

Arizona Health Care Cost Containment System



**Contract Year Ending 2016  
External Quality Review Annual Report**

*for*

**Arizona Long Term Care System  
(ALTCS) Contractors**

*June 2018*



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## 1. Executive Summary

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

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

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

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

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

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

AHCCCS contracted with Health Services Advisory Group, Inc. (HSAG) as its CMS-required EQRO to prepare this CYE 2016 EQR technical report. This report presents AHCCCS' findings from conducting each activity as well as HSAG's analysis and assessment of the reported results for each Contractor's performance and, as applicable, recommendations to improve Contractors' performance.

HSAG is an EQRO that meets the competence and independence requirements set forth in 42 CFR §438.354. HSAG has extensive experience and expertise in both conducting the mandatory activities

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

and in analyzing information obtained from AHCCCS' reviews of the activities. Accordingly, HSAG uses the information and data to draw conclusions and make recommendations about the quality and timeliness of, and access to care and services that AHCCCS' Contractors provide.

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

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

HSAG has prepared the annual technical report for AHCCCS for 13 consecutive years. The report complies with all requirements set forth at 42 CFR §438.364.

This executive summary includes an overview of AHCCCS' CYE 2016 EQR activities as provided to HSAG and a high-level summary of the results. The results include a description of HSAG's findings with respect to performance by the AHCCCS Contractors in complying with the AHCCCS contract requirements and the applicable federal 42 CFR 438 requirements for each activity. In addition, this executive summary includes an assessment of each Contractor's strengths and weaknesses related to the quality of, timeliness of, and access to healthcare services as well as HSAG's recommendations for improving the quality of services.

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

- Section 2—An overview of the AHCCCS program.
- Section 3—A description of the CYE 2016 EQR activities.

- Section 4—An overview of AHCCCS’ statewide quality initiatives across its Medicaid managed care program and those initiatives that are specific to the Arizona Long Term Care (ALTCS) program.
- Section 5—An overview of the Contractors’ best and emerging practices.
- Section 6 (Organizational Assessment and Structure Performance)—An overview of the new AHCCCS methodology for the organizational review (OR) and a presentation of Contractor-specific OR results as well as HSAG’s associated findings and recommendations. (AHCCCS began a new OR in contract year ending [CYE] 2016 [review period October 1, 2015, through September 30, 2016] to assess each Contractor’s compliance with AHCCCS’ contract standards.) For this annual report, AHCCCS provided data and information for all Contractors.
- Section 7 (Performance Measure Performance)—A presentation of rates for AHCCCS-selected performance measures for each ALTCS Contractor and HSAG’s associated findings and recommendations.
- Section 8 (Performance Improvement Project Performance)—A presentation of Contractor-specific PIP results for the ALTCS Contractors as well as HSAG’s associated findings and recommendations.

As CYE 2015 performance measure results are still under review by AHCCCS and its Contractors, all CYE 2015 performance measure results provided in this report should be considered preliminary and are subject to change prior to finalization.

## Overview of the CYE 2016 External Review

During the review period, AHCCCS contracted with the Contractors listed below to provide services to members enrolled in the AHCCCS ALTCS Medicaid managed care program, and members enrolled with

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

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

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

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

## Organizational Assessment and Structure Standards

AHCCCS conducted a comprehensive OR for each Contractor during CYE 2016.

The OR was organized into 12 standard areas. For the ALTCS Contractors, each standard area consisted of several elements designed to measure the Contractor's performance and compliance. The following 12 standards and coinciding numbers of elements are used throughout the report:

- Case Management (CM)—20 elements
- Corporate Compliance (CC)—Five elements
- Claims and Information Systems (CIS)—12 elements
- Delivery Systems (DS)—Nine elements
- General Administration (GA)—Three elements
- Grievance Systems (GS)—17 elements
- Adult; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT); and Maternal Child Health (MCH)—15 elements
- Medical Management (MM)—22 elements
- Member Information (MI)—Nine elements
- Quality Management (QM)—28 elements
- Reinsurance (RI)—Four elements
- Third-Party Liability (TPL)—Seven elements

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

Each standard area contains elements designed to measure the Contractor's performance and compliance with the federal managed care rules and the AHCCCS ALTCS contract provisions. A Contractor may receive up to a maximum possible score of 100 percent for each standard measured during the CYE 2016 OR. Within each standard are specific scoring detail criteria worth a defined percentage of the total possible score.

