9, 12, 18, and 24 months of age and then annually through age 6 years), with appropriate follow-up action taken for those children deemed high-risk based on criteria included within the ADHS *Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning*.
- Arizona Early Intervention Program: The Arizona Early Intervention Program (AzEIP), Arizona's IDEA Part C program, is administered by DES. Maternal and Child Health (MCH) staff in the Clinical Quality Management unit at AHCCCS work with AzEIP to facilitate early intervention services for children under 3 years of age who are enrolled with AHCCCS Contractors. These services are closely monitored to ensure timely access to availability of services to members.
- Arizona Head Start Association: The Arizona Head Start and Early Head Start programs provide education, development, health, nutrition, and family support services to qualifying families. The Arizona Head Start grantees—including the City of Phoenix, Maricopa County, Chicanos Por La Causa, and Southwest Human Development—continue to host community meetings quarterly. The meetings are attended by families participating in the Head Start program along with AHCCCS and the AHCCCS Contractor MCH/EPSDT coordinators.
- Task Force on Prevention of Prenatal Exposure to Alcohol and other Drugs (Task Force): The Task Force is composed of representatives from various agencies who work to increase awareness and address concerns in the community regarding fetal alcohol spectrum disorders. AHCCCS attends the monthly meetings and regularly participates in discussions on solutions to reduce prenatal exposure to alcohol and other drugs. A strategic plan has been finalized by the Task Force, and members are meeting regularly to work on the goals and objectives.
- Arizona Medical Association (ArMA) and the Arizona Chapter of the American Academy of Pediatrics (AAP): AHCCCS collaborates with ArMA and the Arizona Chapter of the AAP in a number of ways, from development and review of assessment tools to data sharing and support of system enhancements for providers, including the Electronic Health Records (EHR) Incentive Program.

- Arizona Perinatal Trust (APT): The APT oversees voluntary certification of hospitals for the appropriate level of perinatal care according to established guidelines and conducts site visits for initial certification and recertification. AHCCCS covers approximately half the births in Arizona; therefore, the site reviews provide AHCCCS with a better assessment of the hospitals that provide care to pregnant women and newborns, from normal labor and delivery to neonatal intensive care. Details of the site visit review are kept confidential; however, site visit reviews do allow opportunities for collaboration among healthcare professionals to learn about innovative practices hospitals have implemented as well as sharing of best practices, policies, and guidelines.
- Arizona Newborn Screening Advisory Committee: The Newborn Screening Advisory Committee is established to provide recommendations and advice to ADHS regarding tests that should be included in the Newborn Screening panel. The committee recommended the 29 disorders, including hearing loss, of the core panel of the Uniform Screening Panel from the U.S. Department of Health and Human Services (HHS) Secretary's Advisory Committee on Heritable Disorders in Newborns and Children. Any recommendation of a test to be added to the panel must be accompanied by a cost-benefit analysis. The committee is chaired by the ADHS Director and meets at least annually. The Director appoints the members of the committee, to include seven physicians representing the medical specialties of endocrinology, pediatrics, neonatology, family practice, otology, and obstetrics; a neonatal nurse practitioner; an audiologist; a representative of an agency that provides services under Part C of the Individuals with Disabilities Education Act; at least one parent of a child with a hearing loss or a congenital disorder; a representative from the insurance industry familiar with healthcare reimbursement issues; the AHCCCS Director; and a representative of the hospital or healthcare industry.
- Arizona Chapter of the American Academy Pediatrics (AzAAP): AzAAP was initially founded to play a vital role in child-oriented public health initiatives. AzAAP's membership boasts more than 900 pediatric and allied health professionals supporting and championing key child health programs, services, and issues from all regions of the State. Efforts include early childhood literacy, fighting childhood obesity, and ensuring that all Arizona children have the best healthcare available by providing the highest quality of continuing education to the professionals who care for them. AHCCCS works closely with the AzAAP seeking stakeholder input regarding its EPSDT program. The AzAAP has been a consistent partner with AHCCCS in developing and implementing developmental screening tools and guidelines, implementing the application of fluoride varnish in primary care offices, ensuring that AHCCCS EPSDT policies and forms reflect best practices and current recommendations, and communicating the needs of children served in Arizona communities. The AzAAP is working with AHCCCS and the Arizona Association of Health Plans to maintain a list and links to developmental tool training opportunities as well as training for PCPs on the application of fluoride varnish during EPSDT visits.
- First Things First Health Advisory Committee: First Things First is committed to helping Arizona kids ages five and younger receive the quality education, healthcare, and family support they need to arrive at school healthy and ready to succeed. The purpose of the First Things First Health Advisory Committee is to provide health content expertise and to make recommendations to the First Things First Board Policy and Program Committee regarding children's healthy development. AHCCCS serves on this committee for the purpose of aligning children's healthcare initiatives; identifying opportunities for AHCCCS to inform other represented organizations regarding AHCCCS-covered

services, policies, and procedures; and to ensure that best practices promoted by First Things First are incorporated when possible into AHCCCS program requirements.

- BUILD Arizona Health Steering Committee (Committee): The Committee is composed of public and private sector early childhood leaders from government agencies, business, the childcare community, and higher education. The Committee includes five work groups: Communications, Early Learning, Professional Development, Health, and Early Grade Success. The Committee and work groups are creating work plans focused on supporting early grade success. Their overall goal is to reframe early care and education from birth to age eight (0–8) as critical components of the overall education system and policy framework. As a member of the Committee, AHCCCS provides information and updates on the comprehensive nature of the AHCCCS EPSDT program. AHCCCS is also a partner in the public health home visitation initiatives.
- Strong Families Interagency Leadership Team (IALT): IALT was established as a result of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant, which ensures that high-risk families have access to home visitation services in Arizona. IALT is composed of various stakeholders in the community including DES, the Department of Education, ADHS, and AHCCCS. The purpose of the leadership team is to discuss strategy for building a statewide home visiting system. Additionally, this team oversees implementation of the MIECHV grant and any decisions that need to be made regarding home visitation practices. The role of AHCCCS is to provide input and support around the implementation efforts of a home-visiting system in Arizona.

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. 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.

Care1st Arizona

- Twenty-four Hour NurseLine: Care1st offers a 24-hour NurseLine that members can call if they need help deciding whether an illness or injury needs attention in an emergency department (ED) or if initial steps may be taken at home and then followed up with their PCPs. In 2014, 1696 unique members called the NurseLine. A survey of 366 of these callers found that about 43 percent of callers had planned to go to the ED, but only about 39 percent ended up going to the ED after calling the NurseLine.
- Outreach to Pregnant Women: Care1st offers an outreach program to pregnant women to educate them about dental care for infants. Flyers are sent to pregnant members in their third trimester, including information on how to care for their infants' teeth and when first dental visits should take place (near the infant's first birthday). This information is also included in the newborn welcome calls made to new mothers.
- E-prescribing Incentives: E-prescribing incentives have been added to agreements with patient-centered medical homes (PCMHs) such as CIGNA Medical Group and Adelante Healthcare and quality improvement (QI) groups (high-volume providers not considered PCMHs but with which Care1st has formal partnerships to improve quality) such as Kids Kare Pediatrics. These incentives are based on the provider's baseline of prescriptions and have a specific target for the provider to meet in order to receive an incentive payment. As part of this, Care1st provided data to PCMHs and QI groups on individual provider rates of e-prescriptions to assist them in problem-solving and improvements within their overall practices.

Health Choice Arizona (HCA)

- Wellness and Preventive Care Programs: HCA has developed and implemented wellness and preventive care programs for the health plan (e.g., breast cancer screenings, colon cancer screenings, immunizations, well-child visits) The plan provides education to members and providers that encompasses preventive care and wellness programs. HCA provider representatives spend 80 percent of their time in the field educating, encouraging, and providing tools to physicians to address members' gaps in care along with educating providers regarding performance measures.
- Early Intervention Programs: HCA participates in the early intervention concept by developing a program wherein obstetric (OB) care navigators visit members who have delivered in the hospital.

During these visits, the OB care navigators provide education and AHCCCS-approved written materials to the mother regarding the ongoing health and wellness of her newborn. Periodicity tables and developmental milestone information are shared to provide the mother with advanced knowledge about ways to maintain maximum wellness for her child.

- EPSDT Health Promotion: HCA EPSDT health promotion specialists receive blood lead level reports and provide appropriate care coordination for any member identified with elevated blood lead levels. Outreach and education regarding the blood lead level monitoring program and requirements are provided to the parent/guardian and the PCP. All data about HCA members enrolled in the elevated blood lead level monitoring program are maintained in a program-specific database, tracked to ensure that testing and retesting are scheduled and completed, and provided assistance with transportation as needed until the member meets program closure requirements. HCA maintains processes to ensure proper and complete continuation of care and monitoring for members with elevated blood lead levels who are transferring to other health plans or medical insurance providers or otherwise terminating enrollment with HCA.

Health Net Access (Health Net)

- "Secret Shopper" Calls: Health Net uses an external vendor to conduct "secret shopper" calls to the contracted provider network and to perform routine telephonic surveys. Health Net surveys a statistically significant random sample of PCPs, specialist, dentists, and maternity providers quarterly to determine provider compliance with the AHCCCS appointment (routine, urgent, and emergent) and wait-time standards. In addition, specialty physicians are contacted to assess those criteria as well as their ability to accept Health Net patients.
- Health Net Access Quality Improvement Corner: The Health Net QI Corner is located on the provider portal and contains information on current best practices. The site provides a wide variety of tools and resources that can assist and support providers in delivering care that meets the standard and performance expectations for Health Net members. The tools available in the Health Net QI Corner support efforts to improve patients' health and, as a result, help to improve Health Net's success on a variety of performance metrics and PIPs.
- Against Medical Advice (AMA) Tracking: Health Net began tracking members that had been discharged from inpatient or ED with an AMA status. One purpose of this tracking was to identify why members chose to go AMA, and another was to improve the following performance measures: Inpatient, ED, and Readmissions. The AMA discharge data collected illustrate the needs of the population and will be used to implement interventions that will target these needs.

Maricopa Health Plan (MHP)

- Healthy Beginnings Program: During CYE 2015, MHP participated in the DentaQuest Healthy Beginnings program, a member outreach/education initiative aimed at the 0-to-2-year-old age group. The parent/guardian receives an initial postcard at birth and additional postcards on the child's first and second birthdays. MHP requested that verbiage be added to the postcards reminding parents to

ask their dentist about the application of fluoride varnish. The Healthy Beginnings Program has increased overall dental participation.

- Early Intervention for Pregnant Members: MHP generates a weekly internal report listing members who may be pregnant, based upon claims data (pregnancy-related office visits and lab data); the AHCCCS 834 report indicating a pregnancy condition; information obtained from the prior authorization department; and referrals from the Customer Care Department. Within five days of receipt of this member information, all members are contacted by telephone and asked if they have scheduled their first prenatal appointment, offered assistance with locating a designated maternity care provider if needed, and informed about specific community-based resources available to the member for prenatal support. The member is offered transportation services in order to receive prenatal care from the assigned provider.
- Provider Appointment Availability Survey: MHP conducts a provider appointment availability survey for primary, specialty, dental, and maternity care providers. The Network Development Department is responsible for the administration of the survey. This survey includes any out-of-network service addresses for primary, specialty, dental, and maternity care providers authorized during the quarter.

Mercy Care Plan (MCP)

- 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.
- Well Child Visits Incentives: MHP offers incentives to parents of 3-month-olds. If the member has six well-child visits before the child is 15 months of age and all required immunizations prior to their second birthday, MCP will send a $40 Target gift card. Incentives are also offered to parents of 13-month-olds with five well-child visits according to claims data. If the member receives the sixth well visit prior to 15 months of age, MCP will send the member a $15 Target gift card.
- Dental home initiative: MCP's dental home initiative program involved partnering with specific group of dental providers who expressed interest in the dental home program and have agreed to conduct outreach efforts to schedule visits for the members assigned to their practices.

Phoenix Health Plan (PHP)

- Childhood Obesity Initiative: PHP educates members about childhood obesity through the member newsletter, PHP website, and the welcome home discharge program. In CYE 2014 the member website was revised to include a section devoted to the childhood obesity initiative. In CYE 2015, members were directed to "The Habits for Healthy Kids" website which is a resource for members, parents, and guardians. The website contains:
  - A body mass index calculator.
  - Physical activity resources and tips for parents.
  - Nutrition tips and healthy recipes.
  - Tips on how to reduce a child's stress level.
  - Healthy sleeping tips.
- Case Management (CM) and Disease Management (DM) Programs: PHP provides care coordination, complex case management, and disease management within the Medical Management Department. The programs seek to optimize targeted healthcare outcomes known to limit morbidity, mortality, and the disease costs. The CM and DM teams work in collaboration with the quality management and pharmacy programs. The goal of case and disease management is to promote members' understanding of diseases/conditions, educate members to become more efficient in self-management of healthcare and coordination of healthcare services, and provide support in creating and sustaining behaviors that result in improved health. Case and disease managers educate members in various ways to use diagnostic/preventive screening for early detection, to continue monitoring the diseases/conditions, and to understand the importance of preventive measures. Clinical staff inform and educate members about their responsibility to comply with prescribed treatments or regimens.
- Member Risk Assessment: PHP uses a member health risk assessment (HRA) to obtain baseline assessments and identify new members' healthcare needs. The assessment is mailed to new members. In the event an HRA is not received by PHP within 60 days, another HRA is sent to the member to complete. Members may return the HRA or call in to the CM voicemail to complete the HRA by phone. In addition, new members are screened if they were hospitalized within the first 90 days of enrollment to PHP. The responses are stratified by risk category, and members identified at moderate risk are referred to existing programs as appropriate. Members identified as high-risk are referred to the complex case management area for further assessment and development of a plan of care.

UnitedHealthcare Community Plan (UHCCP)

- 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 for, ensuring 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 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 ED use and admissions by providing practices with real-time actionable data on access to care, ED utilization, admissions, discharges, and care opportunities; and to facilitate timely PCP follow-up.
- Member Advisory Council (MAC) Quarterly Collaborative Forum: UHCCP understands the importance of obtaining input and feedback from Arizona members regarding the care provided. In addition to existing methods to obtain member input, a MAC convenes quarterly to provide a collaborative forum for Arizona members, community representatives, advocacy groups, and community-based providers to share successes, bring issues and ideas from Arizona members, jointly work on community outreach, identify common ground around legislative issues, provide input and feedback on new and future initiatives, and review and evaluate how UHCCP programs fulfill the mission.

University Family Care (UFC)

- Early Intervention for Pregnant Members: UFC generates a weekly internal report listing members who may be pregnant, based upon claims data (pregnancy-related office visits and lab data); the AHCCCS 834 report indicating a pregnancy condition; information obtained from the prior authorization department; and referrals from the Customer Care Department. Within five days of receipt of this member information, all members are contacted by telephone and asked if they have scheduled their first prenatal appointment, offered assistance with locating a designated maternity care provider if needed, and informed about specific community-based resources available to the member for prenatal support. The member is offered transportation services in order to receive prenatal care from the assigned provider.

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

- Provider Appointment Availability Survey: UFC conducts a provider appointment availability survey for primary, specialty, dental, and maternity care providers. The Network Development Department is responsible for the administration of the survey. This survey includes any out-of-network service addresses for primary, specialty, dental, and maternity care providers authorized during the quarter.
- Patient Education Program: UFC implemented a patient education program modeled after "Ask Me 3." The program encourages members to ask their healthcare providers three questions: What is my main problem? What do I need to do? Why is it important for me to do this? Member letters encourage the members to obtain preventive healthcare services and incorporate the "Ask Me 3" questions to minimize misunderstanding between healthcare professional and members and to increase the likelihood of compliance with the medical plan. In addition, "Ask Me 3" material is included in the member handbook, member newsletters, provider manual, posters to be used by providers, and distributed to members at outreach events and health fairs.

Arizona Department of Economic Security/Comprehensive Medical and Dental Plan (CMDP)

- Inpatient Hospital Review: CMDP reviews inpatient hospital work sheets and other documentation to ensure that reviews are started within one business day of notification. CMDP conducts weekly inpatient rounds to review all cases for medical necessity, discharge planning, Child Protective Services case management involvement, placement issues, and potential healthcare acquired conditions.
- Monthly Staffing meetings with the Regional Behavioral Health Authorities (RBHAs): CMDP participates in staffing meetings with each RBHA at least monthly regarding members participating in the Super Utilizer program. These meetings facilitate the creation of a collaborative care plan with interventions tailored to meet each member's unique needs.
- EPSDT and Dental Visits: CMDP developed a 120-day report which generates monthly emails to the Division of Child Safety (DCS) specialists notifying them of children who have not received an EPSDT or dental visit within 120 days of removal from their home.

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 438.358(a), AHCCCS elected to conduct the functions associated with the federal Medicaid managed care requirements 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 section of the annual EQR report.

CYE 2013 commenced a new, three-year cycle of ORs; and AHCCCS conducted a comprehensive OR for each contractor during CYE 2014. During CYE 2015, AHCCCS monitored the progress of 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 that the expectation was that any issues identified would 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.

Conducting the Review

For the CYE 2015 focused OR, AHCCCS reviewed specific standards in various categories for each Contractor. Not all Contractors had the same standards reviewed. Details regarding the standards reviewed for each Contractor are included in the findings paragraphs following.

Objectives for Conducting the Review

AHCCCS' objectives for conducting ORs are to:

- Determine if the Contractor satisfactorily met AHCCCS' requirements as specified in its contract, AHCCCS policies, Arizona Revised Statutes, the Arizona Administrative Code (AAC), and Medicaid managed care regulations (42 CFR 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 reviews all applicable CMS and AHCCCS contract requirements at least once every three years. AHCCCS follows a CMS-approved process to conduct the ORs that is also consistent with CMS' protocol for EQROs that conduct the reviews.[6-1]

AHCCCS' methodology for conducting the OR included the following:

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

Activities AHCCCS conducted following the review, including:

- Documenting and compiling the results of its review, preparing the draft report of findings, and issuing the draft report to Contractors for their review and comment. In the report, each standard 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

[6-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: February 26, 2015.

  - Noncompliance (NC): 0 percent to 49 percent compliant
  - Not Applicable (N/A): Standard was not applicable to the Contractor

  The report sent to the Contractor also 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 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 each Contractor. HSAG then analyzed the data by performance category (e.g., Quality Management).

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

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.

Care1st Health Plan (Care1st)

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 for review. Table 6-1 presents the overall compliance results and results for each standard reviewed.

Table 6-1—Category of Standards and Compliance Scores for Care1st

Category of Standards	Total No. of Standards	Full Compliance	Substantial Compliance	Partial Compliance	Non-compliance
Maternal and Child Health and EPSDT	5	5	0	0	0
Medical Management	1	1	0	0	0
Quality Management	1	1	0	0	0
Totals	**7**	**7**	**0**	**0**	**0**
% Totals		**100%**	**0%**	**0%**	**0%**

Table 6-1 illustrates the following compliance scores for the seven standards reviewed for the Care1st focused OR:

- Maternal and Child Health and EPSDT: *Full Compliance* for the five standards reviewed.
- Medical 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 seven standards in three categories. Care1st was fully compliant in all standards reviewed.

Opportunities for Improvement and Recommendations

The results of the focused OR demonstrated no opportunities for improvement as Care1st was fully compliant in all standards reviewed. In the report generated from Care1st's OR, AHCCCS included no recommendations or CAPs.

Summary

Care1st was fully compliant for all standards reviewed.

Health Choice Arizona (HCA)

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 for review. Table 6-2 presents the overall compliance results and results for each standard reviewed.

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

Category of Standards	Total No. of Standards	Full Compliance	Substantial Compliance	Partial Compliance	Non-compliance
Claims and Information Systems	3	1	0	1	1
Maternal and Child Health and EPSDT	1	0	0	1	0
Medical Management	1	1	0	0	0
Totals	**5**	**2**	**0**	**2**	**1**
% Totals		**40%**	**0%**	**40%**	**20%**

Table 6-2 illustrates the following compliance scores for the five standards reviewed for the HCA focused OR:

- Claims and Information Systems: For the three standards reviewed, the Contractor received one *Full Compliance* score, one *Partial Compliance* score, and one *Noncompliance* score.
- Maternal and Child Health and EPSDT: *Partial Compliance* for the one standard reviewed.
- Medical Management: *Full Compliance* for the one standard reviewed.