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

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



## Findings

Under Section 6 (“Organizational Assessment and Structure Performance”) of this report, HSAG included details for each Contractor’s performance related to the standards measured in the OR. Based on the data, and considering that each of the 12 standards contained numerous elements, HSAG conducted an analysis of the scores for each standard area.

Table 1-1 summarizes outcomes of the reviews conducted by AHCCCS related to the four Contractors’ scores in the 12 standard areas. Table 1-1 details the numbers of scores at or above 95 percent, numbers of scores below 95 percent, and numbers of corrective actions for the standard. Combined totals for the number of scores above and below the 95 percent compliance threshold are included at the bottom of the table, as well as a combined total number of required corrective actions assigned in all standard areas.

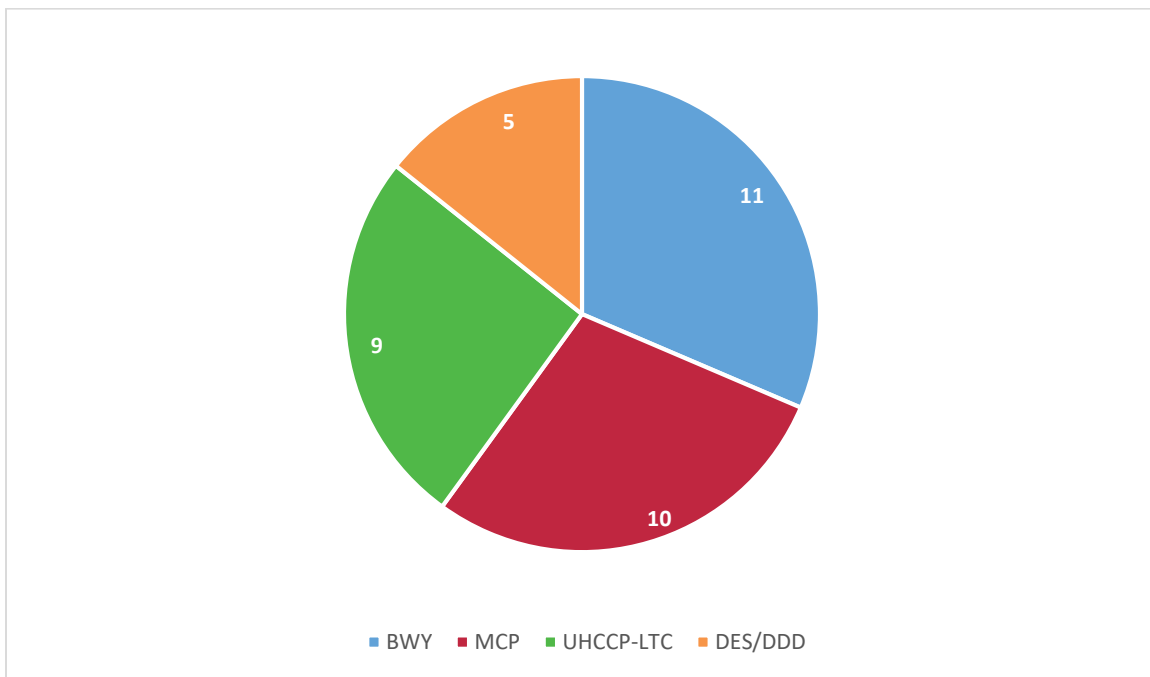
**Table 1-1—Score and CAP Summary per Standard Area**