Strengths

For this focused review, AHCCCS reviewed a total of five standards in three categories. HCA was fully compliant in the one standard reviewed for Medical Management.

Opportunities for Improvement and Recommendations

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

Claims and Information Systems:

- The Contractor must ensure that it includes the reasons for all denials and adjustments, an adequate description of all denials and adjustments, and accurate application of coordination of benefits and copays.
- In absence of a contract specifying otherwise, the Contractor must pay applicable interest on all claims, including overturned claim disputes.

Maternal and Child Health and EPSDT:

- The Contractor must implement a process to identify postpartum depression or other behavioral health concerns and refer to/assist members in connecting with the appropriate behavioral health-care providers as well as conduct appropriate risk assessments and provide appropriate case management (maternity and behavioral health) services. The Contractor must implement follow-up actions and monitoring processes to promote interventions for identified areas of concern in the cases of providers found to have an overall passing score on the medical record review yet deficient in a key area such as postpartum depression screening.

Summary

HCA was fully compliant for the one standard reviewed for Medical Management. For Claims and Information Systems (three standards total) HCA received one *Full Compliance*, one *Partial Compliance*, and one *Noncompliance* score for each standard. For Maternal and Child Health and EPSDT, HCA received a *Partial Compliance* score only. HCA has submitted CAPs to AHCCCS for these standards, which will be reevaluated for compliance at the next OR.

Health Net Access (Health Net)

Findings

For CYE 2015 AHCCCS conducted a focused OR that targeted six categories of OR standards. Within these standard categories, AHCCCS chose specific sub-standards for review. Table 6-3 presents the compliance standard and compliance score results reviewed for Health Net.

Table 6-3—Category of Standards and Compliance Scores for Health Net

Category of Standards	Total No. of Standards	Full Compliance	Substantial Compliance	Partial Compliance	Non-compliance
Claims and Information Systems	4	1	0	0	3
General Administration	9	7	1	0	1

Category of Standards	Total No. of Standards	Full Compliance	Substantial Compliance	Partial Compliance	Non-compliance
Grievance System	17	15	1	1	0
Maternal and Child Health and EPSDT	14	14	0	0	0
Medical Management	8	5	2	0	1
Quality Management	9	9	0	0	0
Totals	**61**	**51**	**4**	**1**	**5**
% Totals		**84%**	**7%**	**2%**	**8%**

*Due to rounding, percentages may not add up to 100 percent.

Table 6-3 illustrates the following compliance scores for the 61 standards reviewed for the Health Net focused OR:

- Claims and Information Systems: For the four standards reviewed, the Contractor received one *Full Compliance* score and three *Noncompliance* scores.
- General Administration: For the nine standards reviewed, the Contractor received seven *Full Compliance* scores, one *Substantial Compliance* score, and one *Noncompliance* score.
- Grievance System: For the 17 standards reviewed, the Contractor received 15 *Full Compliance* scores, one *Partial Compliance* score, and one *Substantial Compliance* score.
- Maternal and Child Health and EPSDT: For the 14 standards reviewed, the Contractor received 14 *Full Compliance* scores.
- Medical Management: For the eight standards reviewed, the Contractor received five *Full Compliance* scores, two *Substantial Compliance* scores, and one *Noncompliance* score.
- Quality Management: For the nine standards reviewed, the Contractor received nine *Full Compliance* scores.

Strengths

For this focused review AHCCCS reviewed a total of 61 standards in six categories. Health Net was fully compliant in the 14 standards reviewed for Maternal and Child Health EPSDT and for the nine standards reviewed for Quality Management.

Opportunities for Improvement and Recommendations

The results of the focused OR demonstrated opportunities for improvement as Health Net was less than fully compliant in the four standards reviewed for Claims and Information Systems, the nine standards reviewed for General Administration, the 17 standards reviewed for Grievance System, and the eight

standards reviewed for Medical Management. In the report generated from Health Net's OR, AHCCCS included recommendations for Health Net which necessitated submitting CAPs. AHCCCS included the following recommendations in the final OR report to Health Net.

Claims and Information Systems

- The Contractor must ensure that remits generated by its own staff contain an accurate application of coordination of benefits, an accurate description of all adjustments, and the amount paid. For remits issued by its subcontractors, the remits must include an adequate description or reasons for all denials and adjustments, instructions for resubmission of a claim, the required language on rights or submission of claims disputes, and the expanded language covering timely claims submission.
- The Contractor must pay applicable interest on all claims, including overturned claim disputes.
- The Contractor must ensure that it accurately applies quick-pay discounts to hospital claims.

General Administration

- The Contractor must ensure that its auditing process includes monitoring post processing /retrospective review of claims to determine if reasonable charges were made for services provided, the appropriateness of inpatient and outpatient care, the appropriate level of care, and/or existence of excessive diagnostic testing or ancillary referrals.
- The Contractor must collect required information for all persons with an ownership or control interest in the Contractor and its fiscal agents and determine monthly whether such individuals have been convicted of a criminal offense related to any program under Medicare, Medicaid, or the Title XX Social Services program. Further, the Contractor's policies and procedures must be updated as noted in the "Comments" section.

Grievance System

- The Contractor must ensure that claim disputes are promptly forwarded to the Dispute Department if filed with another area.
- The Contractor must ensure that all Notices of Decision include the correct time frames for requesting a State fair hearing and the factual and legal basis for the decision.

Medical Management

- The Contractor should include provider profiling in its utilization data management. The Medical Management/Utilization Management (MM/UM) meetings should refer to the Utilization Standards Graphs Summary as an attachment to the minutes when it is reported to the Committee or summarize the report in the MM/UM meeting minutes including analysis, interventions, Committee recommendations, and responsible party.
- The Contractor should consider revising the Disease Management (DM) program to conform to AHCCCS' requirement for updating clinical practice guidelines annually rather than the less stringent, two-year, National Committee for Quality Assurance requirement. The Contractor should

review the Alere clinical practice guidelines annually and document the review and recommendations made by the MM Committee in the MM Committee meeting minutes.

- The Contractor must provide medical home services and monitor the effectiveness of those services.

Summary

Health Net was fully compliant for all standards reviewed for Maternal and Child Health and EPSDT (14 standards) and Quality Management (nine standards). For the four standards reviewed for Claims and Information Systems, Health Net received one *Full Compliance* score and three *Noncompliance* scores. For the nine standards reviewed for General Administration, Health Net received seven *Full Compliance* scores, one *Substantial Compliance* score, and one *Noncompliance* score. For the 17 standards reviewed for Grievance System, Health Net received 15 full compliance scores, one *Substantial Compliance* score, and one *Partial Compliance* score. For the eight standards reviewed for Medical Management, Health Net received five *Full Compliance* scores, two *Substantial Compliance* scores, and one *Noncompliance* score. Health Net has submitted CAPs to AHCCCS for these standards, which will be reevaluated for compliance at the next OR.

Maricopa Health Plan (MHP)

Findings

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

Table 6-4—Category of Standards and Compliance Scores for MHP

Category of Standards	Total No. of Standards	Full Compliance	Substantial Compliance	Partial Compliance	Non-compliance
Claims and Information Systems	6	5	0	1	0
Grievance System	3	3	0	0	0
Maternal and Child Health and EPSDT	4	4	0	0	0
Medical Management	1	1	0	0	0
Quality Management	3	3	0	0	0
Totals	**17**	**16**	**0**	**1**	**0**
% Totals		**94%**	**0%**	**6%**	**0%**

Table 6-4 illustrates the following compliance scores for the 17 standards reviewed for the MHP focused OR:

- Claims and Information System: For the six standards reviewed, the Contractor received five *Full Compliance* scores and one *Partial Compliance* score.
- Grievance System: *Full Compliance* for the three standards reviewed.
- Maternal and Child Health and EPSDT: *Full Compliance* for the four standards reviewed.
- Medical Management: *Full Compliance* for the one standard reviewed.
- Quality Management: *Full Compliance* for the three standards reviewed.

Strengths

For this focused review AHCCCS reviewed a total of 17 standards in five categories. MHP was fully compliant for all standards reviewed for Grievance System (three standards), Maternal and Child Health and EPSDT (four standards), Medical Management (one standard), and Quality Management (three standards).

Opportunities for Improvement and Recommendations

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

Claims and Information Systems:

- The Contractor's remittance advices must include an adequate description of all denials and adjustments and an accurate application of Coordination of Benefits and copays. The Contractor's subcontracted remits must include an adequate description of all denials and adjustments and instructions for the submission of claim disputes or corrected claims.

Summary

MHP was fully compliant for all standards reviewed for all categories of standards with the exceptions of Claims and Information Systems. For Claims and Information Systems (six standards total) MHP received five *Full Compliance* scores and one *Partial Compliance* score. MHP has submitted a CAP to AHCCCS for this standard, which will be reevaluated for compliance at the next OR.

Mercy Care Plan (MCP)

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 for review. Table 6-5 presents the overall compliance results and results for each standard reviewed.

Table 6-5—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	0	1	1	2
Maternal and Child Health and EPSDT	1	1	0	0	0
Medical Management	1	1	0	0	0
Totals	**6**	**2**	**1**	**1**	**2**
% Totals		**33%**	**17%**	**17%**	**33%**

Table 6-5 illustrates the following compliance scores for the six standards reviewed for the MCP focused OR:

- Claims and Information System: For the four standards reviewed, the Contractor received one *Substantial Compliance* score, one *Partial Compliance* score, and two *Noncompliance* scores.
- Maternal and Child Health and EPSDT: *Full Compliance* for the one standard reviewed.
- Medical Management: For the six standards reviewed, the Contractor received two *Full Compliance* scores, one *Substantial Compliance* score, one *Partial Compliance* score, and two *Noncompliance* scores.

Strengths

For this focused review AHCCCS reviewed a total of six standards in three categories. MCP was fully compliant in the one standard reviewed for Maternal and Child Health and EPSDT and the one standard reviewed for Medical 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 the 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 pays applicable interest on all claims, including overturned claim disputes.
- The Contractor must ensure that it accurately applies quick-pay discounts.
- The Contractor must ensure that it processes and pays all overturned claim disputes in a manner consistent with the decision within 15 business days of that decision.
- In the absence of a negotiated rate, the Contractor must reimburse out-of-network providers pursuant to ARS §36-2903, 2904, and 2905.01.

Summary

MCP was fully compliant for all standards reviewed for both Maternal and Child Health and EPSDT (one standard) and Medical Management (one standard). For Claims and Information Systems (four standards total), MCP received one *Partial Compliance* score, one *Substantial Compliance* score, and two *Noncompliance* scores. MCP has submitted CAPs to AHCCCS for these standards, which will be reevaluated for compliance at the next OR.

Phoenix Health Plan, LLC (PHP)

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 for review. Table 6-6 presents the overall compliance results and results for each standard reviewed.

Table 6-6—Category of Standards and Compliance Scores for PHP

Category of Standards	Total No. of Standards	Full Compliance	Substantial Compliance	Partial Compliance	Non-compliance
Maternal and Child Health and EPSDT	5	5	0	0	0
Medical Management	7	7	0	0	0
Quality Management	1	1	0	0	0
Totals	**13**	**13**	**0**	**0**	**0**
% Totals		**100%**	**0%**	**0%**	**0%**

Table 6-6 illustrates the following compliance scores for the 13 standards reviewed for the PHP focused OR:

- Maternal and Child Health and EPSDT: *Full Compliance* for the five standards reviewed.
- Medical Management: *Full Compliance* for the seven standards reviewed.
- Quality Management: *Full Compliance* for the one standard reviewed.

Strengths

For this focused review, AHCCCS reviewed a total of 13 standards in three categories. PHP was fully compliant in all standards reviewed.

Opportunities for Improvement and Recommendations

The results of the focused OR demonstrated no opportunities for improvement as PHP was fully compliant in all standards reviewed. In the report generated from the Contractor's OR, AHCCCS included no recommendations or CAPs for the Contractor.

Summary

PHP was fully compliant for all standards reviewed.

UnitedHealthcare Community Plan (UHCCP)

For CYE 2015 AHCCCS conducted a focused OR that targeted three categories of OR standards. Within these standard categories, AHCCCS chose specific sub-standards for review. Table 6-7 presents the overall compliance results and results for each standard reviewed.

Table 6-7—Category of Standards and Compliance Scores for UHCCP

Category of Standards	Total No. of Standards	Full Compliance	Substantial Compliance	Partial Compliance	Non-compliance
Claims and Information Systems	3	0	0	1	2
Maternal and Child Health and EPSDT	5	5	0	0	0
Medical Management	1	1	0	0	0
Totals	**9**	**6**	**0**	**1**	**2**
% Totals		**67%**	**0%**	**11%**	**22%**

Table 6-7 illustrates the following compliance scores for the nine standards reviewed for the UHCCP focused OR:

- Claims and Information System: For the three standards reviewed, the Contractor received one *Partial Compliance* score and two *Noncompliance* scores.
- Maternal and Child Health and EPSDT: *Full Compliance* for the five standards reviewed.
- Medical Management: *Full Compliance* for the one standard reviewed.

Strengths

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

Opportunities for Improvement and Recommendations

The results of the focused OR demonstrated opportunities for improvement as the Contractor was less than fully compliant in the three standards reviewed for Claims and Information Systems. In the report generated from the Contractor's OR, AHCCCS included recommendations for UHCCP which necessitated submitting CAPs. AHCCCS included the following recommendation in the final OR report to UHCCP.

Claims and Information Systems:

- The Contractor must ensure that all of its and its subcontractor's remittance advices contain the time frames for submission of corrected claims, include adequate descriptions of all denials and adjustments, and reflect the billed amount. For its own remits, the Contractor must ensure the inclusion of reasons for the denials and the proper application of coordination of benefits.
- The Contractor must ensure that it pays applicable interest on all claims, including overturned claim disputes.
- In the absence of a negotiated rate, the Contractor must pay contracted providers according to accurately loaded rates and reimburse out-of-network providers pursuant to ARS §36-2903, 2904, and 2905.01.

Summary

UHCCP was fully compliant for all standards reviewed for both Maternal and Child Health and EPSDT (five standards) and Medical Management (one standard). For Claims and Information Systems (three standards total), UHCCP received one *Partial Compliance* score and two *Noncompliance* scores. UHCCP has submitted CAPs to AHCCCS for these standards, which will be reevaluated for compliance at the next OR.

University Family Care (UFC)

Findings

For CYE 2015 AHCCCS conducted a focused OR that targeted five categories of OR standards. Within these standard categories, AHCCCS chose specific sub-standards for review. Table 6-8 presents the overall compliance results and results for each standard reviewed.

Table 6-8—Category of Standards and Compliance Scores for UFC

Category of Standards	Total No. of Standards	Full Compliance	Substantial Compliance	Partial Compliance	Non-compliance
Claims and Information Systems	6	3	1	2	0
Grievance System	3	2	1	0	0
Maternal and Child Health and EPSDT	4	4	0	0	0
Medical Management	1	1	0	0	0
Quality Management	3	3	0	0	0
Totals	**17**	**13**	**2**	**2**	**0**
% Totals		**76%**	**12%**	**12%**	**0%**

Table 6-8 illustrates the following compliance scores for the 17 standards reviewed for the UFC focused OR:

- Claims and Information System: For the six standards reviewed, the Contractor received three *Full Compliance* scores, one *Substantial Compliance* score, and two *Partial Compliance* scores.
- Grievance System: For the three standards reviewed, the Contractor received two *Full Compliance* scores and one *Substantial Compliance* score.
- Maternal and Child Health and EPSDT: *Full Compliance* for the four standards reviewed.
- Medical Management: *Full Compliance* for the one standard reviewed.
- Quality Management: *Full Compliance* for the three standards reviewed.

Strengths

For this focused review, AHCCCS reviewed a total of 17 standards in five categories. UFC was fully compliant for all standards reviewed for Maternal and Child Health and EPSDT (four standards), Medical Management (one standard), and Quality Management (three standards).

Opportunities for Improvement and Recommendations

The results of the focused OR demonstrated opportunities for improvement as UFC was less than fully compliant in the six standards reviewed for Claims and Information Systems and the three standards reviewed for Grievance System. In the report generated from the UFC's OR, AHCCCS included recommendations for UFC which required submission of CAPs. AHCCCS included the following recommendations in the final OR report to UFC.

Claims and Information Systems:

- The Contractor's remittance advices must include an adequate description of all denials and adjustments and an accurate application of Coordination of Benefits and copays. The Contractor's subcontracted remits must include an adequate description of all denials and adjustments and instructions for the submission of claim disputes or corrected claims.
- For hospital claims, the Contractor must pay interest at the rate of 1 percent per month for each month or portion of a month following the 60th day of receipt of the clean claim until the date of payment.
- The Contractor must ensure that noncontracted providers are reimbursed correctly, in the absence of a written negotiated rate.

Grievance System:

- The Contractor must use the appropriate factual and legal basis for the decision as defined in *Contract/RFP No. YH14-0001 Section F: Attachment F2—Provider Claim Dispute Standards.*

Summary

UFC was fully compliant for all standards reviewed for all categories of standards with the exceptions of Claims and Information Systems and Grievance System. For Claims and Information Systems (six standards total) UFC received three *Full Compliance* scores, one *Substantial Compliance* score, and two *Partial Compliance* scores. UFC has submitted a CAP to AHCCCS for this standard, which will be reevaluated for compliance at the next OR.

DES/Comprehensive Medical and Dental Programs (CMDP)

For CYE 2015 AHCCCS conducted a focused OR that targeted four categories of OR standards. Within these standard categories, AHCCCS chose specific sub-standards for review. Table 6-9 presents the overall compliance results and results for each standard reviewed.

Table 6-9—Category of Standards and Compliance Scores for CMDP

Category of Standards	Total No. of Standards	Full Compliance	Substantial Compliance	Partial Compliance	Non-compliance	Not Applicable
Claims and Information Systems	3	0	0	1	2	0
Maternal and Child Health and EPSDT	3	3	0	0	0	0
Medical Management	4	2	2	0	0	0
Quality Management	6	1	1	1	2	1
Totals	**16**	**6**	**3**	**2**	**4**	**1**
% Totals		**38%**	**19%**	**13%**	**25%**	**6%**

*Due to rounding, percentages may not add up to 100 percent.

Table 6-9 illustrates the following compliance scores for the 16 standards reviewed for the CMDP focused OR:

- Claims and Information System: For the three standards reviewed, the Contractor received one *Partial Compliance* score and two *Noncompliance* scores.
- Maternal and Child Health and EPSDT: *Full Compliance* for the three standards reviewed.
- Medical Management: For the four standards reviewed, the Contractor received two *Full Compliance* scores and two *Substantial Compliance* scores.
- Quality Management: For the six standards reviewed, the Contractor received one *Full Compliance* score, one *Substantial Compliance* score, one *Partial Compliance* score, two *Noncompliance* scores, and had one scored as *Not Applicable*.

Strengths

For this focused review AHCCCS reviewed a total of 16 standards in four categories. CMDP was fully compliant for all standards reviewed for Maternal and Child Health and EPSDT (three standards).

Opportunities for Improvement and Recommendations

The results of the focused OR demonstrated opportunities for improvement as CMDP was less than fully compliant in the three standards reviewed for Claims and Information Systems, the four standards reviewed for Medical Management, and the six standards reviewed for Quality Management. In the report generated from the CMDP's OR, AHCCCS included recommendations for CMDP that required the submission of CAPs. AHCCCS included the following recommendations in the final OR report to CMDP.

Claims and Information Systems:

- The Contractor's remits must include an adequate description of all denials and adjustments, the reasons for all denials and adjustments, and complete instructions for submitting corrected claims.
- The Contractor must ensure that it pays applicable interest on all claims, including overturned claim disputes.
- The Contractor should ensure that it appropriately applies provider information supplied by AHCCCS when reviewing claims for a provider billing outside of that provider's category of service.