| Standard Area                           | Number of Scores 95% and Above | Number of Scores Below 95% | Required Corrective Actions |
|---|--------------------------------|----------------------------|-----------------------------|
| Case Management                         | 2                              | 2                          | 11                          |
| Corporate Compliance                    | 1                              | 3                          | 4                           |
| Claims and Information Systems          | 1                              | 3                          | 13                          |
| Delivery Systems                        | 2                              | 2                          | 4                           |
| General Administration                  | 4                              | 0                          | 0                           |
| Grievance Systems                       | 4                              | 0                          | 1                           |
| Adult, EPSDT, and Maternal Child Health | 4                              | 0                          | 0                           |
| Medical Management                      | 3                              | 1                          | 11                          |
| Member Information                      | 4                              | 0                          | 1                           |
| Quality Management                      | 4                              | 0                          | 11                          |
| Reinsurance                             | 3                              | 1                          | 3                           |
| Third-Party Liability                   | 3                              | 1                          | 3                           |
| <b>Combined Totals</b>                  | <b>35</b>                      | <b>13</b>                  | <b>62</b>                   |

Standards with greatest opportunity for improvement, based on the number of CAPs required, were CM, CIS, MM, and QM. Even though for QM all Contractors scored above 95 percent, AHCCCS required 11 CAPs. Strongest performances were in the following standards: GA, GS, MCH, MI, and QM. The two standard areas for which the most Contractors scored below 95 percent were the CC and CIS standards.

Following, Figure 1-1 details, by Contractor, the number of standard area scores at 95 percent and above.

**Figure 1-1—Total Standard Areas With Scores at 95% and Above by Contractor**



For BWY, 11 of 12 standard areas demonstrated scores of 95 percent and above. BWY had the highest number of standard areas at or above 95 percent, compared to the other three Contractors. Only for CIS did BWY not achieve a score of 95 percent or above. MCP-LTC demonstrated the second highest number of standard areas scored at 95 percent and above, with 10 of 12 standards. UHCCP-LTC had nine of 12 standard areas scored at or above 95 percent, while DES/DDD had the lowest number of standard areas at 95 percent and above.

### Conclusions

For the CYE 2016 AHCCCS OR, the four Contractors demonstrated overall positive results. All four Contractors were in full compliance (100 percent) with the GA and MCH standards. The two standard areas for which most Contractors scored below 95 percent were the CC and CIS standards. When considering the compliance scores, the GA, GS, MCH, MI, and QM standards were strengths across all four Contractors as all four Contractors scored at or above the 95 percent compliance threshold for each standard. The CC and CIS standards resulted in the highest number of scores below 95 percent.

### Recommendations

Based on AHCCCS’ review of the ALTCS and DES/DDD Contractor performance in CYE 2016 and the associated opportunities for improvement identified during the OR, HSAG recommends the following:

- Contractors should conduct internal reviews of operational systems to identify barriers that impact compliance with AHCCCS standards, State rules, and federal regulations. Specifically, Contractors

should cross-reference existing policies and procedures with AHCCCS requirements and ensure, at a minimum, alignment with both the intent and content of AHCCCS standards, State rules, and federal regulations.

- Contractors should assess current monitoring programs and activities to identify strengths and vulnerable areas. When deficiencies are noted, the Contractors should develop mechanisms to address such areas and enhance the existing properties.
- Contractors should apply lessons learned from improving performance in one category of standards to other categories. Specifically, Contractors can learn from earlier completed CAPs as identified in previous ORs to determine best practices specific to their organizations, identifying and correcting deficient standards, and monitoring the subsequent compliance.
- Based on highest number of CAPs, AHCCCS should concentrate improvement efforts on the following standard areas: CIS, CM, MM, and QM. AHCCCS should specifically consider the CIS standard as this is the standard for which most Contractors scored under 95 percent and the standard with the highest number of related CAPs.

### ALTCS Performance Measures

AHCCCS collected data and reported Contractor performance for a set of performance measures selected by AHCCCS for the CYE 2015 measurement period. For CYE 2015, AHCCCS selected six performance measure rates for the ALTCS Contractors. The following tables display those performance measure rates with an established minimum performance standard (MPS). An MPS had not yet been established for all reported performance measure rates. Rates for performance measures without an established MPS are found in the “Performance Measure Performance” section of this report.

### Findings

Table 1-2 presents the following information for each performance measure indicator for all the ALTCS Contractors: CYE 2014 performance; CYE 2015 performance; the relative percentage change between the CYE 2014 and CYE 2015 rates; the statistical significance of the relative percentage change; and the AHCCCS MPS, when applicable.

**Table 1-2—ALTCS Contractors—Performance Measurement Results**

| Performance Measure  | CYE 2014 Performance | CYE 2015 Performance | Relative Percentage Change | Significance Level (p value) | Minimum Performance Standard |
|--|----------------------|----------------------|----------------------------|------------------------------|------------------------------|
| <i>Adults’ Access to Preventive/Ambulatory Health Services</i> |                      |                      |                            |                              |                              |
| <i>Adults’ Access to Preventive/Ambulatory Health Services</i> | —                    | 90.5%                | —                          | —                            | 75.0%                        |

— Indicates that the Contractor was not required to report the measure or that comparison of performance between CYE 2014 and CYE 2015 is not applicable.

The performance measure rate for *Adults’ Access to Preventive/Ambulatory Health Services* exceeded the CYE 2015 MPS for the ALTCS Contractors by 15.5 percentage points.

**Conclusions**

For ALTCS, the performance measure rate for *Adults’ Access to Preventive/Ambulatory Health Services* exceeded the MPS.

**Recommendations**

HSAG recommends that the ALTCS Contractors monitor and improve care for members related to those rates without established MPSs.

**DES/DDD Performance Measures**

AHCCCS collected data and reported Contractor performance for a set of performance measures selected by AHCCCS for the CYE 2015 measurement period. For CYE 2015, AHCCCS selected 18 performance measure rates for DES/DDD. The following tables display those performance measure rates with established MPSs. An MPS had not yet been established for all reported performance measure rates. Rates for performance measures without established MPSs are found in the “Performance Measure Performance” section of this report.

**Findings**

Table 1-3 presents the performance measure rates for DES/DDD. The table displays the following information: CYE 2014 performance; CYE 2015 performance; the relative percentage change between the CYE 2014 and CYE 2015 rates; the statistical significance of the relative percentage change; and the AHCCCS MPS, when applicable.

**Table 1-3—DES/DDD—Performance Measurement Results**

| Performance Measure   | CYE 2014 Performance | CYE 2015 Performance | Relative Percentage Change | Significance Level ( <i>p</i> value) <sup>1</sup> | Minimum Performance Standard |
|---|----------------------|----------------------|----------------------------|---|------------------------------|
| <b><i>Adolescent Well-Care Visits</i></b>                             |                      |                      |                            |   |                              |
| <i>Adolescent Well-Care Visits</i>                                    | 35.8%                | 39.8%                | 11.4%                      | <b>P&lt;.001</b>                                  | 41.0%                        |
| <b><i>Adults’ Access to Preventive/Ambulatory Health Services</i></b> |                      |                      |                            |   |                              |
| <i>Adults’ Access to Preventive/Ambulatory Health Services</i>        | —                    | 85.2%                | —                          | —   | 75.0%                        |
| <b><i>Annual Dental Visits</i><sup>2</sup></b>                        |                      |                      |                            |   |                              |
| <i>2–20 Years</i>   | 52.9%                | 55.7%                | 5.3%                       | <b>P&lt;.001</b>                                  | 60.0%                        |
| <b><i>Breast Cancer Screening</i></b>                                 |                      |                      |                            |   |                              |