Medical Management:

- The Contractor must use and accurately complete the correct Enrollment Transition Information (ETI) form.
- Although the Contractor is appropriately issuing notice of actions (NOAs) and notice of extensions (NOEs), the Contractor did not provide a policy and/or procedure devoted to NOAs and NOEs that includes all requirements outlined in AHCCCS policy. The policy must address the right of the member to have services continue during the appeal process.

Quality Management:

- The Contractor must identify in the credentialing/recredentialing policy all members of its Credentialing Committee, including participation of Arizona Medicaid network providers. The Contractor must continue to implement the AHCCCS-approved implementation plan submitted by the Arizona Association of Health Plans for provisional and initial credentialing of providers in accordance with *AHCCCS Medical Policy Manual, Chapter 900, Section 950* requirements. The Contractor must add the date of the provider's most recent credentialing or recredentialing by the Contractor.
- The Contractor must continue to implement the AHCCCS-approved implementation plan submitted by the Arizona Association for Health Plans for initial credentialing of providers in accordance with *AHCCCS Medical Policy Manual, Chapter 900, Section 950* requirements. The Contractor must add the date of the provider's most recent credentialing or re-credentialing by the Contractor.
- The Contractor must develop and implement an organizational credentialing policy according to the requirement of the *AHCCCS Medical Policy Manual, Chapter 900, Section 950*.
- The Contractor must develop a medical record review policy. The Contractor must continue to implement the AHCCCS-approved implementation plan with the Arizona Association of Health Plans for medical record reviews.

Summary

CMDP was fully compliant for all standards reviewed for Maternal and Child Health and EPSDT (three standards). For the three standards reviewed for Claims and Information System, CMDP received one *Partial Compliance* score and two *Noncompliance* scores. For the four standards reviewed for Medical

Management, CMDP received two *Full Compliance* scores and two *Substantial Compliance* scores. For the six standards reviewed for Quality Management, CMDP received one *Full Compliance* score, one *Substantial Compliance* score, and one *Partial Compliance* score, two *Noncompliance* scores, and one standard was not applicable. CMDP has submitted CAPs to AHCCCS for these standards which will be reevaluated for compliance at the next OR.

Overall Results for Acute Care and DES/CMDP Contractors

Findings

AHCCCS conducted a focused OR for the nine Contractors for CY 2015. The six categories and numerous standards reviewed varied among the Contractors, which did not allow for a uniform comparative analysis. However, HSAG was able to review and compare the outcomes and recommendations for purposes of this report. In the six categories evaluated during the focused OR, AHCCCS reviewed two categories (Maternal and Child Health and EPSDT and Medical Management) for all Contractors. AHCCCS reviewed all six categories for Health Net. AHCCCS reviewed 78 percent of the Contractors for Claims and Information Systems and 67 percent for Quality Management. AHCCCS reviewed General Administration for one Contractor. AHCCCS reviewed three categories for each of five Contractors.

Two Contractors (Care1st and PHP) received 100 percent fully compliance scores in all categories.

AHCCCS reviewed the Claims and Information Systems category for seven of the nine Contractors, finding that six of the Contractors had a prevalent deficiency regarding the adequate description of all denials and adjustments and that some failed to have an accurate application of Coordination of Benefits and copays. Five Contractors had deficiencies related to the payment of applicable interest on all claims, including overturned claim disputes. Three of seven Contractors failed to reimburse out-of-network providers in accordance with the State statute in the absence of a written negotiated rate. Two of the seven Contractors failed to accurately apply quick-pay discounts.

AHCCCS reviewed all Contractors for the Maternal and Child Health and EPSDT category and found that eight of the nine Contractors scored full compliance for all standards. HCA scored *Partial Compliance* with one standard under this category.

For the Medical Management category, AHCCCS found all except two Contractors (Health Net and CMDP) in full compliance. AHCCCS found that Health Net was not in compliance with the standards that require the Contractor to provide medical home services and funding toward effectiveness of those services.

AHCCCS reviewed six Contractors for the Quality Management category. Five of the six were found to be in compliance with all standards. CMDP had deficiencies in the Quality Management category, specifically regarding development and implementation of its credentialing policy according to the requirement enforced by the *AHCCCS Policy Manual*. In addition, CMDP was found in noncompliance with the requirement to implement an AHCCCS-approved medical record review process.

Health Net was the only Contractor for which the General Administration category was reviewed. Of the nine standards reviewed, Health Net scored seven at *Full Compliance*, one *Substantial Compliance*, and one *Noncompliance*. AHCCCS found that Health Net failed both to collect required information regarding ownership and controlling interest in the Contractor and to determine monthly whether or not such individuals had been convicted of criminal offenses related to any program under Medicare or Medicaid.

AHCCCS reviewed the Grievance category for three of the nine Contractors. Two Contractors (Health Net and UFC) presented deficiencies in the Grievance Category. AHCCCS found that UFC scored *Substantial Compliance* in one sub-standard as it pertains to the Contractor using the appropriate factual and legal basis for the decision as defined in *Contract/RFP No. YH14-0001 Section F: Attachment F2*. Health Net scored *Full Compliance* in 15 of the 17 total standards reviewed, with one score of *Substantial Compliance*, and only one *Partial Compliance*.

Strengths

Each of the nine Contractors had at least one category in which all related standards were scored as fully compliant. Two Contractors, Care1st and PHP, scored *Full Compliance* for 100 percent of the standards. Four Contractors—Care1st, PHP, Health Net, and MHP—each had at least 84.0 percent of all standards scored as fully compliant. When examining specific categories, complying with Maternal and Child Health and EPSDT standards was an apparent strength among the Contractors. The category showed 41 of the reviewed standards (97.6 percent) to be in full compliance. The Grievance System and Medical Management categories were also identified as strengths for the nine Contractors.

Opportunities for Improvement and Recommendations

All Contractors made progress in meeting the standards; however, opportunities for improvement do exist. Three Contractors—HCA at 40 percent, MCP at 33 percent, and CMDP at 38 percent—scored under 50 percent fully compliant in the categories in which they were reviewed. No Contractors scored over 50 percent noncompliant. The highest scores for noncompliance were MCP at 33 percent followed by CMDP at 25 percent.

Based on AHCCCS' review of Acute Care and DES/CMDP Contractor performance in CYE 2015 and 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 procedures.

- Contractors should apply lessons learned from improving performance for one category of standards to other categories. Specifically, Contractors should look to CAPs completed from earlier ORs to determine best practices specific to their organizations to identify and correct deficient standards and monitor subsequent compliance.

Summary

AHCCCS' CYE 2015 Acute Care and DES/CMDP OR had positive results overall. All Contractors scored fully compliant in at least one category; and two Contractors, Care1st and PHP, scored 100 percent fully compliant. Three Contractors scored under 50 percent fully compliant; however, no Contractor scored over 50 percent noncompliant.

Maternal and Child Health and EPSDT standards were a strength across Acute Care and DES/CMDP Contractors. Almost 100 percent of Contractors were in full compliance with this standard. In addition, the Grievance System and Medical Management categories were identified as strengths for the nine Acute Care and DES/CMDP Contractors. The standard that resulted in the highest number of noncompliant scores was Claims and Information Systems.

7. Performance Measure Performance

In accordance with 42 CFR 438.240(b), AHCCCS contractually requires Contractors to have a QAPI program that includes measuring and submitting to AHCCCS data related to Contractor performance. Validating MCO and PIHP performance measures is one of the three mandatory external quality review activities described at 42 CFR 438.358(b)(2). The requirement at 438.358(a) allows the state, its agent that is not an MCO or PIHP, or an EQRO to conduct the mandatory activities. MCOs/PIHPs may report performance results to a state (as required by the state), or the state may calculate MCO/PIHP 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 Medicaid managed care act 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 Acute Care Contractors for CYE 2013:

- *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 First 15 Months of Life—6+ Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

For DES/CMDP 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 Acute Care Contractors for CYE 2014:

- *Adolescent Well-Care Visits*
- *Ambulatory Care—Emergency Department Visits—Total per 1,000 Member Months*
- *Annual Dental Visits—2–21 Years*
- *Asthma in Younger Adults Admission Rate per 100,000*
- *Children's Access to Primary Care Providers (PCPs)—12–24 Months, 25 Months–6 Years, 7–11 Years,* and *12–19 Years,* and *Total*
- *Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate*
- *Dental Participation*
- *Developmental Screening in the First Three Years of Life—1 Year, 2 Years, 3 Years,* and *Total*
- *Diabetes Short-Term Complications Admission Rate*
- *EPSDT Participation*
- *Heart Failure Admission Rate*
- *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*
- *Use of Appropriate Medications for People With Asthma*
- *Well-Child Visits in the First 15 Months of Life—6+ Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

For DES/CMDP, 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*
- *Children's Access to Primary Care Providers (PCPs)—12–24 Months, 25 Months–6 Years, 7–11 Years,* and *12–19 Years,* and *Total*
- *Dental Participation*
- *Developmental Screening in the First Three Years of Life—1 Year, 2 Years, 3 Years,* and *Total*

- *EPSDT Participation*
- *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 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 nine Acute Care and DES/CMDP Contractors for the Contractors' 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 AHCCCS-selected measure.
- 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 considering 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 associated Contractor-reported data collected 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.

Corrective action plans (CAPs) are key components of the AHCCCS Quality Strategy and general quality improvement processes used as foundational elements to improve performance rates below contractual minimum performance standards. At the time of 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 supporting documentation.

With the exception of the *Dental Participation* and *EPSDT Participation* measures, performance measures used the HEDIS 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. The National Committee for Quality Assurance (NCQA) updates its methodology annually to add new codes to better identify the eligible population and/or services being measured or to delete codes such as Current Procedural Terminology (CPT) and International Classification of Diseases (ICD) coding retired from standardized coding sets used by providers.

The *EPSDT Participation* and *Dental Participation* measures were calculated by AHCCCS based on administrative data only. For these measures, AHCCCS followed a methodology that CMS developed for the EPSDT Form 416 report which all state Medicaid agencies must submit annually to CMS.[7-1]

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

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

[7-1] Technical Specifications—EPSDT Annual Participation Rate. Available at: http://www.azahcccs.gov/reporting/Downloads/PerformanceMeasures/altcs/ALTCS_CMS416EPSDTCoding_1-2011.pdf. Accessed on December 2, 2016.

Using the performance rates which AHCCCS calculated and the statistical analysis that AHCCCS conducted 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 its recommendations to improve Contractor performance rates.

It is important to note that 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 considering all Contractors for CYE 2013 and CYE 2014.

Contractor-Specific Results—CYE 2013

AHCCCS provided data to HSAG on the CYE 2013 performance measure rates for eight Acute Care Contractors and for DES/CMDP. The eight CYE 2013 Acute Care Contractors were Bridgeway Health Solutions (BHS), Care1st Health Plan (Care1st), Health Choice Arizona (HCA), Maricopa Health Plan (MHP), Mercy Care Plan (MCP), Phoenix Health Plan, LLC (PHP), University Family Care (UFC), and UnitedHealthcare Community Plan (UHCCP). Comparative data for the two most recent measurement periods for all measures are reported here. The performance measures reported for the Acute Care Contractors and DES/CMDP are listed in the "Conducting the Review" section preceding. No CAPs data are included for any Contractors in the report this year.

Bridgeway Health Solutions (BHS)

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] (*p* value)	Minimum Performance Standard
Adolescent Well-Care Visits	32.4%	29.3%	-9.5%	***p*=0.033**	42.0%
Annual Dental Visits—2–21 Years	62.9%	63.3%	0.6%	*p*=0.674	57.0%
Children's Access to Primary Care Practitioners (PCPs)	90.1%	89.2%	-1.0%	*p*=0.160	**
12–24 Months	98.1%	96.7%	-1.4%	*p*=0.274	93.0%
25 Months–6 Years	87.4%	86.5%	-1.0%	*p*=0.447	83.0%
7–11 Years	90.3%	90.9%	0.7%	*p*=0.600	83.0%
12–19 Years	91.3%	89.2%	-2.3%	*p*=0.063	81.0%
Dental Participation	45.7%	44.4%	-2.9%	*p*=0.067	46.0%
EPSDT Participation	58.8%	50.1%	-14.8%	***p*<0.001**	68.0%
Well-Child Visits in the First 15 Months of Life—6+ Visits	90.1%	70.8%	-21.4%	***p*<0.001**	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	58.1%	52.5%	-9.7%	***p*=0.003**	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.

** 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 are included in this report.

Strengths

BHS' performance for the *Annual Dental Visits—2–21 Years* and *Children's Access to PCPs—7–11 Years* measures was a demonstrated strength for the Contractor as each of these measures continued to meet its AHCCCS MPS and demonstrated improvement from CYE 2012.

Opportunities for Improvement

HSAG recommends that BHS monitor the *Adolescent Well-Care Visits; EPSDT Participation*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rates given the challenges meeting the established AHCCCS MPS for each and declines in performance in CYE 2013. Additionally, AHCCCS should focus efforts on identifying improvement strategies to raise *EPSDT Participation* and well-care visit rates for adolescents and children. Although the *Well-Child Visits in the*

First 15 Months of Life—6+ Visits measure rate met its respective AHCCCS MPS, the rate demonstrated a significant decline from CYE 2012.

Summary

BHS' *Annual Dental Visits—2–21 Years* and *Children's Access to PCPs—7–11 Years* measure rates increased, and each exceeded its established AHCCCS MPS in CYE 2013. The remaining *Children's Access to PCPs* indicators and *Well-Child Visits in the First 15 Months of Life—6+ Visits* measures met each respective CYE 2013 AHCCCS MPS but demonstrated decreases in rates from CYE 2012. The *Adolescent Well-Care Visits; EPSDT Participation*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rates demonstrated decreases. Not one of the latter listed measures met its CYE 2013 AHCCCS MPS.

Care1st Health Plan (Care1st)

Findings

Table 7-2 presents the performance measure rates for Care1st. 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 Care1st

Performance Measure	CYE 2012 Performance	CYE 2013 Performance	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Adolescent Well-Care Visits	34.7%	36.1%	3.9%	*p*=0.124	42.0%
Annual Dental Visits—2–21 Years	62.9%	61.6%	-2.2%	***p*=0.006**	57.0%
Children's Access to Primary Care Practitioners (PCPs)	88.5%	91.0%	2.8%	***p*<0.001**	**
12–24 Months	97.8%	98.0%	0.2%	*p*=0.704	93.0%
25 Months–6 Years	87.5%	90.9%	3.8%	***p*<0.001**	83.0%
7–11 Years	89.4%	91.3%	2.2%	***p*=0.002**	83.0%
12–19 Years	85.8%	88.2%	2.9%	***p*=0.002**	81.0%
Dental Participation	43.6%	44.4%	1.7%	***p*=0.046**	46.0%
EPSDT Participation	65.7%	64.3%	-2.1%	***p*<0.001**	68.0%
Well-Child Visits in the First 15 Months of Life—6+ Visits	80.4%	76.3%	-5.1%	***p*=0.012**	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	67.0%	69.3%	3.5%	***p*=0.006**	66.0%

Performance Measure	CYE 2012 Performance	CYE 2013 Performance	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
[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					

CAPs

No CAPs are included in this report.

Strengths

Care1st's performance for the *Children's Access to PCPs* indicators (*12–24 Months, 25 Months–6 Years, 7–11 Years, 12–19 Years,* and *Total*) and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure was a demonstrated strength for the Contractor as these measures continued to meet each AHCCCS MPS and demonstrated improvement from CYE 2012.

Opportunities for Improvement

Care1st's reported rate for the *EPSDT Participation* measure demonstrated a decline from the previous year and did not meet its respective AHCCCS MPS. HSAG recommends that Care1st monitor the *EPSDT Participation* measure rate given its decline in performance in CYE 2013 and focus efforts on identifying improvement strategies to raise rates for this measure. Although the rate for *Dental Participation* increased between CYE 2012 and CYE 2013, the measure fell below the AHCCCS MPS. Care1st should continue interventions to raise this rate.

Summary

Care1st continued to show strong performance for the *Children's Access to PCPs* indicators and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures during CYE 2013 by meeting each AHCCCS MPS and showing improvement from CYE 2012. One measure rate (*EPSDT Participation*) failed to meet its corresponding AHCCCS MPS and demonstrated a decline in performance from CYE 2012.

Health Choice Arizona (HCA)

Findings

Table 7-3 presents the performance measure rates for HCA. 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 7-3—Performance Measurement Review for HCA

Performance Measure	CYE 2012 Performance	CYE 2013 Performance	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Adolescent Well-Care Visits	32.2%	36.5%	13.2%	***p*<0.001**	42.0%
Annual Dental Visits—2–21 Years	65.3%	53.9%	-17.4%	***p*<0.001**	57.0%
Children's Access to Primary Care Practitioners (PCPs)	85.8%	88.6%	3.3%	***p*<0.001**	**
12–24 Months	95.7%	96.9%	1.2%	***p*=0.005**	93.0%
25 Months–6 Years	84.4%	87.6%	3.8%	***p*<0.001**	83.0%
7–11 Years	87.2%	90.1%	3.3%	***p*<0.001**	83.0%
12–19 Years	83.8%	86.8%	3.5%	***p*<0.001**	81.0%
Dental Participation	46.8%	37.1%	-20.8%	***p*<0.001**	46.0%
EPSDT Participation	58.2%	56.0%	-3.8%	***p*<0.001**	68.0%
Well-Child Visits in the First 15 Months of Life—6+ Visits	52.2%	60.6%	16.1%	***p*<0.001**	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	60.8%	61.6%	1.2%	*p*=0.150	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.

** 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 are included in this report.

Strengths

HCA's performance for the *Children's Access to PCPs* indicators (*12–24 Months*, *25 Months–6 Years*, *7–11 Years*, *12–19 Years*, and *Total*) was a demonstrated strength for the Contractor as these measures continued to meet each AHCCCS MPS and demonstrated improvement from CYE 2012.

Opportunities for Improvement

Three measures, *Annual Dental Visits—2–21 Years*, *Dental Participation*, and *EPSDT Participation*, reported decreases and did not meet the CYE 2013 AHCCCS MPS. HCA should therefore study the causes for decreases in these two measures. HSAG recommends that HCA monitor the *Annual Dental*

Visits—2–21 Years, *Dental Participation*, and *EPSDT Participation* measure rates given the declines in performance in CYE 2013 and focus efforts on identifying improvement strategies to raise these rates. Additionally, the rate for the *Well-Child Visits in the First 15 Months of Life—6+ Visits* measure did not meet its respective AHCCCS MPS, despite a significant increase in performance in CYE 2013, HCA should continue interventions to raise this rate.

Summary

HCA continued to show strong performance for the *Children's Access to PCPs* indicators during CYE 2013 by meeting each AHCCCS MPS and showing improvement from CYE 2012. Three measure rates (*Annual Dental Visits—2–21 Years*, *Dental Participation*, and *EPSDT Participation*) each failed to meet its corresponding AHCCCS MPS and demonstrated declines in performance from CYE 2012.

Maricopa Health Plan (MHP)

Findings

Table 7-4 presents the performance measure rates for MHP. 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 MHP

Performance Measure	CYE 2012 Performance	CYE 2013 Performance	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Adolescent Well-Care Visits	40.3%	42.9%	6.5%	***p*=0.001**	42.0%
Annual Dental Visits—2–21 Years	59.8%	59.1%	-1.2%	*p*=0.155	57.0%
Children's Access to Primary Care Practitioners (PCPs)	86.1%	89.4%	3.9%	***p*<0.001**	**
12–24 Months	95.6%	97.6%	2.1%	***p*=0.004**	93.0%
25 Months–6 Years	86.3%	89.3%	3.5%	***p*<0.001**	83.0%
7–11 Years	86.1%	89.6%	4.1%	***p*<0.001**	83.0%
12–19 Years	82.9%	87.3%	5.2%	***p*<0.001**	81.0%
Dental Participation	24.7%	37.5%	51.8%	***p*<0.001**	46.0%
EPSDT Participation	63.7%	63.0%	-1.0%	*p*=0.123	68.0%
Well-Child Visits in the First 15 Months of Life—6+ Visits	78.8%	72.5%	-8.0%	***p*<0.001**	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.6%	73.2%	0.9%	*p*=0.443	66.0%

Performance Measure	CYE 2012 Performance	CYE 2013 Performance	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
[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.					

CAPs

No CAPs are included in this report.

Strengths

The rates for the *Adolescent Well-Care Visits*; *Children's Access to PCPs*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure indicators are noted as strengths for MHP because performance for these measures improved and each met its respective AHCCCS MPS. Additionally, the measure rate for *Annual Dental Visits—2–21 Years* met the AHCCCS MPS, despite a decrease in performance from CYE 2012.

Opportunities for Improvement

One measure reported in CYE 2013, *EPSDT Participation*, failed to meet its respective AHCCCS MPS and demonstrated a decline in performance from CYE 2012. HSAG recommends that MHP monitor the *EPSDT Participation* measure rate, given its decline in performance in CYE 2013, and focus efforts on identifying improvement strategies. Additionally, the *Dental Participation* measure fell well below the AHCCCS MPS, despite a statistically significant increase in performance from CYE 2012. MHP should continue interventions to raise this rate.

Summary

MHP's *Children's Access to PCPs* indicators as well as *Adolescent Well-Care Visits* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rates increased and exceeded each related AHCCCS MPS in CYE 2013. The *EPSDT Participation* measure rate demonstrated a decrease and did not meet the CYE 2013 AHCCCS MPS.

Mercy Care Plan (MCP)

Findings

Table 7-5 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 7-5—Performance Measurement Review for MCP

Performance Measure	CYE 2012 Performance	CYE 2013 Performance	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Adolescent Well-Care Visits	38.5%	38.7%	0.6%	*p*=0.466	42.0%
Annual Dental Visits—2–21 Years	63.7%	63.2%	-0.7%	***p*=0.016**	57.0%
Children's Access to Primary Care Practitioners (PCPs)	90.0%	91.5%	1.6%	***p*<0.001**	**
12–24 Months	97.6%	97.8%	0.2%	*p*=0.419	93.0%
25 Months–6 Years	89.0%	90.8%	2.0%	***p*<0.001**	83.0%
7–11 Years	91.0%	92.3%	1.4%	***p*<0.001**	83.0%
12–19 Years	88.6%	90.2%	1.8%	***p*<0.001**	81.0%
Dental Participation	48.9%	49.6%	1.6%	***p*<0.001**	46.0%
EPSDT Participation	67.0%	63.1%	-5.8%	***p*<0.001**	68.0%
Well-Child Visits in the First 15 Months of Life—6+ Visits	77.9%	73.8%	-5.2%	***p*<0.001**	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.0%	66.7%	-2.0%	***p*<0.001**	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.

** 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 are included in this report.

Strengths

MCP's performance for the *Children's Access to PCPs* indicators (*12–24 Months*, *25 Months–6 Years*, *7–11 Years*, *12–19 Years*, and *Total*) and *Dental Participation* were demonstrated strengths for the Contractor as these measures continued to meet the AHCCCS MPS and demonstrated improvement from CYE 2012. Additionally, the *Annual Dental Visits—2–21 Years*; *Well-Child Visits in the First 15 Months of Life—6+ Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rates each met its respective AHCCCS MPS, despite decreases in rates from CYE 2012.

Opportunities for Improvement

MCP's reported rate for the *EPSDT Participation* measure demonstrated a decline from the previous year and did not meet its respective AHCCCS MPS. 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 rate for this measure. Although the rate for *Adolescent Well-Care Visits* increased between CYE 2012 and CYE 2013, the measure fell below the AHCCCS MPS. MCP should continue interventions to raise this rate.

Summary

MCP continued to show strong performance for the *Children's Access to PCPs* indicators and *Dental Participation* measures during CYE 2013 by meeting each related AHCCCS MPS and showing improvement from CYE 2012. One measure rate (*EPSDT Participation*) failed to meet its corresponding AHCCCS MPS and demonstrated a decline in performance from CYE 2012.

Phoenix Health Plan, LLC (PHP)

Findings

Table 7-6 presents the performance measure rates for PHP. 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 7-6—Performance Measurement Review for PHP

Performance Measure	CYE 2012 Performance	CYE 2013 Performance	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Adolescent Well-Care Visits	46.9%	48.9%	4.3%	***p*<0.001**	42.0%
Annual Dental Visits—2–21 Years	62.6%	61.9%	-1.0%	***p*=0.015**	57.0%
Children's Access to Primary Care Practitioners (PCPs)	90.9%	92.6%	1.8%	***p*<0.001**	**
12–24 Months	96.6%	98.1%	1.5%	***p*<0.001**	93.0%
25 Months–6 Years	89.5%	91.3%	2.0%	***p*<0.001**	83.0%
7–11 Years	92.3%	93.6%	1.4%	***p*<0.001**	83.0%
12–19 Years	90.0%	91.9%	2.1%	***p*<0.001**	81.0%
Dental Participation	45.8%	46.2%	0.9%	***p*=0.034**	46.0%
EPSDT Participation	72.8%	67.7%	-7.0%	***p*<0.001**	68.0%
Well-Child Visits in the First 15 Months of Life—6+ Visits	78.2%	75.1%	-4.0%	***p*=0.001**	65.0%

Performance Measure	CYE 2012 Performance	CYE 2013 Performance	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.2%	72.9%	-1.6%	***p*=0.008**	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.					
** 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 are included in this report.

Strengths

The rates for the *Children's Access to PCPs* indicators as well as *Adolescent Well-Care Visits* and *Dental Participation* measures are noted as strengths for PHP because performance for these measures improved and each met its respective AHCCCS MPS. Additionally, the rates for *Annual Dental Visits—2–21 Years*; *Well-Child Visits in the First 15 Months of Life—6+ Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* met each related CYE 2013 AHCCCS MPS despite small decreases in performance from CYE 2012.

Opportunities for Improvement

One measure, *EPSDT Participation*, reported a decrease in rate, which resulted in the failure to meet the CYE 2013 AHCCCS MPS. PHP should study the causes for the decrease in this measure. HSAG recommends that PHP monitor the *EPSDT Participation* measure rate, given the decline in performance in CYE 2013.

Summary

PHP demonstrated overall positive performance during CYE 2013, with only one measure failing to meet its related AHCCCS MPS. PHP continued to show strong performance for the *Children's Access to PCPs* indicators as well as *Adolescent Well-Care Visits* and *Dental Participation* measures during CYE 2013 by meeting each related AHCCCS MPS and showing improvement from CYE 2012.

University Family Care (UFC)

Findings

Table 7-7 presents the performance measure rates for UFC. 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 7-7—Performance Measurement Review for UFC

Performance Measure	CYE 2012 Performance	CYE 2013 Performance	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Adolescent Well-Care Visits	39.5%	42.3%	7.0%	***p*<0.001**	42.0%
Annual Dental Visits—2–21 Years	53.5%	53.8%	0.4%	*p*=0.661	57.0%
Children's Access to Primary Care Practitioners (PCPs)	89.1%	90.7%	1.8%	***p*<0.001**	**
12–24 Months	97.9%	97.4%	-0.5%	*p*=0.377	93.0%
25 Months–6 Years	87.6%	88.9%	1.4%	***p*=0.018**	83.0%
7–11 Years	88.6%	91.0%	2.7%	***p*<0.001**	83.0%
12–19 Years	89.0%	90.8%	2.0%	***p*=0.001**	81.0%
Dental Participation	23.0%	37.8%	64.2%	***p*<0.001**	46.0%
EPSDT Participation	61.8%	60.5%	-2.2%	***p*<0.001**	68.0%
Well-Child Visits in the First 15 Months of Life—6+ Visits	67.1%	69.2%	3.1%	*p*=0.260	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.7%	66.7%	-2.8%	***p*=0.022**	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.

** 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 are included in this report.

Strengths

UFC's performance for the *Adolescent Well-Care Visits*; *Children's Access to PCPs—25 Months–6 Years*, *7–11 Years*, and *12–19 Years;* and *Well-Child Visits in the First 15 Months of Life—6+ Visits* measures were demonstrated strengths for the Contractor as these measures continued to meet each related AHCCCS MPS and demonstrated improvement from CYE 2012. Additionally, the measure rates for each of *Children's Access to PCPs—12–24 Months* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* met its respective AHCCCS MPS despite decreases in performance from CYE 2012.

Opportunities for Improvement

One measure reported in CYE 2013, *EPSDT Participation*, failed to meet its respective AHCCCS MPS and demonstrated a decline in performance from CYE 2012. HSAG recommends that UFC monitor the *EPSDT Participation* measure rate, given its decline in performance in CYE 2013, and focus efforts on identifying improvement strategies. Additionally, the *Annual Dental Visits—2–21 Years* and *Dental Participation* measures fell below each related AHCCCS MPS, despite increases in performance from CYE 2012. MHP should continue interventions to raise these rates.

Summary

UFC continued to show strong performance for the *Adolescent Well-Care Visits*; *Children's Access to PCPs—25 Months–6 Years*, *7–11 Years*, and *12–19 Years;* and *Well-Child Visits in the First 15 Months of Life—6+ Visits* measures during CYE 2013 by meeting each related AHCCCS MPS and showing improvement from CYE 2012. One measure rate (*EPSDT Participation*) failed to meet its corresponding AHCCCS MPS and demonstrated a decline in performance from CYE 2012.

UnitedHealthcare Community Plan (UHCCP)

Findings

Table 7-8 presents the performance measure rates for UHCCP. 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 7-8—Performance Measurement Review for UHCCP

Performance Measure	CYE 2012 Performance	CYE 2013 Performance	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Adolescent Well-Care Visits	33.8%	38.0%	12.4%	***p*<0.001**	42.0%
Annual Dental Visits—2–21 Years	57.6%	63.4%	10.1%	***p*<0.001**	57.0%
Children's Access to Primary Care Practitioners (PCPs)	88.8%	90.9%	2.5%	***p*<0.001**	**
12–24 Months	97.2%	97.8%	0.7%	***p*=0.028**	93.0%
25 Months–6 Years	87.1%	89.7%	3.0%	***p*<0.001**	83.0%
7–11 Years	90.0%	92.2%	2.4%	***p*<0.001**	83.0%
12–19 Years	87.7%	89.9%	2.5%	***p*<0.001**	81.0%
Dental Participation	41.3%	46.5%	12.4%	***p*<0.001**	46.0%
EPSDT Participation	62.8%	59.8%	-4.8%	***p*<0.001**	68.0%

Performance Measure	CYE 2012 Performance	CYE 2013 Performance	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Well-Child Visits in the First 15 Months of Life—6+ Visits	51.9%	67.8%	30.7%	***p*<0.001**	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	62.5%	63.6%	1.8%	***p*=0.011**	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.					
** 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 are included in this report

Strengths

UHCCP's performance for the *Annual Dental Visits—2–21 Years*, all *Children's Access to PCPs* indicators, *Dental Participation*, and *Well-Child Visits in the First 15 Months of Life—6+ Visits* measures were demonstrated strengths for the Contractor as these measures continued to meet each related AHCCCS MPS and demonstrated improvement from CYE 2012.

Opportunities for Improvement

One measure reported in CYE 2013, *EPSDT Participation*, failed to meet its respective AHCCCS MPS and demonstrated a decline in performance from CYE 2012. 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 *EPSDT Participation* rates. Additionally, *Adolescent Well-Care Visits* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures fell below each related AHCCCS MPS despite increases in performance from CYE 2012. UHCCP should continue interventions to raise these rates.

Summary

All UHCCP's *Children's Access to PCPs* indicators as well as *Annual Dental Visits—2–21 Years*, *Dental Participation*, and *Well-Child Visits in the First 15 Months of Life—6+ Visits* measure rates increased and exceeded each related AHCCCS MPS in CYE 2013. The *EPSDT Participation* measure rate demonstrated a decrease and did not meet the CYE 2013 AHCCCS MPS.

Arizona Department of Economic Security/Comprehensive Medical and Dental Program (DES/CMDP)

Findings

Table 7-9 presents the performance measure rates for DES/CMDP. 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 7-9—Performance Measurement Review for DES/CMDP

Performance Measure	CYE 2012 Performance	CYE 2013 Performance	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Adolescent Well-Care Visits	63.8%	68.3%	7.0%	***p*=0.003**	42.0%
Annual Dental Visits—2–21 Years	82.6%	81.9%	-0.9%	*p*=0.336	57.0%
Children's Access to Primary Care Practitioners (PCPs)	94.2%	95.5%	1.4%	***p*=0.007**	**
12–24 Months	99.7%	98.8%	-0.9%	*p*=0.126	93.0%
25 Months–6 Years	91.1%	93.6%	2.8%	***p*=0.002**	83.0%
7–11 Years	94.8%	94.7%	-0.1%	*p*=0.964	83.0%
12–19 Years	96.8%	98.2%	1.4%	*p*=0.064	81.0%
Dental Participation	79.0%	76.0%	-3.8%	***p*<0.001**	46.0%
EPSDT Participation	100.0%	92.6%	-7.4%	***p*<0.001**	68.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	63.7%	71.8%	12.7%	***p*<0.001**	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.

** 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 are included in this report.

Strengths

DES/CMDP's displayed overall positive performance for CYE 2013 as each measure met its respective AHCCCS MPS. The *Adolescent Well-Care Visits*; *Children's Access to PCPs—25 Months–6 Years*; *Children's Access to PCPs—12–19 Years*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth*

Years of Life measures were demonstrated strengths for the Contractor as these measures continued to meet each related AHCCCS MPS and demonstrated improvement from CYE 2012.

Opportunities for Improvement

Each measure in CYE 2013 met its respective AHCCCS MPS, but two (*Dental Participation* and *EPSDT Participation*) demonstrated significant declines in rates from CYE 2012. DES/CMDP should continue to monitor the rates for the measures to ensure that performance does not drop below the AHCCCS MPS in future years.

Summary

DES/CMDP's CYE 2013 performance was very positive; each measure met its respective MPS, and only two measures (*Dental Participation* and *EPSDT Participation*) reported significantly decreased rates since the previous measurement period.

Comparative Results for Acute Care and DES/CMDP Contractors

Findings

Table 7-10 presents aggregate performance measure rates for all Acute Care and DES/CMDP Contractors with 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. Only one measure, *Well-Child Visits in the First 15 Months of Life—6+ Visits*, was not reported by DES/CMDP in CYE 2013 and was not included in the aggregate rate.

Table 7-10—Performance Measurement Review for Acute Care and DES/CMDP Contractors

Performance Measure	CYE 2012 Performance	CYE 2013 Performance	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Adolescent Well-Care Visits	38.0%	40.5%	6.5%	***p*<0.001**	42.0%
Annual Dental Visits—2–21 Years	61.8%	61.1%	-1.2%	***p*<0.001**	57.0%
Children's Access to Primary Care Practitioners (PCPs)	89.0%	90.9%	2.3%	***p*<0.001**	**
12–24 Months	97.0%	97.7%	0.7%	***p*<0.001**	93.0%
25 Months–6 Years	87.7%	89.9%	2.6%	***p*<0.001**	83.0%
7–11 Years	90.0%	91.9%	2.1%	***p*<0.001**	83.0%
12–19 Years	87.7%	89.8%	2.4%	***p*<0.001**	81.0%

Performance Measure	CYE 2012 Performance	CYE 2013 Performance	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Dental Participation	43.8%	45.3%	3.3%	***p*<0.001**	46.0%
EPSDT Participation	65.6%	62.4%	-4.9%	***p*<0.001**	68.0%
Well-Child Visits in the First 15 Months of Life—6+ Visits[B]	67.8%	70.6%	4.0%	***p*<0.001**	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.8%	66.7%	-0.2%	*p*=0.584	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] CMDP was not included in the aggregate rate for this measure.					
** 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

All *Children's Access to PCPs* indicators and *Well-Child Visits in the First 15 Months of Life—6+ Visits* measure were recognized strengths because the aggregate rates among the Contractors and DES/CMDP increased from CYE 2012 and each measure met its respective AHCCCS MPS. Additionally, the *Annual Dental Visits—2–21 Years* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* aggregate measure rates met each related AHCCCS MPS, despite small decreases in performance.

Opportunities for Improvement and Recommendations

During CYE 2013, all Acute Care Contractors had opportunities for improvement because all failed to meet the AHCCCS MPS for at least one measure. DES/CMDP was the only Contractor to meet the MPS for all measures. Overall, the *EPSDT Participation* measure presented the greatest opportunity for improvement as no Acute Care Contractors achieved the MPS and many Contractors demonstrated a decline in rates from CYE 2012.

Summary

Aggregate rates for *Children's Access to PCPs* indicators and *Well-Child Visits in the First 15 Months of Life—6+ Visits* were demonstrated strengths for all Acute Care and DES/CMDP Contractors. The Contractors continued to show good potential for the second year reporting the *Dental Participation* measure as the aggregate rate improved between CYE 2012 and CYE 2013 and is within 1 percentage point of the MPS. Additionally, the aggregate rate for *Well-Child Visits in the Third, Fourth, Fifth, and*

Sixth Years of Life met the AHCCCS MPS, despite a decrease in aggregate performance from CYE 2012.

EPSDT Participation displayed the greatest opportunity for improvement as the aggregate rate failed to meet the CYE 2013 AHCCCS MPS and demonstrated a significant decline from CYE 2012.

Overall Recommendations

Please refer to the CYE 2014 "Comparative Results" section for recommendations based on the most recently reported data.

Contractor-Specific Results—CYE 2014

AHCCCS provided data to HSAG on the CYE 2014 performance measure rates for eight Acute Care Contractors and for DES/CMDP. The eight CYE 2014 Acute Care Contractors were Care1st, HCA, Health Net Access (Health Net), MHP, MCP, PHP, UFC, and UHCCP. 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 Acute Care Contractors and DES/CMDP 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.

Care1st Health Plan (Care1st)

Findings

Table 7-11 presents performance measure rates for Care1st. 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 7-11—Performance Measurement Review for Care1st

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Adolescent Well-Care Visits	36.1%	45.1%	25.1%	***p*<0.001**	41.0%
Ambulatory Care—ED Visits—Total per 1,000 Member Months	—	53	—	—	—
Annual Dental Visits—2–21 Years	61.6%	67.2%	9.2%	***p*<0.001**	60.0%

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Asthma in Younger Adults Admission Rate	—	82.4	—	—	—
Children's Access to Primary Care Practitioners (PCPs)	91.0%	90.8%	-0.2%	*p*=0.509	**
12–24 Months	98.0%	97.8%	-0.2%	*p*=0.739	93.0%
25 Months–6 Years	90.9%	89.3%	-1.7%	***p*=0.002**	84.0%
7–11 Years	91.3%	93.2%	2.0%	***p*=0.001**	83.0%
12–19 Years	88.2%	88.1%	-0.1%	*p*=0.864	82.0%
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	—	777.4	—	—	—
Dental Participation	44.4%	42.4%	-4.5%	***p*<0.001**	46.0%
Developmental Screening in the First Three Years of Life	—	9.2%	—	—	—
1 Year	—	8.7%	—	—	—
2 Years	—	9.6%	—	—	—
3 Years	—	9.7%	—	—	—
Diabetes Short-Term Complications Admission Rate	—	304.0	—	—	—
EPSDT Participation	64.3%	60.6%	-5.8%	***p*<0.001**	68.0%
Heart Failure Admission Rate	—	304.0	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Total Inpatient Discharges per 1,000 Member Months	—	9	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Maternity Discharges per 1,000 Member Months	—	4	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Surgery Discharges per 1,000 Member Months	—	2	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Medicine Discharges per 1,000 Member Months	—	4	—	—	—
Plan All-Cause Readmissions[B]	—	14.2%	—	—	<11.5%
18–64 Years of Age[B]	—	15.7%	—	—	—
65+ Years of Age[B]	—	3.6%	—	—	—

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Use of Appropriate Medications for People With Asthma	—	79.3%	—	—	86.0%
Well-Child Visits in the First 15 Months of Life—6+ Visits	76.3%	72.8%	-4.6%	***p*=0.049**	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.3%	72.5%	4.5%	***p*<0.001**	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 (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 are included in this report.