| Performance Measure  | CYE 2014 Performance | CYE 2015 Performance | Relative Percentage Change | Significance Level (p value) <sup>1</sup> | Minimum Performance Standard |
|--|----------------------|----------------------|----------------------------|---|------------------------------|
| <i>Breast Cancer Screening</i>   | —                    | 45.1%                | —                          | —   | 50.0%                        |
| <b><i>Cervical Cancer Screening</i></b>  |                      |                      |                            |   |                              |
| <i>Cervical Cancer Screening</i>   | —                    | 18.0%                | —                          | —   | 64.0%                        |
| <b><i>Children and Adolescents' Access to Primary Care Practitioners</i></b>         |                      |                      |                            |   |                              |
| <i>12–24 Months</i>  | 93.4%                | 98.3%                | 5.3%                       | P=.228                                    | 93.0%                        |
| <i>25 Months–6 Years</i>   | 86.6%                | 90.1%                | 4.0%                       | <b>P&lt;.001</b>                          | 84.0%                        |
| <i>7–11 Years</i>  | 90.1%                | 91.1%                | 1.1%                       | P=.114                                    | 83.0%                        |
| <i>12–19 Years</i>   | 87.3%                | 88.4%                | 1.2%                       | P=.087                                    | 82.0%                        |
| <b><i>Chlamydia Screening in Women</i></b>   |                      |                      |                            |   |                              |
| <i>Total</i>   | —                    | 8.3%                 | —                          | —   | 63.0%                        |
| <b><i>Follow-Up After Hospitalization</i></b>  |                      |                      |                            |   |                              |
| <i>7-Day Follow-Up</i>   | —                    | 37.8%                | —                          | —   | 50.0%                        |
| <i>30-Day Follow-Up</i>  | —                    | 75.5%                | —                          | —   | 70.0%                        |
| <b><i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i></b> |                      |                      |                            |   |                              |
| <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>        | 48.0%                | 52.1%                | 8.5%                       | <b>P=.002</b>                             | 66.0%                        |

<sup>1</sup> Significance levels (p values) noted in the table were calculated by AHCCCS and HSAG and demonstrate whether the differences in performance between CYE 2014 and CYE 2015 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤ 0.05. Significance levels (p-values) in bold font indicate statistically significant values.

<sup>2</sup> Due to measure specification changes, exercise caution when comparing CYE 2015 performance measure rates for this measure to prior years' rates.

— Indicates that the Contractor was not required to report the measure or that comparison of performance between CYE 2014 and CYE 2015 was not possible.

A statically significant increase was demonstrated by DES/DDD for four of seven performance rates (*Adolescent Well-Care Visits; Annual Dental Visits—2–20 Years; Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years; and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) with rates in both CYE 2014 and CYE 2015. No measures demonstrated a statistically significant decline in performance between CYE 2014 and CYE 2015. Further, DES/DDD exceeded the CYE 2015 MPSs for six of 13 performance measure rates (*Adults' Access to Preventive/Ambulatory Health Services; Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years; and Follow-Up After Hospitalization—30-Day Follow-Up*).

## Conclusions

For DES/DDD, seven performance measure rates (*Adolescent Well-Care Visits; Annual Dental Visits—2–20 Years; Breast Cancer Screening; Cervical Cancer Screening; Chlamydia Screening in Women—Total; Follow-Up After Hospitalization—7-Day Follow-Up; and Well-Child Visits in the Third, Fourth,*

*Fifth, and Sixth Years of Life*) did not meet the MPSs for CYE 2015. Further, for *Follow-Up After Hospitalization—7-Day Follow-Up*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; *Cervical Cancer Screening*; and *Chlamydia Screening in Women—Total*, the rates were below the respective MPSs by 12.2 percentage points, 13.9 percentage points, 46.0 percentage points, and 54.7 percentage points, respectively, demonstrating opportunities for improvement. Conversely, three measure rates, *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years, 7–11 Years, and 12–19 Years*, exceeded the respective MPSs by 6.1 percentage points, 8.1 percentage points, and 6.4 percentage points, respectively, demonstrating a strength for DES/DDD.