Strengths

Care1st's performance for the *Adolescent Well-Care Visits*; *Annual Dental Visits—2–21 Years*; *Children's Access to PCPs—7–11 Years*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures were demonstrated strengths for the Contractor as these measures continued to meet each related AHCCCS MPS and demonstrated improvement from CYE 2013. Additionally, the remaining three *Children's Access to PCPs* indicators and *Well-Child Visits in the First 15 Months of Life—6+ Visits* measure rates met each respective CYE 2014 AHCCCS MPS, despite decreases in rates from CYE 2013.

Opportunities for Improvement

Care1st's reported rates for the *Dental Participation* and *EPSDT Participation* measures demonstrated declines from the previous year and did not meet each respective AHCCCS MPS. HSAG recommends that Care1st monitor the *Dental Participation* and *EPSDT Participation* measure rates, given their declines in performance in CYE 2014, and focus efforts on identifying improvement strategies to raise rates for these measures. Rates for *Plan All-Cause Readmissions—Total* and *Use of Appropriate Medications for People With Asthma* did not have comparable CYE 2013 rates but fell below each related AHCCCS MPS. Care1st should focus interventions to raise these rates after the CYE 2014 measurement period.

Summary

Care1st continued to show strong performance for the *Children's Access to PCPs* indicators and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures and exhibited strengths for the *Adolescent Well-Care Visits* and *Annual Dental Visits—2–21 Years* measures during CYE 2014 by meeting each related AHCCCS MPS and showing improvement from CYE 2013. Two measure rates (*Dental Participation* and *EPSDT Participation*) each failed to meet its corresponding AHCCCS MPS and demonstrated declines in performance from CYE 2013.

Health Choice Arizona (HCA)

Findings

Table 7-12 presents performance measure rates for HCA. 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 7-12—Performance Measurement Review for HCA

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Adolescent Well-Care Visits	36.5%	37.1%	1.6%	*p*=0.162	41.0%
Ambulatory Care—ED Visits—Total per 1,000 Member Months	—	58	—	—	—
Annual Dental Visits—2–21 Years	53.9%	59.9%	11.2%	***p*<0.001**	60.0%
Asthma in Younger Adults Admission Rate	—	98.1	—	—	—
Children's Access to Primary Care Practitioners (PCPs)	88.6%	88.0%	-0.7%	***p*=0.001**	**
12–24 Months	96.9%	95.9%	-1.0%	*p*=0.030	93.0%
25 Months–6 Years	87.6%	85.7%	-2.1%	***p*<0.001**	84.0%
7–11 Years	90.1%	90.3%	0.3%	*p*=0.506	83.0%
12–19 Years	86.8%	86.9%	0.2%	*p*=0.702	82.0%
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	—	1141.7	—	—	—
Dental Participation	37.1%	45.3%	22.1%	***p*<0.001**	46.0%
Developmental Screening in the First Three Years of Life	—	12.6%	—	—	—

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
1 Year	—	12.2%	—	—	—
2 Years	—	14.7%	—	—	—
3 Years	—	11.7%	—	—	—
Diabetes Short-Term Complications Admission Rate	—	245.5	—	—	—
EPSDT Participation	56.0%	46.4%	-17.2%	***p*<0.001**	68.0%
Heart Failure Admission Rate	—	294.0	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Total Inpatient Discharges per 1,000 Member Months	—	8	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Maternity Discharges per 1,000 Member Months	—	4	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Surgery Discharges per 1,000 Member Months	—	2	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Medicine Discharges per 1,000 Member Months	—	3	—	—	—
Plan All-Cause Readmissions[B]	—	11.9%	—	—	<11.5%
18–64 Years of Age[B]	—	12.5%	—	—	—
65+ Years of Age[B]	—	8.2%	—	—	—
Use of Appropriate Medications for People With Asthma	—	77.6%	—	—	86.0%
Well-Child Visits in the First 15 Months of Life—6+ Visits	60.6%	68.9%	13.8%	***p*<0.001**	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	61.6%	59.4%	-3.5%	***p*<0.001**	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 are included in this report.

Strengths

HCA exceeded each related AHCCCS MPS and demonstrated improvement from CYE 2013 for *Children's Access to PCPs—7–11Years*, *Children's Access to PCPs—12–19 Years*, and *Well-Child Visits in the First 15 Months of Life—6+ Visits* in CYE 2014. Additionally, each of the remaining two *Children's Access to PCPs* indicators exceeded its respective AHCCCS MPS, despite decreases in rates from CYE 2013.

Opportunities for Improvement

The rates for *EPSDT Participation* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* fell below each related AHCCCS MPS and demonstrated declines in performance from CYE 2013. 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. Additionally, the rate for each of *Adolescent Well-Care Visits*, *Annual Dental Visits—2–21 Years*, *Dental Participation*, *Plan All-Cause Readmissions—Total*, and *Use of Appropriate Medications for People With Asthma* fell below its respective AHCCCS MPS.

Summary

HCA's *Children's Access to PCPs—7–11Years* and *12–19 Years* as well as *Well-Child Visits in the First 15 Months of Life—6+ Visits* measure rates increased and exceeded each related AHCCCS MPS in CYE 2014. The *EPSDT Participation* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rates demonstrated decreases and did not meet the CYE 2014 AHCCCS MPS.

Health Net Access (Health Net)

Findings

Table 7-13 presents performance measure rates for Health Net. 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. A CYE 2014 performance of "NA" indicates that the denominator was too small (<30) to report a valid rate.

Table 7-13—Performance Measurement Review for Health Net

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Adolescent Well-Care Visits	—	23.9%	—	—	41.0%
Ambulatory Care—ED Visits—Total per 1,000 Member Months	—	49	—	—	—
Annual Dental Visits—2–21 Years	—	33.1%	—	—	60.0%
Asthma in Younger Adults Admission Rate	—	106.6	—	—	—
Children's Access to Primary Care Practitioners (PCPs)	—	80.6%	—	—	**
12–24 Months	—	84.9%	—	—	93.0%
25 Months–6 Years	—	79.9%	—	—	84.0%
7–11 Years	—	NA	—	—	83.0%
12–19 Years	—	NA	—	—	82.0%
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	—	443.2	—	—	—
Dental Participation	—	7.9%	—	—	46.0%
Developmental Screening in the First Three Years of Life	—	NA	—	—	—
1 Year	—	NA	—	—	—
2 Years	—	NA	—	—	—
3 Years	—	NA	—	—	—
Diabetes Short-Term Complications Admission Rate	—	155.0	—	—	—
EPSDT Participation	—	36.0%	—	—	68.0%
Heart Failure Admission Rate	—	325.1	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Total Inpatient Discharges per 1,000 Member Months	—	9	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Maternity Discharges per 1,000 Member Months	—	2	—	—	—

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Inpatient Utilization—General Hospital/Acute Care—Surgery Discharges per 1,000 Member Months	—	3	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Medicine Discharges per 1,000 Member Months	—	5	—	—	—
Plan All-Cause Readmissions[B]	—	NA	—	—	<11.5%
18–64 Years of Age[B]	—	NA	—	—	—
65+ Years of Age[B]	—	NA	—	—	—
Use of Appropriate Medications for People With Asthma	—	NA	—	—	86.0%
Well-Child Visits in the First 15 Months of Life—6+ Visits	—	NA	—	—	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	53.8%	—	—	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 (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 are included in this report.

Strengths

Health Net was new to Acute Care reporting, and no measure reported for CYE 2014 met its AHCCCS MPS; however, the *Children's Access to PCPs—25 Months–6 Years* measure was within 5 percentage points of the target, showing potential for positive performance for this measure.

Opportunities for Improvement

Health Net has opportunities for improvement across all measures reported in CYE 2014 as no measure rates met the CYE 2014 AHCCCS MPS. The annual measures reported require one year of enrollment; therefore, it is likely that many members did not meet enrollment criteria to be included in the CYE

2014 rates for these measures. The Contractor should monitor these measures closely in the following years to ensure that members are receiving appropriate care as more individuals are enrolled for an extended period of time.

Summary

As Health Net was new to Acute Care reporting in CYE 2014, no measure rates met or exceeded each related AHCCCS CYE 2014 MPS. One measure, *Children's Access to PCPs—25 Months–6 Years*, reported a rate within 5 percentage points of the MPS. Health Net had several non-reportable rates in CYE 2014 and has opportunities for improvement across all measures for future reporting.

Maricopa Health Plan (MHP)

Findings

Table 7-14 presents performance measure rates for MHP. 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 7-14—Performance Measurement Review for MHP

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Adolescent Well-Care Visits	42.9%	42.9%	-0.2%	*p*=0.902	41.0%
Ambulatory Care—ED Visits—Total per 1,000 Member Months	—	62	—	—	—
Annual Dental Visits—2–21 Years	59.1%	61.2%	3.4%	***p*<0.001**	60.0%
Asthma in Younger Adults Admission Rate	—	91.9	—	—	—
Children's Access to Primary Care Practitioners (PCPs)	89.4%	88.9%	-0.5%	*p*=0.184	**
12–24 Months	97.6%	95.1%	-2.6%	***p*=0.001**	93.0%
25 Months–6 Years	89.3%	87.8%	-1.7%	***p*=0.001**	84.0%
7–11 Years	89.6%	90.2%	0.6%	*p*=0.359	83.0%
12–19 Years	87.3%	88.0%	0.9%	*p*=0.251	82.0%
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	—	1138.0	—	—	—
Dental Participation	37.5%	33.7%	-10.1%	***p*<0.001**	46.0%

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Developmental Screening in the First Three Years of Life	—	5.7%	—	—	—
1 Year	—	4.2%	—	—	—
2 Years	—	7.7%	—	—	—
3 Years	—	6.1%	—	—	—
Diabetes Short-Term Complications Admission Rate	—	358.0	—	—	—
EPSDT Participation	63.0%	54.4%	-13.7%	***p*<0.001**	68.0%
Heart Failure Admission Rate	—	495.2	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Total Inpatient Discharges per 1,000 Member Months	—	10	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Maternity Discharges per 1,000 Member Months	—	3	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Surgery Discharges per 1,000 Member Months	—	3	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Medicine Discharges per 1,000 Member Months	—	5	—	—	—
Plan All-Cause Readmissions[B]	—	15.3%	—	—	<11.5%
18–64 Years of Age[B]	—	15.9%	—	—	—
65+ Years of Age[B]	—	12.2%	—	—	—
Use of Appropriate Medications for People With Asthma	—	77.8%	—	—	86.0%
Well-Child Visits in the First 15 Months of Life—6+ Visits	72.5%	70.4%	-2.8%	*p*=0.304	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.2%	71.3%	-2.6%	***p*=0.029**	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.

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
[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 (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 are included in this report.

Strengths

MHP's performance for the *Annual Dental Visits—2–21 Years*, *Children's Access to PCPs—7–11 Years*, and *Children's Access to PCPs—12–19 Years* were demonstrated strengths for the Contractor as these measures met each related AHCCCS MPS and demonstrated improvement from CYE 2013. Additionally, *Adolescent Well-Care Visits*; *Children's Access to PCPs—12–24 Months*; *Children's Access to PCPs—25 Months–6 Years*; *Well-Child Visits in the First 15 Months of Life—6+ Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* met each related CYE 2014 AHCCCS MPS, despite decreases in performance from the prior year.

Opportunities for Improvement

Two measures reported in CYE 2014, *Dental Participation* and *EPSDT Participation*, each failed to meet its respective AHCCCS MPS and demonstrated declines in performance from CYE 2013. HSAG recommends that MHP monitor the *EPSDT Participation* measure rate, given its decline in performance in CYE 2014, and focus efforts on identifying improvement strategies to raise *EPSDT Participation* rates. Additionally, though these are first-year measures for reporting, *Plan All-Cause Readmissions—Total* and *Use of Appropriate Medications for People With Asthma* each fell below its respective AHCCCS MPS.

Summary

MHP's *Annual Dental Visits—2–21 Years*, *Children's Access to PCPs—7–11 Years*, and *Children's Access to PCPs—12–19 Years* measure rates increased and exceeded each related AHCCCS MPS in CYE 2014. The remaining *Children's Access to PCPs* indicators as well as *Adolescent Well-Care Visits; Well-Child Visits in the First 15 Months of Life—6+ Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rates also met each respective CYE 2014 AHCCCS MPS but demonstrated decreases in rates from CYE 2013. The *Dental Participation* and *EPSDT Participation* measure rates demonstrated decreases and did not meet the CYE 2014 AHCCCS MPS.

Mercy Care Plan (MCP)

Findings

Table 7-15 presents 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 7-15—Performance Measurement Review for MCP

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Adolescent Well-Care Visits	38.7%	41.8%	8.0%	***p*<0.001**	41.0%
Ambulatory Care—ED Visits—Total per 1,000 Member Months	—	56	—	—	—
Annual Dental Visits—2–21 Years	63.2%	65.7%	4.0%	***p*<0.001**	60.0%
Asthma in Younger Adults Admission Rate	—	109.7	—	—	—
Children's Access to Primary Care Practitioners (PCPs)	91.5%	91.7%	0.2%	*p*=0.093	**
12–24 Months	97.8%	98.0%	0.2%	*p*=0.382	93.0%
25 Months–6 Years	90.8%	90.4%	-0.4%	*p*=0.069	84.0%
7–11 Years	92.3%	92.9%	0.7%	***p*=0.005**	83.0%
12–19 Years	90.1%	90.7%	0.6%	***p*=0.033**	82.0%
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	—	932.5	—	—	—
Dental Participation	49.6%	48.8%	-1.7%	***p*<0.001**	46.0%
Developmental Screening in the First Three Years of Life	—	10.9%	—	—	—
1 Year	—	10.0%	—	—	—
2 Years	—	15.8%	—	—	—
3 Years	—	8.4%	—	—	—
Diabetes Short-Term Complications Admission Rate	—	233.3	—	—	—
EPSDT Participation	63.1%	58.8%	-7.0%	***p*<0.001**	68.0%
Heart Failure Admission Rate	—	260.6	—	—	—

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Inpatient Utilization—General Hospital/Acute Care—Total Inpatient Discharges per 1,000 Member Months	—	9	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Maternity Discharges per 1,000 Member Months	—	5	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Surgery Discharges per 1,000 Member Months	—	2	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Medicine Discharges per 1,000 Member Months	—	4	—	—	—
Plan All-Cause Readmissions[B]	—	14.6%	—	—	<11.5%
18–64 Years of Age[B]	—	14.9%	—	—	—
65+ Years of Age[B]	—	13.2%	—	—	—
Use of Appropriate Medications for People With Asthma	—	82.9%	—	—	86.0%
Well-Child Visits in the First 15 Months of Life—6+ Visits	73.8%	74.5%	0.8%	*p*=0.453	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.7%	68.0%	2.0%	**p=0.001**	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 (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 are included in this report.

Strengths

MCP's performance for the *Adolescent Well-Care Visits*; *Annual Dental Visits—2–21 Years*; *Children's Access to PCPs—12–24 Months; Children's Access to PCPs—7–11 Years; Children's Access to PCPs—12–19 Years*; *Well-Child Visits in the First 15 Months of Life—6+ Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* were demonstrated strengths for the Contractor as these measures continued to meet each related AHCCCS MPS and demonstrated improvement from CYE 2013. Additionally, each of *Children's Access to PCPs—25 Months–6 Years* and *Dental Participation* met its 2014 AHCCCS MPS, despite decreases in rates from CYE 2013.

Opportunities for Improvement

One measure reported in CYE 2014, *EPSDT Participation*, failed to meet its respective AHCCCS MPS and demonstrated a decline in performance from CYE 2013. HSAG recommends that MCP monitor the *EPSDT Participation* measure rate, given its decline in performance in CYE 2014, and focus efforts on identifying improvement strategies. Additionally, though first-year measures for reporting, *Plan All-Cause Readmissions—Total* and *Use of Appropriate Medications for People With Asthma* each fell below its respective AHCCCS MPS.

Summary

MCP demonstrated strong performance for the *Adolescent Well-Care Visits*; *Annual Dental Visits—2–21 Years*; *Children's Access to PCPs—12–24 Months; Children's Access to PCPs—7–11 Years; Children's Access to PCPs—12–19 Years*; *Well-Child Visits in the First 15 Months of Life—6+ Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures during CYE 2014 by meeting each established AHCCCS MPS and showing improvement from CYE 2013. One measure rate (*EPSDT Participation*) failed to meet its corresponding AHCCCS MPS and demonstrated a decline in performance from CYE 2013.

Phoenix Health Plan, LLC (PHP)

Findings

Table 7-16 presents performance measure rates for PHP. 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 7-16—Performance Measurement Review for PHP

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Adolescent Well-Care Visits	48.9%	56.6%	15.6%	***p*<0.001**	41.0%
Ambulatory Care—ED Visits—Total per 1,000 Member Months	—	56	—	—	—
Annual Dental Visits—2–21 Years	61.9%	70.1%	13.1%	***p*<0.001**	60.0%
Asthma in Younger Adults Admission Rate	—	35.0	—	—	—
Children's Access to Primary Care Practitioners (PCPs)	92.6%	93.7%	1.2%	***p*<0.001**	**
12–24 Months	98.1%	97.9%	-0.2%	*p*=0.599	93.0%
25 Months–6 Years	91.3%	92.3%	1.1%	***p*=0.002**	84.0%
7–11 Years	93.6%	94.9%	1.4%	***p*<0.001**	83.0%
12–19 Years	91.9%	93.2%	1.5%	***p*<0.001**	82.0%
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	—	509.0	—	—	—
Dental Participation	46.2%	50.1%	8.5%	***p*<0.001**	46.0%
Developmental Screening in the First Three Years of Life	—	11.9%	—	—	—
1 Year	—	9.5%	—	—	—
2 Years	—	17.2%	—	—	—
3 Years	—	11.1%	—	—	—
Diabetes Short-Term Complications Admission Rate	—	64.5	—	—	—
EPSDT Participation	67.7%	64.2%	-5.1%	***p*<0.001**	68.0%
Heart Failure Admission Rate	—	89.1	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Total Inpatient Discharges per 1,000 Member Months	—	3	—	—	—

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Inpatient Utilization—General Hospital/Acute Care—Maternity Discharges per 1,000 Member Months	—	2	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Surgery Discharges per 1,000 Member Months	—	1	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Medicine Discharges per 1,000 Member Months	—	1	—	—	—
Plan All-Cause Readmissions[B]	—	13.9%	—	—	<11.5%
18–64 Years of Age[B]	—	15.4%	—	—	—
65+ Years of Age[B]	—	5.9%	—	—	—
Use of Appropriate Medications for People With Asthma	—	79.9%	—	—	86.0%
Well-Child Visits in the First 15 Months of Life—6+ Visits	75.1%	76.5%	1.9%	*p*=0.226	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.9%	77.6%	6.3%	***p*<0.001**	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 (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 are included in this report.

Strengths

The rates for the *Adolescent Well-Care Visits*; *Annual Dental Visits—2–21 Years*; *Children's Access to PCPs—25 Months–6 Years; Children's Access to PCPs—7–11 Years; Children's Access to PCPs—12–19 Years*; *Dental Participation*; *Well-Child Visits in the First 15 Months of Life—6+ Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures are noted as strengths for PHP because performance for these measures improved and the rate for each met its respective AHCCCS MPS. Additionally, the rate for *Children's Access to PCPs—12–24 Months* met the CYE 2014 AHCCCS MPS despite a small decrease in performance from CYE 2013.

Opportunities for Improvement

PHP's reported rate for the *EPSDT Participation* measure demonstrated a decline from the previous year, and the measure did not meet its respective AHCCCS MPS. HSAG recommends that PHP monitor the *EPSDT Participation* measure rate, given its decline in performance in CYE 2014, and focus efforts on identifying improvement strategies to raise the rate for this measure. Additionally, each of *Plan All-Cause Readmissions—Total* and *Use of Appropriate Medications for People With Asthma,* though first-year measures, fell below its respective AHCCCS MPS.

Summary

PHP demonstrated overall positive performance with each of the *Adolescent Well-Care Visits*; *Annual Dental Visits—2–21 Years*; *Children's Access to PCPs—25 Months–6 Years; Children's Access to PCPs—7–11 Years; Children's Access to PCPs—12–19 Years*; *Dental Participation*; *Well-Child Visits in the First 15 Months of Life—6+ Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures meeting its respective established AHCCCS MPS and showing improvement from CYE 2013. One measure rate (*EPSDT Participation*) failed to meet its corresponding AHCCCS MPS and demonstrated a decline in performance from CYE 2013.

University Family Care (UFC)

Findings

Table 7-17 presents performance measure rates for UFC. 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 7-17—Performance Measurement Review for UFC

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Adolescent Well-Care Visits	42.3%	41.1%	-2.7%	*p*=0.081	41.0%
Ambulatory Care—ED Visits—Total per 1,000 Member Months	—	58	—	—	—
Annual Dental Visits—2–21 Years	53.7%	55.7%	3.6%	***p*<0.001**	60.0%
Asthma in Younger Adults Admission Rate	—	63.5	—	—	—
Children's Access to Primary Care Practitioners (PCPs)	90.7%	89.7%	-1.0%	***p*=0.001**	**
12–24 Months	97.4%	95.0%	-2.5%	***p*=0.001**	93.0%
25 Months–6 Years	88.9%	86.8%	-2.3%	***p*<0.001**	84.0%
7–11 Years	91.0%	91.8%	0.8%	*p*=0.160	83.0%
12–19 Years	90.8%	91.0%	0.2%	*p*=0.659	82.0%
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	—	710.8	—	—	—
Dental Participation	37.8%	34.0%	-10.1%	***p*<0.001**	46.0%
Developmental Screening in the First Three Years of Life	—	12.3%	—	—	—
1 Year	—	12.3%	—	—	—
2 Years	—	14.2%	—	—	—
3 Years	—	10.6%	—	—	—
Diabetes Short-Term Complications Admission Rate	—	220.7	—	—	—
EPSDT Participation	60.5%	51.7%	-14.4%	***p*<0.001**	68.0%
Heart Failure Admission Rate	—	279.1	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Total Inpatient Discharges per 1,000 Member Months	—	8	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Maternity Discharges per 1,000 Member Months	—	4	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Surgery	—	2	—	—	—

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Discharges per 1,000 Member Months					
Inpatient Utilization—General Hospital/Acute Care—Medicine Discharges per 1,000 Member Months	—	3	—	—	—
Plan All-Cause Readmissions[B]	—	12.0%	—	—	<11.5%
18–64 Years of Age[B]	—	12.2%	—	—	—
65+ Years of Age[B]	—	10.6%	—	—	—
Use of Appropriate Medications for People With Asthma	—	77.7%	—	—	86.0%
Well-Child Visits in the First 15 Months of Life—6+ Visits	69.2%	67.3%	-2.7%	*p*=0.338	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.7%	64.1%	-3.8%	***p*=0.002**	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 (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 are included in this report.

Strengths

The rates for the *Children's Access to PCPs—7–11 Years* and *Children's Access to PCPs—12–19 Years* measures are noted as strengths for UFC because performance for these measures improved and each met its respective AHCCCS MPS. Additionally, the measure rates for *Adolescent Well-Care Visits*, *Children's Access to PCPs—12–24 Months*, *Children's Access to PCPs—25 Months–6 Years*, and *Well-Child Visits in the First 15 Months of Life—6+ Visits* met each related AHCCCS MPS, despite small decreases in performance from CYE 2013.

Opportunities for Improvement

UFC's reported rates for the *Dental Participation*; *EPSDT Participation*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures demonstrated declines from the previous year, with not one meeting its respective AHCCCS MPS. HSAG recommends that UFC monitor these measure rates, given their significant declines in performance in CYE 2014, and focus efforts on identifying improvement strategies to raise the rates for these measures. Although the rate for *Annual Dental Visits—2–21 Years* increased between CYE 2013 and CYE 2014, the measure fell below the AHCCCS MPS. UFC should continue interventions to improve this rate after the CYE 2014 measurement period. Additionally, though first-year measures, *Plan All-Cause Readmissions—Total* and *Use of Appropriate Medications for People With Asthma* each fell below its respective AHCCCS MPS.

Summary

UFC's *Children's Access to PCPs—7–11 Years* and *Children's Access to PCPs—12–19 Years* measure rates increased and exceeded each related AHCCCS MPS in CYE 2014. *Adolescent Well-Care Visits*, *Children's Access to PCPs—12–24 Months*, *Children's Access to PCPs—25 Months–6 Years*, and *Well-Child Visits in the First 15 Months of Life—6+ Visits* measure rates each met its respective CYE 2014 AHCCCS MPS but demonstrated a decrease in rate from CYE 2013. The *Dental Participation*; *EPSDT Participation*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rates demonstrated decreases, and not one met its CYE 2014 AHCCCS MPS.

UnitedHealthcare Community Plan (UHCCP)

Findings

Table 7-18 presents 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 7-18—Performance Measurement Review for UHCCP

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Adolescent Well-Care Visits	38.0%	35.7%	-6.2%	***p*<0.001**	41.0%
Ambulatory Care—ED Visits—Total per 1,000 Member Months	—	56	—	—	—
Annual Dental Visits—2–21 Years	63.4%	63.6%	0.3%	*p*=0.411	60.0%
Asthma in Younger Adults Admission Rate	—	145.9	—	—	—

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Children's Access to Primary Care Practitioners (PCPs)	90.9%	90.4%	-0.6%	***p*<0.001**	**
12–24 Months	97.8%	97.5%	-0.3%	*p*=0.246	93.0%
25 Months–6 Years	89.7%	87.5%	-2.5%	***p*<0.001**	84.0%
7–11 Years	92.2%	92.6%	0.4%	*p*=0.143	83.0%
12–19 Years	89.9%	90.6%	0.6%	***p*=0.023**	82.0%
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	—	870.8	—	—	—
Dental Participation	46.5%	45.6%	-1.8%	***p*<0.001**	46.0%
Developmental Screening in the First Three Years of Life	—	12.9%	—	—	—
1 Year	—	11.1%	—	—	—
2 Years	—	17.8%	—	—	—
3 Years	—	11.9%	—	—	—
Diabetes Short-Term Complications Admission Rate	—	198.8	—	—	—
EPSDT Participation	59.8%	47.5%	-20.6%	***p*<0.001**	68.0%
Heart Failure Admission Rate	—	299.1	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Total Inpatient Discharges per 1,000 Member Months	—	8	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Maternity Discharges per 1,000 Member Months	—	3	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Surgery Discharges per 1,000 Member Months	—	2	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Medicine Discharges per 1,000 Member Months	—	3	—	—	—
Plan All-Cause Readmissions[B]	—	13.1%	—	—	<11.5%
18–64 Years of Age[B]	—	14.6%	—	—	—

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
65+ Years of Age[B]	—	7.9%	—	—	—
Use of Appropriate Medications for People With Asthma	—	80.9%	—	—	86.0%
Well-Child Visits in the First 15 Months of Life—6+ Visits	67.8%	67.6%	-0.3%	*p*=0.854	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	63.6%	57.9%	-8.9%	***p*<0.001**	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 (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 are included in this report.

Strengths

UHCCP's performance for the *Annual Dental Visits—2–21 Years*, *Children's Access to PCPs—7–11 Years*, and *Children's Access to PCPs—12–19 Years* measures were demonstrated strengths for the Contractor as these measures continued to meet each related AHCCCS MPS and demonstrated improvement from CYE 2013. Additionally, each of the remaining three *Children's Access to PCPs* indicators and *Well-Child Visits in the First 15 Months of Life—6+ Visits* measure rates met its respective CYE 2014 AHCCCS MPS, despite decreases in rates from CYE 2013.

Opportunities for Improvement

Four measures reported in CYE 2014 (*Adolescent Well-Care Visits*; *Dental Participation*; *EPSDT Participation*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) each failed to meet its respective AHCCCS MPS and demonstrated declines in performance from CYE 2013. Additionally, though first-year measures, *Plan All-Cause Readmissions—Total* and *Use of Appropriate Medications for People With Asthma* each fell below its respective AHCCCS MPS.

Summary

UHCCP's *Annual Dental Visits—2–21 Years*, *Children's Access to PCPs—7–11 Years*, and *Children's Access to PCPs—12–19 Years* measure rates increased and exceeded each related AHCCCS MPS in CYE 2014. The *Adolescent Well-Care Visits*; *Dental Participation*; *EPSDT Participation*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rates demonstrated decreases, and not one met its CYE 2014 AHCCCS MPS.

Arizona Department of Economic Security/Comprehensive Medical and Dental Program (DES/CMDP)

Findings

Table 7-19 presents performance measure rates for DES/CMDP. 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. A CYE 2014 performance of "NA" indicates that the denominator was too small (<30) to report a valid rate.

Table 7-19—Performance Measurement Review for DES/CMDP

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Adolescent Well-Care Visits	68.3%	68.2%	-0.2%	*p*=0.937	41.0%
Ambulatory Care—ED Visits—Total per 1,000 Member Months	—	42	—	—	—
Annual Dental Visits—2–21 Years	81.9%	78.8%	-3.8%	***p*<0.001**	65.0%
Children's Access to Primary Care Practitioners (PCPs)	95.5%	95.6%	0.1%	*p*=0.886	**
12–24 Months	98.8%	98.7%	-0.1%	*p*=0.881	93.0%
25 Months–6 Years	93.6%	93.8%	0.2%	*p*=0.754	84.0%
7–11 Years	94.7%	96.9%	2.3%	*p*=0.057	83.0%
12–19 Years	98.2%	96.4%	-1.9%	***p*=0.014**	82.0%
Dental Participation	76.0%	69.8%	-8.2%	***p*<0.001**	46.0%
Developmental Screening in the First Three Years of Life	—	6.0%	—	—	—
1 Year	—	4.8%	—	—	—
2 Years	—	9.6%	—	—	—
3 Years	—	3.1%	—	—	—

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
EPSDT Participation	92.6%	82.6%	-10.8%	***p*<0.001**	68.0%
Inpatient Utilization—General Hospital/Acute Care—Total Inpatient Discharges per 1,000 Member Months	—	4	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Maternity Discharges per 1,000 Member Months	—	1	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Surgery Discharges per 1,000 Member Months	—	1	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Medicine Discharges per 1,000 Member Months	—	3	—	—	—
Plan All-Cause Readmissions[B]	—	NA	—	—	—
18–64 Years of Age[B]	—	NA	—	—	—
65+ Years of Age[B]	—	NA	—	—	—
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.8%	71.8%	-0.1%	*p*=0.973	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 (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 are included in this report.

Strengths

DES/CMDP displayed overall positive performance for CYE 2014 as each measure met its respective AHCCCS MPS. The *Children's Access to PCPs—25 Months–6 Years* and *Children's Access to PCPs—7–11 Years* measures were demonstrated strengths for the Contractor as these measures continued to meet each related AHCCCS MPS and demonstrated improvement from CYE 2012. Additionally, despite a decrease from the prior year, DES/CMDP displayed positive performance for the *EPSDT Participation* measure as the rate exceeded the MPS by nearly 15 percentage points.

Opportunities for Improvement

Each measure in CYE 2014 met its respective AHCCCS MPS, but three (*Children's Access to PCPs—12–19 Years*, *Dental Participation*, and *EPSDT Participation*) demonstrated significant declines in rates from CYE 2013. DES/CMDP should continue to monitor the rates for these measures to ensure that performance does not drop below the AHCCCS MPS in future years.

Summary

DES/CMDP's CYE 2014 performance was very positive; each measure met its respective MPS, and only three measures (*Children's Access to PCPs—12–19 Years*, *Dental Participation*, and *EPSDT Participation*) reported significantly decreased rates since the previous measurement period.

Comparative Results for Acute Care and DES/CMDP Contractors—CYE 2014

Findings

Table 7-20 presents aggregate performance measure rates for all Acute Care Contractors and DES/CMDP 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 7-20—Performance Measurement Review for Acute Care and DES/CMDP Contractors

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Adolescent Well-Care Visits	40.5%	41.1%	1.5%	***p*=0.001**	41.0%
Ambulatory Care—ED Visits—Total per 1,000 Member Months	—	56	—	—	—
Annual Dental Visits—2–21 Years	61.1%	63.8%	4.4%	***p*<0.001**	60.0%

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Asthma in Younger Adults Admission Rate[B]	—	104.2	—	—	—
Children's Access to Primary Care Practitioners (PCPs)	90.9%	90.7%	-0.3%	***p*<0.001**	**
12–24 Months	97.7%	97.2%	-0.6%	***p*<0.001**	93.0%
25 Months–6 Years	89.9%	88.6%	-1.5%	***p*<0.001**	84.0%
7–11 Years	91.9%	92.5%	0.6%	***p*<0.001**	83.0%
12–19 Years	89.8%	90.2%	0.5%	***p*=0.002**	82.0%
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate[B]	—	875.7	—	—	—
Dental Participation	45.3%	43.4%	-4.2%	***p*<0.001**	46.0%
Developmental Screening in the First Three Years of Life	—	11.4%	—	—	—
1 Year	—	10.2%	—	—	—
2 Years	—	15.1%	—	—	—
3 Years	—	10.0%	—	—	—
Diabetes Short-Term Complications Admission Rate[B]	—	225.0	—	—	—
EPSDT Participation	62.4%	53.8%	-13.9%	***p*<0.001**	68.0%
Heart Failure Admission Rate[B]	—	290.9	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Total Inpatient Discharges per 1,000 Member Months	—	8	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Maternity Discharges per 1,000 Member Months	—	4	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Surgery Discharges per 1,000 Member Months	—	2	—	—	—
Inpatient Utilization—General Hospital/Acute Care—Medicine Discharges per 1,000 Member Months	—	4	—	—	—
Plan All-Cause Readmissions	—	13.6%	—	—	<11.5%
18–64 Years of Age	—	14.4%	—	—	—
65+ Years of Age	—	10.3%	—	—	—

Performance Measure	CYE 2013 Performance	CYE 2014 Performance*	Relative Percentage Change	Significance Level[A] (*p* value)	Minimum Performance Standard
Use of Appropriate Medications for People With Asthma[B]	—	80.6%	—	—	86.0%
Well-Child Visits in the First 15 Months of Life—6+ Visits[B]	70.6%	71.4%	1.2%	*p*=0.061	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.7%	65.1%	-2.4%	***p*<0.001**	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] CMDP was not included in the aggregate rate for this measure.					
[C] 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 (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

Of the 11 measures each with an AHCCCS MPS reported in CYE 2014, five aggregate measure rates—*Adolescent Well-Care Visits*, *Annual Dental Visits—2–21 Years*, *Children's Access to PCPs—7–11 Years*, *Children's Access to PCPs—12–19 Years*, and *Well-Child Visits in the First 15 Months of Life—6+ Visits*—each met its established AHCCCS MPS and demonstrated improvement from CYE 2013. PHP exhibited the greatest strength in CYE 2014 for the performance measures. PHP met each AHCCCS MPS and demonstrated improvement for *Adolescent Well-Care Visits*; *Annual Dental Visits—2–21 Years*; *Children's Access to PCPs—12–24 Months; Children's Access to PCPs—7–11 Years; Children's Access to PCPs—12–19 Years*; *Dental Participation*; *Well-Child Visits in the First 15 Months of Life—6+ Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*. Similarly, DES/CMDP exhibited positive performance by meeting the AHCCCS MPS for each measure.

Opportunities for Improvement and Recommendations

During CYE 2014, all Acute Care Contractors had opportunities for improvement because all Contractors failed to meet the AHCCCS MPS for at least one measure. Overall, the *EPSDT Participation* measure presented the greatest opportunity for improvement as no Acute Care Contractors achieved the MPS. DES/CMDP demonstrated the greatest strength across all measures, meeting the MPS for every measure and exceeding the MPS for *EPSDT Participation* by almost 15 percentage

points. Conversely, DES/CMDP still demonstrated a statistically significant decline from CYE 2013 for *EPSDT Participation*.

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 to meet the AHCCCS MPS for the *EPSDT Participation* measure by all Acute Care Contractors, Contractors should consider implementing improvement strategies that aim to ensure that communications with members are clear about the services available to members as well as when those services should be used (i.e., what types of preventive screenings should be conducted and when). Furthermore, Contractors should ensure that their care managers understand the importance and necessity of EPSDT screenings in order to effectively engage members and schedule appropriate preventive appointments, including providing assistance with transportation services when appropriate.

Summary

Table 7-20 shows an increase in aggregate rates for five performance measures among all Acute Care Contractors and DES/CMDP: *Adolescent Well-Care Visits*, *Annual Dental Visits—2–21 Years*, *Children's Access to PCPs—7–11 Years*, *Children's Access to PCPs—12–19 Years*, and *Well-Child Visits in the First 15 Months of Life—6+ Visits*. One measure rate, *EPSDT Participation*, had a statistically significant decrease and did not meet the AHCCCS MPS for CYE 2014. For the first year of reporting the *Plan All-Cause Readmissions—Total* measure, the Contractors demonstrated strong potential for positive future performance with an aggregate rate within 3 percentage points of the AHCCCS MPS for CYE 2014.

Overall Recommendations for CYE 2013 and CYE 2014

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

- Conduct focus groups with adults whose children did not access care during the previous measurement year to gain a better understanding of why these children did not receive care. Soliciting input from members or members' surrogates is an important investment for Contractors to make to determine whether or not interventions appropriately address the underlying barriers involving members' access to care. Additionally, such focus groups would allow Contractors to determine the impact on performance measures from other sources of ambulatory care (i.e., walk-in clinics co-located with retail pharmacies). The widespread availability of such ambulatory care providers in urban and suburban areas may result in members receiving preventive care while yet having a negative impact on performance measure rates.
- Implement targeted causal/barrier analyses with detailed drill-down analyses for member and/or provider demographics to better identify subgroups within the populations with disproportionately

lower performance rates (which adversely affected the overall rate). Such in-depth analyses allow for the development of precise, concentrated interventions addressing the members who will benefit most.

- Conduct interim performance measure calculations in addition to the formal annual evaluation. Conducting interim measurements and evaluating results may assist the Contractors in identifying and eliminating barriers that contribute to decreases in performance. Such measurements provide valuable evidence of the effectiveness of current interventions, affording more timely adjustment of less effective interventions.
- Enhance 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 quality assessment and performance improvement (QAPI) program that (1) includes ongoing programs of performance improvement projects (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 required by a state and 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 evaluations 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.

[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: February 19, 2014.

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.

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 Acute Care Contractor as well as statewide comparative results for these Contractors.

Contractor-Specific Results

AHCCCS provided HSAG with its CYE 2015 Contractor PIP results for seven Acute Care Contractors and for DES/CMDP. The Acute Care Contractors for which data were provided were Care1st, HCA, MHP, MCP, PHP, UFC, UHCCP and DES/CMDP. The PIP conducted during CYE 2015 for the Acute Care Contractors and for DES/CMDP was *E-Prescribing,* which focused on increasing 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.

Care1st Health Plan (Care1st)

Findings

Table 8-1 presents the baseline results for the *E-Prescribing* PIP for Care1st's members, including those members from 0–64 years of age and those members 65 years of age and over.

Table 8-1—Care1st *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.	48.68%	NA	NA	NA	52.99%
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider sent electronically.	39.62%	NA	NA	NA	42.35%

*Percentages reflect 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 48.68 percent of Care1st's providers prescribed at least one prescription electronically and that 39.62 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. The AHCCCS aggregate rate for providers prescribing electronically all ages combined is 52.99 percent, and the AHCCCS aggregate rate for prescriptions prescribed electronically for all ages is 42.35 percent. Care1st's baseline rate for all ages for providers prescribing electronically is 48.68 percent, or 4.31 percent below the aggregate rate. Care1st's baseline rate for prescriptions prescribed electronically for all ages is 39.62 percent, or 2.73 percent below the AHCCCS aggregate rate.