## Recommendations

The performance for seven of 13 measure rates for DES/DDD fell below the established MPSs, demonstrating that the Contractor has opportunities for improvement. Therefore, HSAG recommends focusing efforts on increasing follow-up care after hospitalization, well-child visits, dental visits, and screenings in women. Results of these focused efforts should be used to identify strategies that can be applied to drive improvement for other performance measures.

## 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: Remeasurement 1 period in CYE 2016 (October 1, 2015, through September 30, 2016), and Remeasurement 2 period in CYE 2017 (October 1, 2016, through September 30, 2017). As CYE 2015 was an intervention year, this annual report will include CYE 2015 qualitative analyses and interventions only.

AHCCCS implemented the *E-Prescribing* PIP to improve preventable errors in communicating a medication between a prescriber and a pharmacy. Research found that clinicians make fewer errors using an electronic system than with handwritten prescriptions.<sup>1-2</sup> AHCCCS found that sending electronic prescriptions can reduce mistakes related to medication types, dosages, and member information and that electronic prescribing assists pharmacies in identifying potential problems related to medication management as well as potential reactions that members may encounter, especially for those taking multiple medications.

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

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<sup>1-2</sup> Kaushal R, Kern LM, Barrón Y, et al. Electronic prescribing improves medication safety in community-based office practices. *Journal of General Internal Medicine*, 2010 Jun;25(6):530-6.

## Findings

CYE 2015 was the intervention reporting period for the *E-Prescribing* PIP. The Contractors implemented many solid interventions to improve both the rate of providers prescribing prescriptions electronically and the rate of prescriptions sent electronically. For example, all Contractors participated in an e-prescribing workgroup formed with other Arizona Contractors, Arizona Alliance of Health Plans (AzAHP) and Health Current (formerly known as Health-e Connection) (collectively referred to as “workgroup”). The workgroup is a group of Contractor representatives who collaborate to increase the rate of e-prescribing within the AHCCCS program and the state of Arizona. The workgroup developed two surveys; one survey asked providers to identify factors contributing to e-prescribing rates to identify best practices or barriers, and the other addressed Arizona electronic health record (EHR) vendors to determine 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.

## Overall Findings and Conclusions

AHCCCS has completed a strategic plan for SFY 2017–2022 that includes goals related to long-term strategies that bend the cost curve while improving member outcomes, the pursuit of continuous quality improvement, and the reduction of fragmentation through an integrated healthcare system. The results of the three mandatory activities relative to Contractor performance support these goals. AHCCCS has a comprehensive system to monitor and improve the timeliness of, access to, and quality of care that Contractors provide to Medicaid members. All Acute Care and CMDP Contractors are working toward improving the delivery of services and quality of care provided to their members. All Contractors demonstrated improvement in nearly all areas in the focused OR. Overall, performance for the ALTCS Contractors varied across the areas of quality and access. AHCCCS has selected a new PIP, *E-Prescribing*, for all lines of business which, to increase patient safety, measures the number of providers that write electronic prescriptions and the number of prescriptions submitted electronically. Initial results are not available for this report; however, the Contractors have employed significant interventions to improve the results of this PIP.

## Organizational Assessment and Structure Standards

AHCCCS conducted a comprehensive OR for each ALTCS and DES/DDD Contractor during CYE 2016. AHCCCS organized the OR into 12 standard areas, including Case Management; Corporate Compliance; Claims and Information Systems; Delivery Systems; General Administration; Grievance Systems; Adult, EPSDT, and Maternal Child Health; Medical Management; Member Information; Quality Management; Reinsurance; and Third-Party Liability.