Care1st completed the following quantitative analysis:

- Care1st conducted a systematic literature review that identified the primary barriers to greater use of e-prescribing as being:
  - Cost of implementing an e-prescribing system.
  - E-prescribing system errors.
  - Privacy and legal issues.[8-3]
- Care1st participated in the AzAHP E-Rx Workgroup (Workgroup), a group of health plan representatives who collaborate to increase the rate of e-prescribing within the AHCCCS program

[8-3] Porterfield, Engelbert, Coustasse. "Electronic Prescribing: Improving the Efficiency and Accuracy of Prescribing in the Ambulatory Care Setting." Perspectives in Health Information Management (Spring 2014): 1-13.

and the state of Arizona. The Workgroup surveyed providers to identify major barriers to e-prescribing. Care1st received feedback from 19 providers, with the following barriers identified:

  - Patients and/or physicians prefer hard-copy prescriptions.
  - Some pharmacies have limited ability to accept electronic prescriptions (particularly small, independent pharmacies).
  - Technical problems occur with the e-prescribing transmission.
  - Belief exists that controlled substance-related prescriptions cannot be electronically transmitted.
  - EHR used by the provider does not support electronic prescribing of controlled substances (EPCS).
  - EPCS is more time consuming.
- Baseline data reported by AHCCCS and the Workgroup's data mining revealed significant barriers to e-prescribing in the long-term care (LTC) setting, with faxed prescriptions the predominant method among LTC providers.
- Care1st's analysis of AHCCCS-reported data by age group revealed no specific opportunities for improvement (i.e., there is no indication of older patients opting out of e-prescribing).

Care1st initiated the following interventions to improve both the rate of providers prescribing prescriptions electronically and the rate of prescriptions sent electronically:

- Collaborate with other AHCCCS Contractors through the Workgroup to mine data and survey providers about barriers to e-prescribing and identify opportunities for improvement (i.e., high-volume prescribers with low rates of e-prescribing). Contractors have pulled data extracts by pharmacy and by prescriber, which have been merged into a software tool that allows for data analysis and identification of opportunities for meaningful impact.
- Incorporate incentives to e-prescribing into amendments for PCMHs and QI partnership agreements to encourage higher rates. Incentives are based on the provider's baseline of prescriptions, with a specific target for the provider to meet in order to receive an incentive payment. As part of this, Care1st provided data to PCMHs and QI groups on individual provider rates of e-prescribing to assist in problem solving and improvement within the practice.
- Educate members about the benefits of electronic prescriptions, beginning with the Care1st *Spring/Summer Member Newsletter*.
- Educate providers about the benefits of e-prescribing, how to get started, and solutions to barriers, including the clarification that EPCS is legal in Arizona and specific requirements for EPCS.
- Explore funding sources to assist selected providers with technical upgrades/other fees in order to have e-prescribing functionality.
- Target high-volume prescribers for education with a focus on EPCS through Workgroup collaboration since providers contract with multiple health plans.
- Identify opportunities to move volume from fax to e-prescribing.

Strengths

Care1st has completed additional analyses such as the literature review to determine why rates are below the State aggregate rates. The analyses have yielded useful data that assisted Care1st to formulate strong interventions to improve the indicators. In addition to collaborating with other AHCCCS Contractors through the Workgroup to mine data and survey providers, Care1st has incorporated incentives into Contractor agreements to encourage higher rates for e-prescribing.

Opportunities for Improvement and Recommendations

Care1st 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 Care1st 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

Care1st's baseline rate for the *E-Prescribing* PIP Indicator 1 (the percentage of AHCCCS-contracted providers who prescribed at least one electronic prescription) was 48.68 percent and for Indicator 2 (the percentage of prescriptions prescribed by an AHCCCS-contracted provider sent electronically) was 39.62 percent. Both indicators are below the AHCCCS aggregate rate. Care1st 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.

Health Choice Arizona (HCA)

Findings

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

Table 8-2—HCA *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.	56.56%	NA	NA	NA	52.99%

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 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider sent electronically.	43.44%	NA	NA	NA	42.35%

*Percentages reflect 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 56.56 percent of HCA's providers prescribed at least one prescription electronically and that 43.44 percent of prescriptions were sent by an AHCCCS-contracted provider electronically. The AHCCCS aggregate rate for providers prescribing electronically all ages combined is 52.99 percent, and the AHCCCS aggregate rate for prescriptions prescribed electronically for all ages is 42.35 percent. HCA's baseline rate for all ages for providers prescribing electronically is 56.56 percent, or 3.57 percent above the aggregate rate. HCA's baseline rate for prescriptions prescribed electronically for all ages is 43.44 percent, or 1.09 percent above the AHCCCS aggregate rate.

HCA completed the following quantitative analysis:

- HCA sent a survey to providers who use EHRs and those who do not. Questions to the EHR providers included inquiries about the EHR and what ideas they had to increase e-prescribing as well as what barriers they encountered. The survey asked specific questions about EPCS. Non-EHR providers were asked if they had plans to implement EHRs and if they needed help from HCA.

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

- Use internal data from the pharmacy to determine top providers who are not e-prescribing.
- Incorporate e-prescribing into contracting and value based partnerships.
- Join forces with the Workgroup to collaborate on the e-prescribing initiative.
- Survey providers about e-prescribing.

Strengths

HCA surveyed providers who use EHRs and those who do not. Questions to the EHR providers included inquiries about the EHR and their ideas about e-prescribing as well as what barriers they encountered. Non-EHR providers were asked if they had plans to implement EHRs and if they needed help from HCA. In addition, HCA used internal data to determine top providers who are not e-prescribing, incorporated e-prescribing into contracting, and is collaborating with the Workgroup.

Opportunities for Improvement and Recommendations

HCA has an opportunity to increase provider prescribing electronically and prescriptions sent electronically, even though HCA's rates are slightly above the aggregate rates. HSAG recommends that HCA continue to monitor the outcomes associated with the reported interventions. Even though the rates of providers that prescribe electronically and the prescriptions sent electronically are higher than the aggregate rate, HCA should strive to improve the rates as this is a patient safety issue. In addition, HSAG recommends that AHCCCS continue the collaboration among Contractors to improve these indicators.

Summary

HCA's baseline rate for the *E-Prescribing* PIP Indicator 1 (the percentage of AHCCCS-contracted providers who prescribed at least one prescription electronically) was 56.56 percent and for Indicator 2 (the percentage of prescriptions prescribed by an AHCCCS-contracted provider sent electronically) was 43.44 percent. Indicator 1 is above the AHCCCS aggregate rate, but only by 3.57 percent; while Indicator 2 is above the aggregate rate by 1.59 percent. HCA 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. In addition, HCA is encouraged to develop other solid interventions to increase both rates as studies have demonstrated a correlation between e-prescribing and patient safety.

Health Net Access (Health Net)

Findings

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

Table 8-3—Health Net *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.	51.42%	NA	NA	NA	52.99%

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 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider sent electronically.	36.09%	NA	NA	NA	42.35%

*Percentages reflect 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 51.42 percent of Health Net's providers prescribed at least one prescription electronically and that 36.09 percent of the prescriptions were sent by an AHCCCS-contracted provider electronically. The AHCCCS aggregate rate for providers prescribing electronically all ages combined is 52.99 percent, and the AHCCCS aggregate rate for prescriptions prescribed electronically for all ages is 42.35 percent. Health Net's baseline rate for all ages for providers prescribing electronically is 51.42 percent, or 1.57 percent below the aggregate rate. Health Net's baseline rate for prescriptions prescribed electronically for all ages is 36.09 percent, or 6.26 percent under the AHCCCS aggregate rate.

Health Net completed the following quantitative analysis:

- Health Net completed a comparative analysis for the following:
  - The use of e-prescribing seen within the various product lines of business compared to Health Net.
  - The percentage of new prescriptions e-prescribed by contracted providers by quarter for the last three quarters of the contract year ending 2014.
  - The percentage of Health Net Access contracted providers who use e-prescribing.

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

- Developed a provider online news article that detailed the potential benefits of e-prescribing and provided a list of available e-prescribing resources.
- Developed provider education for provider forums.
- Included an educational article on e-prescribing in the planned Provider Quality Resource booklet.
- Developed a member educational article for inclusion in the member newsletter that provided the benefits of using e-prescribing options when visiting healthcare providers.
- Developed a "Pharmacy Update" article related to the value of using e-prescribing.
- Participated in the E-Prescribing Workgroup, focusing on data mining, member and provider education, the LTC setting, and provider assistance.

Strengths

Health Net used internal data to perform a comparative analysis of the use of e-prescribing and the rates for providers and prescriptions. In addition, Health Net developed provider online material and education at provider forums as well as a "Pharmacy Update" article that informed providers about the use of e-prescribing. In addition, Health Net is working on educating members about the benefits of using e-prescribing options when visiting healthcare providers. Finally, Health Net is an active collaborator with the Workgroup.

Opportunities for Improvement and Recommendations

Health Net has an opportunity for improvement to increase both the rates of providers that prescribe prescriptions electronically and prescriptions that are electronically prescribed as Health Net's rate is below the aggregate rate. HSAG recommends that Health Net monitor the outcomes associated with the reported interventions. HSAG also recommends that Health Net develop more interventions based on received data, to increase the rates of both indicators. In addition, HSAG recommends that AHCCCS continue the collaboration among Contractors to improve these indicators.

Summary

Health Net's baseline rate for the *E-Prescribing* PIP Indicator 1 (the percentage of AHCCCS-contracted providers who prescribed at least one prescription electronically) was 51.42 percent and for Indicator 2 (the percentage of prescriptions prescribed by an AHCCCS-contracted provider sent electronically) was 36.09 percent. Both indicators are below the AHCCCS aggregate rate. Health Net 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. In addition, Health Net is encouraged to develop other solid interventions to increase both rates as studies have demonstrated a correlation between e-prescribing and patient safety.

Maricopa Health Plan (MHP)

Findings

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

Table 8-4—MHP *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.	44.11%	NA	NA	NA	52.99%
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider sent electronically.	40.34%	NA	NA	NA	42.35%

*Percentages reflect 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 44.11 percent of MHP's providers prescribed at least one prescription electronically and that 40.34 percent of prescriptions were sent by an AHCCCS-contracted provider electronically. The AHCCCS aggregate rate for providers prescribing electronically all ages combined is 52.99 percent, and the AHCCCS aggregate rate for prescriptions prescribed electronically for all ages is 42.35 percent. MHP's baseline rate for all ages for providers prescribing electronically is 44.11 percent, or 8.88 percent below the aggregate rate. MHP's baseline rate for prescriptions prescribed electronically for all ages is 40.34 percent, or 2.01 percent above the AHCCCS aggregate rate.

MHP completed the following quantitative analysis:

- MHP conducted an informal survey with providers and had discussions with its value-based purchasing (VBP) providers. The survey revealed that providers were unaware that controlled substances could be e-prescribed. In addition, MHP discovered that the e-prescribing software must be certified and approved for e-prescribing of controlled substances and that the prescriber must implement additional identity and security measures. MHP concluded that this may impart additional costs to the prescriber and that these costs may be the major barrier to improving e-prescribing rates. MHP plans to focus future interventions on educating providers on e-prescribing of controlled substances.

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

- Participated in the AzAHP E-Prescribing Workgroup.

- Conducted a telephonic provider survey.
- Conducted provider forums.
- Initiated VBP provider arrangements.
- Performed quarterly provider notification about e-prescribing.

Strengths

MHP conducted an informal survey with providers and had discussions with its VBP providers to learn about the barriers to e-prescribing. In addition, MHP conducted provider forums to educate providers about the use of e-prescribing. MHP has initiated VBP provider arrangements to assist providers with the cost of e-prescribing methods and performed quarterly notification to providers to increase compliance.

Opportunities for Improvement and Recommendations

MHP has an opportunity to increase both the rates of providers that prescribe prescriptions electronically and prescriptions that are electronically prescribed as MHP's rate is below the aggregate rate. HSAG recommends that MHP monitor outcomes associated with the reported interventions. HSAG also recommends that MHP develop more interventions based on received data, to increase the rates of both indicators. In addition, HSAG recommends that AHCCCS continue the collaboration among Contractors to improve these indicators.

Summary

MHP's baseline rate for the *E-Prescribing* PIP Indicator 1 (the percentage of AHCCCS-contracted providers who prescribed at least one prescription electronically) was 44.11 percent and for Indicator 2 (the percentage of prescriptions prescribed by an AHCCCS-contracted provider sent electronically) was 40.34 percent. Indicator 1 is below the AHCCCS aggregate rate. MHP 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. In addition, MHP is encouraged to develop other solid interventions to increase both rates as studies have demonstrated a correlation between e-prescribing and patient safety.

Mercy Care Plan (MCP)

Findings

Table 8-5 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 8-5—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.	51.20%	NA	NA	NA	52.99%
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider sent electronically.	40.13%	NA	NA	NA	42.35%

*Percentages reflect 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 8-5 shows that 51.20 percent of MCP's providers prescribed at least one prescription electronically and that 40.13 percent of prescriptions were sent by an AHCCCS-contracted provider electronically. The AHCCCS aggregate rate for providers prescribing electronically all ages combined is 52.99 percent, and the AHCCCS aggregate rate for prescriptions prescribed electronically for all ages is 42.35 percent. MCP's baseline rate for all ages for providers prescribing electronically is 51.20 percent, or 1.79 percent below the aggregate rate. MCP's baseline rate for prescriptions prescribed electronically for all ages is 40.13 percent, or 2.22 percent below the AHCCCS aggregate rate.

MCP completed the following quantitative analysis:

- A survey of providers was conducted by all Contractors in the Arizona Association of Health Plans. The findings by MCP are as follows:
  - Almost all providers surveyed by MCP have an EHR.
  - Barriers identified by MCP:
  - Prescriptions written in a hospital setting, rather than the clinic, did not allow for the provider to use e-prescribing software.
  - Lack of understanding exists about the ability to use e-prescribing for all prescriptions, including controlled substances.
  - Belief exists that prescriptions are submitted electronically, when actually the prescription is submitted into an EHR but then converted to a fax or paper script.

  - Additional cost is assessed to the practice to add to their EHR the ability to e-prescribe.
  - EHR system limitations exist—multiple providers reported that their EHR systems did not allow e-prescribing of narcotics.
  - Providers reported that pharmacies rejected any controlled substances e-prescribed, indicating it was "illegal" to e-prescribe as they needed an original signature on the script.
  - A practice was told that in order to be able to e-prescribe they would need to add a finger printing security system to their current EHR, which may be costly and time-consuming for the practice.
  - Usually, a two-day delay for pharmacies to process and dispense the prescription for the members occurred if submitted electronically, which may cause an issue if the medication is needed urgently/emergently.
  - Providers that have e-prescribed control medications reported the process to be difficult, including the need to have a different password and a key tag to facilitate a revolving identification.
  - Additional costs are incurred to add the ability to e-prescribe controlled substances to their EHR.
- Barriers identified by other MCOs, not listed preceding:
  - EHR system glitches sometimes caused electronic prescription transmission errors.
  - Provider preference for writing prescriptions--physicians prefer to hand prescriptions to members.
  - System limitations exist for e-prescribing.
  - Difficulty exists with the ability of pharmacies to accept prescriptions electronically, specifically in rural areas.
  - Specifically related to e-prescribing controlled substances, one physician provided the following feedback:
    - It is more complicated to e-prescribe controlled substances since the regulatory changes took effect in October 2014.
    - Availability of Class 2 controlled substances in the area, especially oxytocin and oxycodone, is limited.
    - Once an e-prescription was sent, it would have to be cancelled before another could be sent. This could be extremely time consuming and is not something that could be done timely.
    - When a patient used a pharmacy other than their usual, the new pharmacy insisted that all of that member's medications (not just the narcotics) be filled at that pharmacy; so the same requirement would likely apply for non-narcotic medications.

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

- Mined data, including mining data extracts by pharmacy and by prescriber, which were merged into a software tool that allowed for analysis and target identification.

- Investigated the current LTC-setting environment and work with the Arizona Health Care Association to identify opportunities to move volume from fax to e-prescriptions in the LTC environment.
- Surveyed providers to identify contributing factors to e-prescribing rates, including best practices or barriers.
- Developed a fact sheet for providers on the topic of EPCS.
- Surveyed Arizona EHR vendors to determine their system capabilities for e-prescribing controlled substances.
- Conducted on-site visits and distributed an e-prescribing controlled substances fact sheet. Visits were 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 PCMHs. Improvements in e-prescribing will be measured for 2015, with targets and rewards varying by practice based on baseline and actual practice performance.
- Developed member educational materials to communicate the benefits of e-prescribing.
- Obtained the information on which EHRs allowed for prescribing controlled substances and which did not and then determined certification needs.
- Provided updated information on each practice's e-prescribing rate to the practice representatives and had them discuss the results with each practice periodically, making it specific to individual doctors and concentrating on outlier low users.
- Reached out to pharmacies to identify some of the daily logistical challenges.

Strengths

MCP conducted a survey with providers to learn about the barriers to e-prescribing specific to each provider. Some barriers identified were issues with the EHR, especially in the rural areas; providers' reluctance to e-prescribe controlled substances; and provider preferences for writing prescriptions—physicians prefer to hand prescriptions to members. MCP initiated many different interventions to combat the barriers, including developing educational materials for providers and members, incentivizing of e-prescribing with PCMHs, conducting on-site visits and distributing an EPCS fact sheet, and providing updated information on each practice's e-prescribing rate to the practice representatives.

Opportunities for Improvement and Recommendations

MCP 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 MCP monitor outcomes associated with the reported interventions. HSAG also recommends that MCP develop more interventions based on received data, to increase both the rates of providers that prescribe prescriptions electronically and prescriptions that are electronically prescribed since these are both patient safety issues. 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 51.20 percent and for Indicator 2 (the percentage of prescriptions prescribed by an AHCCCS-contracted provider sent electronically) was 40.13 percent. Both indicators are below 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. In addition, MCP is encouraged to develop other solid interventions to increase both rates as studies have demonstrated a correlation between e-prescribing and patient safety.

Phoenix Health Plan, LLC (PHP)

Findings

Table 8-6 presents the baseline results for the *E-Prescribing* PIP for PHP's members, including members from all age groups.

Table 8-6—PHP *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.	47.09%	NA	NA	NA	52.99%
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider sent electronically.	40.49%	NA	NA	NA	42.35%

*Percentages reflect 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 8-6 shows that 47.09 percent of PHP's providers prescribed at least one prescription electronically and 40.49 percent of the prescriptions were sent by an AHCCCS-contracted provider electronically. The AHCCCS aggregate rate for providers prescribing electronically all ages combined is 52.99 percent, and the AHCCCS aggregate rate for prescriptions prescribed electronically for all ages is 42.35 percent. PHP's baseline rate for all ages for providers prescribing electronically is 47.09 percent, or 5.90 percent below

the aggregate rate. PHP's baseline rate for prescriptions prescribed electronically for all ages is 40.49 percent, or 1.86 percent below the AHCCCS aggregate rate.

PHP completed the following quantitative analysis:

- In its analysis, PHP found that the rate of e-prescribing was likely to increase over time even without Contractor interventions. PHP compared the month-to-month performance to an acute care Contractor willing to share data to help assess whether or not Contractor efforts were contributing to an increase in the rates of providers prescribing or prescriptions being submitted electronically. PHP was able to compare progress from baseline to Remeasurement Period 2 between PHP and the other Contractor. PHP experienced approximately twice the rate of improvement as did that Contractor.
- PHP conducted a qualitative provider survey at a PHP provider forum. Provider office staff in attendance documented what they perceived to be barriers to the adoption of e-prescribing in their offices. PHP compiled and analyzed the survey results and then used those results to develop interventions that began in early 2015. For example, PHP identified the cost of an EHR as a barrier; and the intervention was to connect offices with a non-profit organization that could educate the providers on no-cost e-prescribing software and inform the providers of incentives that could offset the cost of more sophisticated systems.

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

- Hosted provider education with AZ Health eConnection.
- Sends to providers annually a fax about the importance of e-prescribing.
- Wrote member-level article about the importance of e-prescribing.
- Attended e-prescribing conferences to increase expertise.
- Incorporated e-prescribing into a pay-for-performance (P4P) payment model.
- Implemented a new system for the foundation for the P4P analytics.

Strengths

PHP performed an analysis of the results of a provider survey and learned that the rate of e-prescribing was likely to increase over time, even without Contractor interventions. PHP took an additional step by contacting another MCO willing to share both results of its survey and data to improve the rates of e-prescribing. This intervention allowed PHP to compare progress from baseline to Remeasurement Period 2 between PHP the other MCO. PHP also demonstrated creativity by conducting a qualitative provider survey at a PHP provider forum, which allowed PHP staff to learn from the end users what prevented those end users from using e-prescribing. PHP also has implemented strong interventions like educating providers and members about the benefits of e-prescribing and implementing a P4P incentive model.

Opportunities for Improvement and Recommendations

PHP 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 PHP monitor the outcomes associated with the reported interventions. HSAG also recommends that PHP develop more interventions based on received data, to increase both the rates of providers that prescribe prescriptions electronically and prescriptions that are electronically prescribed since these are both patient safety issues. In addition, HSAG recommends that AHCCCS continue the collaboration among Contractors to improve these indicators.

Summary

PHP's baseline rate for the e-prescribing PIP Indicator 1 (the percentage of AHCCCS-contracted providers who prescribed at least one prescription electronically) was 47.09 percent and for Indicator 2 (the percentage of prescriptions prescribed by an AHCCCS-contracted provider sent electronically) was 40.49 percent. Both indicators are below the AHCCCS aggregate rate. PHP 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. In addition, PHP is encouraged to develop other interventions to increase both rates as studies have demonstrated a correlation between e-prescribing and patient safety.

UnitedHealthcare Community Plan (UHCCP)

Findings

Table 8-7 presents the baseline results for the *E-Prescribing* PIP for UHCCP's members, including members from all age groups.

Table 8-7—UHCCP *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.	62.76%	NA	NA	NA	52.99%

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 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider sent electronically.	44.19%	NA	NA	NA	42.35%

*Percentages reflect 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 8-7 shows that 62.76 percent of UHCCP's providers prescribed at least one prescription electronically and 44.19 percent of the prescriptions were sent by an AHCCCS-contracted provider electronically. The AHCCCS aggregate rate for providers prescribing electronically all ages combined is 52.99 percent, and the AHCCCS aggregate rate for prescriptions prescribed electronically for all ages is 42.35 percent. UHCCP's baseline rate for all ages for providers prescribing electronically is 62.76 percent, or 9.77 percent above the aggregate rate. UHCCP's baseline rate for prescriptions prescribed electronically for all ages is 44.19 percent, or 1.84 percent above the AHCCCS aggregate rate.

UHCCP completed the following quantitative analysis:

- UHCCP participated in the completion of two surveys as part of an E-Prescribing Workgroup that was formed with other Arizona MCOs. One survey asked providers to identify contributing factors to e-prescribing rates to identify best practices or barriers, while another asked Arizona EHR vendors to determine their system capabilities for e-prescribing controlled substances.
  - UHCCP found that the most common perceived barriers to e-prescriptions of any kind were as follows: providers stated that they mostly prescribe controlled substances and do not use e-prescribing for controlled substances; providers listed technical difficulties in using and transmitting the e-prescription. More than 50 percent of providers identified a barrier to e-prescribing controlled substances, with the most common perceived barriers to adoption of EPCS as follows: provider not aware it is legal, provider preferred to handwrite controlled substance prescriptions, and provider's EHR system did not support EPCS.
  - UHCCP surveyed the electronic medical record (EMR) vendors to see if their systems were capable of supporting EPCS E-Prescriptions. Nine vendors were surveyed, and all responded. Four of the nine did not support EPCS in Arizona. The five remaining vendors stated that their EMR systems were targeted to support EPCS by the end of 2015. Prescribers using EMR systems that do not support EPCS would not be able to increase their EPCS rates.
- The group also compiled prescriber data that looked at e-prescribing rates and included which providers in each MCO had the lowest rates.

- UHCCP identified several opportunities from the surveys, including the need for further education on e-prescribing, the need to evaluate the ability for current EHR systems to support EPCS, and identification and ranking of providers' e-prescribing practices.

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

- Reported on the ranking of providers with the greatest volume of prescriptions and the lowest e-prescribing rate for intervention.
- Educated prescribers on advantages of e-prescribing and offered assistance in connecting with e-prescribing vendors.
- Incorporated e-prescribing into provider forums and provider engagement meetings.

Strengths

For the baseline measurement period, UHCCP has rates above the AHCCCS aggregate rates for the providers prescribing at least one prescription electronically and the prescriptions sent by an AHCCCS-contracted provider electronically. To increase those rates, UHCCP has analyzed the data from the surveys conducted and developed interventions to address the education barriers to e-prescribing. UHCCP has educated prescribers on the advantages of e-prescribing, offered assistance in connecting with e-prescribing vendors, and incorporated e-prescribing into provider forums and provider engagement meetings.

Opportunities for Improvement and Recommendations

Even with rates above the AHCCCS aggregate rates, UHCCP 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 UHCCP 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

UHCCP's baseline rate for the *E-Prescribing* PIP Indicator 1 (the percentage of AHCCCS-contracted providers who prescribed at least one prescription electronically) was 62.76 percent and for Indicator 2 (the percentage of prescriptions prescribed by an AHCCCS-contracted provider sent electronically) was 44.19 percent. Both indicators are above the AHCCCS aggregate rate. UHCCP 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. In addition, UHCCP is encouraged to develop other interventions to increase both rates as studies have demonstrated a correlation between e-prescribing and patient safety.

University Family Care (UFC)

Findings

Table 8-8 presents the baseline results for the *E-Prescribing* PIP for UFC's members, including members from all age groups.

Table 8-8—UFC *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.	49.65%	NA	NA	NA	52.99%
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider sent electronically.	47.36%	NA	NA	NA	42.35%

*Percentages reflect 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 8-8 shows that 49.65 percent of UFC's providers prescribed at least one prescription electronically and that 47.36 percent of prescriptions ordered were sent by an AHCCCS-contracted provider electronically. The AHCCCS aggregate rate for providers prescribing electronically all ages combined is 52.99 percent, and the AHCCCS aggregate rate for prescriptions prescribed electronically for all ages is 42.35 percent. UFC's baseline rate for all ages for providers prescribing electronically is 49.65 percent, or 3.34 percent below the aggregate rate. UFC's baseline rate for prescriptions prescribed electronically for all ages is 47.36 percent, or 5.01 percent points above the AHCCCS aggregate rate.

UFC completed the following quantitative analysis:

- UFC conducted an informal survey with providers and had discussions with its VBP providers. The survey revealed that providers were unaware that controlled substances could be e-prescribed. In addition, UFC discovered that the e-prescribing software must be certified and approved for e-

prescribing of controlled substances and that the prescriber must implement additional identity and security measures. UFC concluded that this may impart additional costs to the prescriber and that these costs may be the major barrier to improving e-prescribing rates. UFC plans to focus future interventions on educating providers on EPCS.

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

- Participated in the AzAHP E-Prescribing Workgroup.
- Conducted a telephonic provider survey.
- Conducted provider forums
- Initiated VBP provider arrangements.
- Performed quarterly provider notification about e-prescribing.

Strengths

UFC conducted an informal survey with providers and had discussions with its VBP providers to learn about the barriers to e-prescribing. Consequently, UFC initiated VBP provider arrangements to assist providers with the cost of e-prescribing methods and performed quarterly notification to providers to increase compliance. In addition, UFC conducted provider forums to educate providers about the use of e-prescribing.

Opportunities for Improvement and Recommendations

UFC has an opportunity for improvement for the rates of providers that prescribe prescriptions electronically as UFC's rate is slightly below the aggregate rate. HSAG recommends that UFC monitor outcomes associated with the reported interventions. HSAG also recommends that, to increase both the rates of providers prescribing prescriptions electronically and of prescriptions prescribed electronically (as these are both patient safety issues), MHP develop more interventions based on received data. In addition, HSAG recommends that AHCCCS continue the collaboration among Contractors to improve these indicators.

Summary

UFC's baseline rate for the e-prescribing PIP Indicator 1 (the percentage of AHCCCS-contracted providers who prescribed at least one prescription electronically) was 49.65 percent and for Indicator 2 (the percentage of prescriptions prescribed by an AHCCCS-contracted provider sent electronically) was 47.36 percent. Indicator 1 is slightly below the AHCCCS aggregate rate. UFC 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. In addition, UFC is encouraged to develop other solid interventions to increase both rates as studies have demonstrated a correlation between e-prescribing and patient safety.

Arizona Department of Economic Security/Comprehensive Medical and Dental Program (CMDP)

Findings

Table 8-9 presents the baseline results for the *E-Prescribing* PIP for CMDP's members.

Table 8-9—CMDP *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.	47.31%	NA	NA	NA
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider sent electronically.	46.70%	NA	NA	NA

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-9 shows that 47.31 percent of CMDP's providers prescribed at least one prescription electronically and that 46.70 percent of prescriptions were sent by an AHCCCS provider electronically.

CMDP completed the following quantitative analysis:

- CMDP attributes a high score to the push to place a child with a qualified relative or a licensed placement, which may have resulted in a higher propensity for CMDP's population to use providers outside the "typical" AHCCCS/Medicaid provider network.
- CMDP believes the high percentage rates may be related to its pediatric membership that has historically had a miniscule percentage of prescriptions for controlled substances.
- CMDP members typically are prescribed less-complicated medications such as antibiotics and asthma/allergy medications, allowing for easier implementation of e-prescribing.

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

- CMDP's Provider Services Unit sent out an email blast to 216 providers both regarding e-prescribing and including a Provider Profile update containing information related to e-prescribing.

- Administered a provider survey to identify and analyze obstacles providers experience with implementing or using e-prescribing.
- Targeted high-utilizing paper prescribers.
- Developed e-prescribing brochures highlighting the benefits to providers.
- Incorporated e-prescribing protocols as a formal item to be addressed as part of provider education during office on-site visits conducted by the Provider Services Unit.
- Developed and inserted e-prescription check-stuffers into envelopes with paper checks and remittance statements for providers.
- Generated monthly e-prescriber reports to identify the top 10 percent of providers who prescribe medications to CMDP members but are either not or inconsistently using e-prescribing.
- Supported and continues to support the efforts of AzAHP to encourage e-prescribing.

Strengths

CMDP developed strong interventions to improve both the rate of providers prescribing prescriptions electronically and the rate of prescriptions sent electronically. For example, CMDP is participating in the Workgroup and has administered a provider survey to identify and analyze obstacles providers experience with implementing or using e-prescribing. CMDP developed e-prescribing brochures for providers, incorporated e-prescribing protocols as a formal item to be addressed as part of provider education during office on-site visits, and inserted e-prescription check-stuffers into envelopes with paper checks and remittance statements for providers. CMDP initially targeted high-utilizing paper prescribers by generating monthly e-prescriber reports to identify the top 10 percent of providers who prescribe medications to CMDP members but are either not or inconsistently using e-prescribing.

Opportunities for Improvement and Recommendations

CMDP 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 CMDP 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

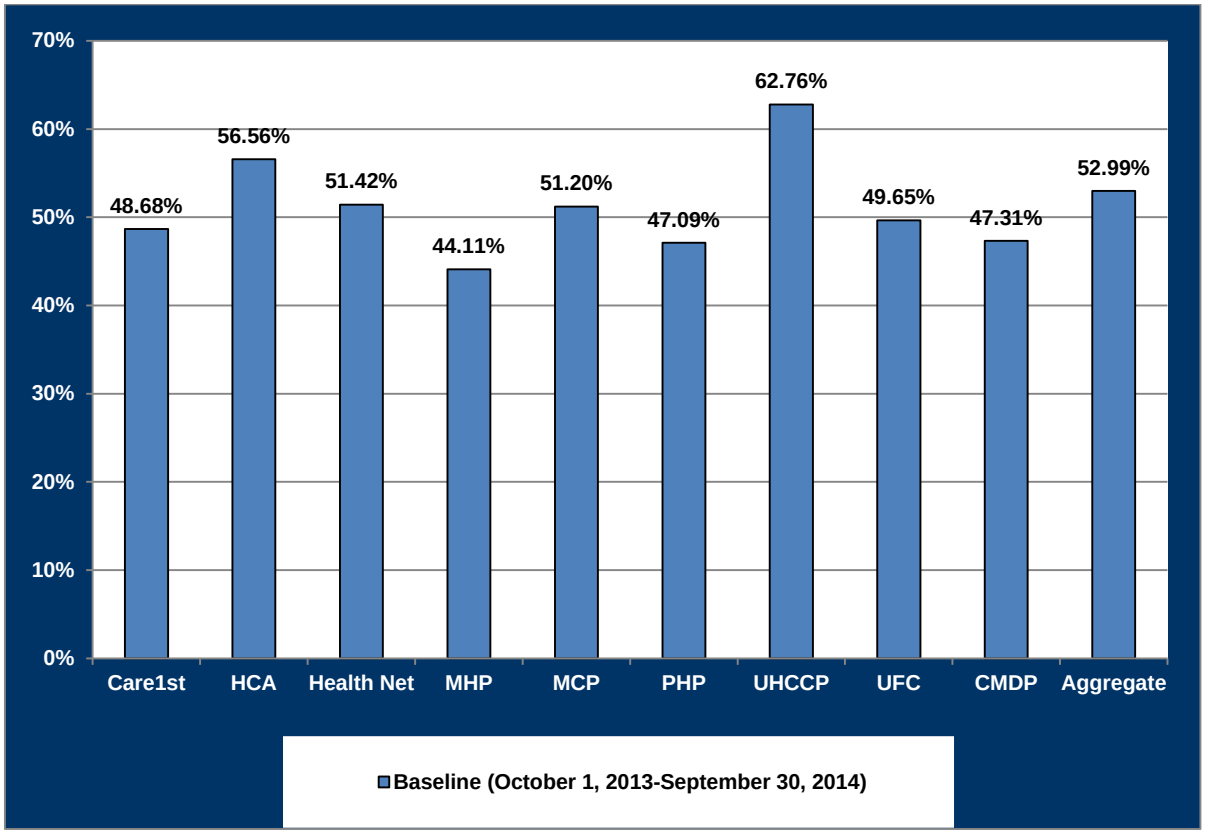
CMDP's baseline rate for the *E-Prescribing* PIP Indicator 1 (the percentage of AHCCCS-contracted providers who prescribed at least one prescription electronically) was 47.31 percent and for Indicator 2 (the percentage of prescriptions prescribed by an AHCCCS-contracted provider sent electronically) was 46.70 percent. CMDP 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 Acute Care and DES/CMDP 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 nine Acute Care and DES/CMDP Contractors and among all Contractors combined. (Aggregate rate does not include DES/CMDP data.)

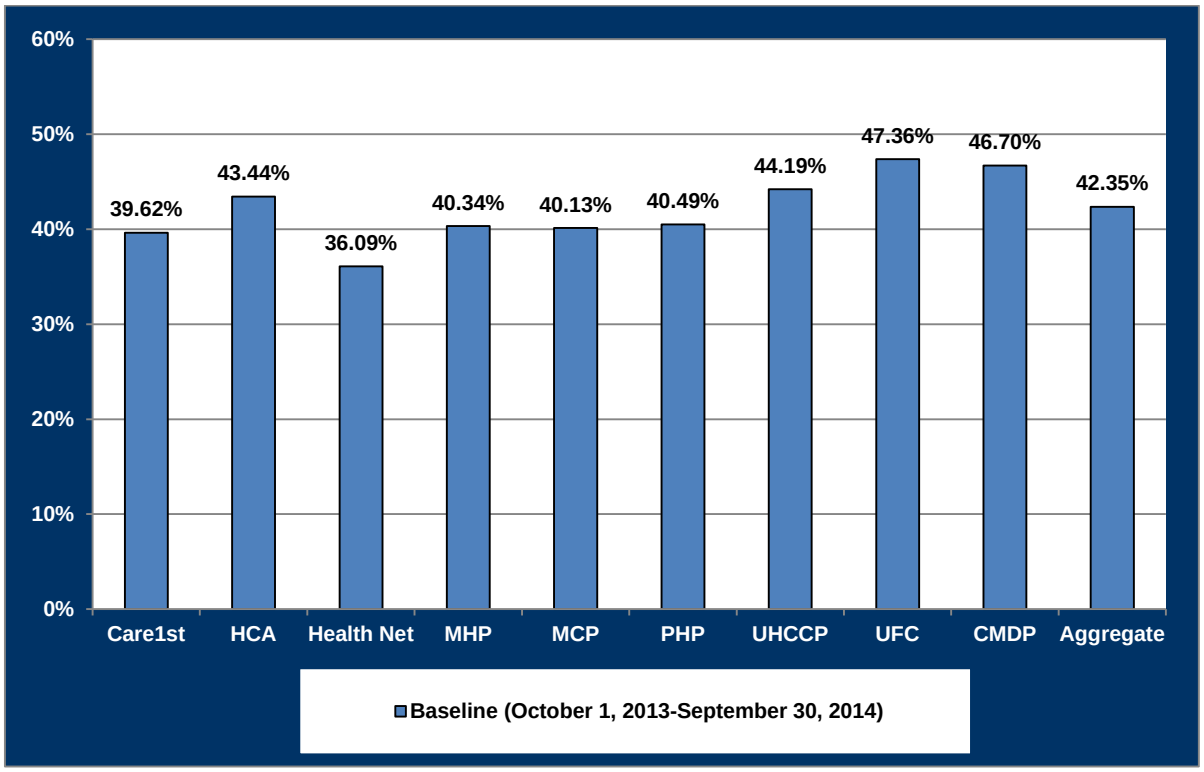
Figure 8-1—Performance Improvement Projects—*E-Prescribing:* Indicator 1: The percentage of providers who prescribed at least one prescription electronically—All Acute and DES/CMDP Contractors*



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

Figure 8-1 shows that two Contractors, HCA and UHCCP, reported a higher percentage of providers using e-prescribing during the baseline measurement period than the AHCCCS aggregate rate of 52.99 percent. All other Contractors reported rates lower than the AHCCCS aggregate rate. At 44.11 percent, MHP was 8.88 percent below the AHCCCS aggregate rate, thereby having the greatest opportunity for improvement among the Contractors. At 62.76 percent, UHCCP had the highest baseline rate for this PIP at 9.77 percent above the AHCCCS aggregate rate, followed by HCA at 3.57 percent above the AHCCCS aggregate rate.

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



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

Figure 8-2 shows that four Contractors—HCA, UHCCP, UFC, and CMDP—reported a higher percentage of prescriptions sent electronically during the baseline measurement period than the AHCCCS aggregate rate of 42.35 percent. Health Net reported the lowest rate of 36.09 percent or 6.26 percent lower than the AHCCCS aggregate rate. Health Net has the greatest opportunity for improvement among the Contractors. Three Contractors—MHP, MCP and PHP—clustered around 40 percent. At 47.36 percent, UFC had the highest baseline rate for this PIP, followed by CMDP, UHCCP and HCA respectively.

Strengths

All Contractors participated in the completion of two surveys as part of the E-Prescribing Workgroup formed with other Arizona Contractors. The surveys asked providers to identify contributing factors to e-prescribing rates to identify best practices or barriers and requested that Arizona EHR vendors determine their system capabilities for e-prescribing controlled substances. In addition, all Contractors provided education to providers, with several plans including members in their education interventions. Several Contractors targeted high-volume prescribers and provided incentives to encourage e-prescribing. One Contractor notified providers quarterly about their rates, while others conducted on-site visits to encourage e-prescribing.

Opportunities for Improvement and Recommendations

MHP demonstrated the greatest opportunity for improvement (i.e., the lowest rate of providers using e-prescribing) as the Contractor's rate was 8.88 percentage points lower than the AHCCCS aggregate rate for Indicator 1. Health Net had the greatest opportunity for improvement (i.e., the lowest rate of prescriptions sent electronically) as the Contractor's rate was 6.26 percentage points 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 44.11 percent for MHP to 62.76 percent for UHCCP for Indicator 1. For Indicator 2, Contractor performance ranged from 36.09 percent for Health Net to 47.36 percent for UFC. This is the baseline year; therefore, comparisons cannot be made between rates for each indicator. HSAG recommends that the Contractors continually monitor the PIP rates to determine whether or not interventions are successful prior to the first remeasurement of the PIP.