All Contractors scored fully compliant in the Adult, EPSDT, and Maternal Child Health and General Administration standards. One Contractor received a 100 percent score for five standards and scored between 96 and 98 percent for another five standards—a high overall performance result. Another Contractor was in full compliance with six of the 12 standards reviewed and had strong performance in three additional of the standards, with scores between the 97 and 98 percent. The Contractor with the

lowest overall scores was fully compliant with four of the total standards reviewed and scored above 90 percent in four other of the standards.

Although all Contractors made progress in meeting the standards, opportunities for improvement do exist. The two standard areas for which most Contractors scored below 95 percent were Corporate Compliance and Claims and Information Systems. The Claims and Information Systems standard resulted in the highest number of Contractors scoring below 95 percent and the most CAPs.

### Performance Measures

Overall, performance for the ALTCS Contractors varied across the areas of **quality** and **access**. For the **quality** area, the *Plan All-Cause Readmissions* performance measure rate showed statistically significant improvement for the ALTCS Contractors. Further, positive performance was demonstrated in the **access** area, with the *Adults' Access to Preventive/Ambulatory Health Services* measure exceeding the CYE 2015 MPS for ALTCS Contractors. **Timeliness** was not appropriate to evaluate for the reported performance measure rates; therefore, this area was not discussed.

Compared to the CYE 2015 MPSs, DES/DDD's performance in the **quality** and **timeliness** areas demonstrated mixed performance as the *Follow-Up After Hospitalization—30-Day Follow-Up* performance measure rate exceeded the established MPS and the *Follow-Up After Hospitalization—7-Day Follow-Up* measure rate did not. The DES/DDD Contractor demonstrated positive performance in the **access** area exceeding the CYE 2015 MPS for the *Adults' Access to Preventive/Ambulatory Health Services*, *Children and Adolescents' Access to Primary Care Practitioners*, and *Follow-Up After Hospitalization—30-Day Follow-Up* measure rates.

### Performance Improvement Projects

During CYE 2015, the *E-Prescribing* PIP was in its intervention phase. Baseline data were used to assist AHCCCS Contractors in identifying and/or implementing strategies for increasing the number of providers ordering prescriptions electronically and for increasing the percentage of prescriptions submitted electronically. Contractor, provider, and member education efforts during the intervention phase should result in rate increases for Indicator 1 and Indicator 2 in CYE 2016.

### Conclusions

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



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

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

### AHCCCS Medicaid Managed Care Program History

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

AHCCCS has an allocated budget of approximately \$12 billion to administer its programs, coordinating services through its Contractors and delivering care for 1.9 million individuals and families in Arizona through a provider network of over 60,000 healthcare providers.

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

ALTCS provides acute care, behavioral health services, long-term care, and case management to AHCCCS members who are elderly, physically disabled, or developmentally disabled and who meet the criteria for institutionalization.

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

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

## AHCCCS' Strategic Plan

AHCCCS' Strategic Plan for State Fiscal Years 2017–2022 presents the strategy and direction for AHCCCS, including new programs, initiatives, and past accomplishments. The strategic plan identifies AHCCCS' mission, vision, and the agency's guiding principles:<sup>2-1</sup>

- AHCCCS Vision: Shaping tomorrow's managed healthcare...from today's experience, quality, and innovation.
- AHCCCS Mission: Reaching across Arizona to provide comprehensive quality healthcare to those in need.
- Guiding Principles:
  - A Strategic Plan is the result of a collaborative process and reflects informed planning efforts by the Executive Management Team.
  - AHCCCS continues to pursue multiple long-term strategies already in place that can effectively bend the cost curve including: system alignment and integration, value-based purchasing (VBP), 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.

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<sup>2-1</sup> AHCCCS Strategic Plan State Fiscal Years 2017-2022 Available at: [https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan\\_17-22.pdf](https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan_17-22.pdf). Accessed on: April 4, 2017.

The plan offers four overarching goals:

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

- Increase use of alternative payment models for all lines of business (LOBs). For example, the VBP initiative is a critical policy strategy allowing AHCCCS to progress toward a financially sustainable healthcare delivery system, which rewards high quality care provided at affordable costs.
- Increase use of value-based access fee schedule differentiation. AHCCCS pursued adjustments in the fee-for-service payment schedule to incentivize certain value measures for providers. Additionally, AHCCCS recently created a program for first responders to provide treatment and referrals instead of requiring transportation to an emergency room to receive payment.
- Modernize hospital payments to better align incentives, increase efficiency, and improve the quality of care provided to members.
- Achieve the Program Integrity Plan goals that improve Third Party Liability (TPL), Coordination of Benefits (COB), and Fraud and Abuse programs. As part of the initiatives to bend the cost curve and ensure overall fiduciary oversight, AHCCCS continues to dedicate significant resources to Program Integrity efforts.
- Reduce administrative burden on providers while expanding access to care.

**2. AHCCCS must pursue continuous quality improvement.**

- Achieve statistically significant improvements on Contractor Performance Improvement Projects (PIPs). For example, AHCCCS Contractors are expected to conduct PIPs in clinical care and non-clinical areas that are anticipated to have a favorable impact on health outcome and member satisfaction.
- Achieve and maintain improvement on quality performance measures.
- Leverage American Indian care management program to improve health outcomes.
- Increase transparency in health plan performance to inform health plan selection. AHCCCS continues to grow and strengthen its quality structure by incorporating the latest national standards and regional trends. In addition, AHCCCS is working on improving and updating the Health Plan scorecard to provide accurate and timely information to its members.

**3. AHCCCS must reduce fragmentation driving towards an integrated healthcare system.**

- Establish a system of an integrated care organization that serves all AHCCCS members. The following are integration models AHCCCS is currently implementing:
  - CRS - Previously 17,000 children with complex medical needs were served by three different payers. These included an acute plan, RBHA and CRS plan. These members are now served by a single Integrated Contractor.
  - During 2014 and 2015, almost 40,000 individuals with Serious Mental Illness were transitioned to a single organization that was responsible for all services.



- Currently, 80,000 dual eligible members receive integrated general mental health and substance abuse services.
  - In 2016, the requirements for Tribal Regional Behavioral Health Authority (TRBHA) contractors were streamlined to enhance and create integration and care coordination opportunities for members served by the TRBHAs.
  - In 2016, AHCCCS had approximately 48% of the dual eligible member population aligned which is the highest percentage ever.
  - Establish policies and programs to support integrated providers. For example, the structure of AHCCCS is transforming towards integrated care delivery systems with better alignment of incentives that seeks to efficiently improve health outcomes.
  - Leverage health information technology (HIT) investments to create more data flow in healthcare delivery system. AHCCCS devoted significant resources to integrate health information across providers and now it has a fully functioning Health Information Exchange to facilitate the coordination of information for all the delivery systems.
  - Develop a strategy to strengthen the availability of behavioral health resources within the integrated delivery system. AHCCCS is planning on offering fully integrated services to all its members by 2019.
  - Develop comprehensive strategy to curb opioid abuse and dependency.
  - Improve access for individuals transitioning out of the justice system.
- 4. AHCCCS must maintain core organizational capacity, infrastructure and workforce planning that effectively serve its operations.**
- Pursue continued deployment of electronic solutions to reduce health care administrative burden. In addition, define strategies to make data available and reliable for decision-making processes.
  - 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 and data by evaluating, analyzing and addressing potential security risks.
  - Improve and maintain information technology (IT) infrastructure, including server based applications, ensuring business continuity.
  - Continue work and effort around implementation of the Arizona management system.

## 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 §438.340 implement Section 1932(c)(1) of the Medicaid managed care act, which defines 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 quality strategy must include all of the following:

- The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs as well as examples of evidence-based clinical practice guidelines required by the State.
- The State's goals and objectives for continuous quality improvement, which must be measurable and take into consideration the health status of each population that the State serves.
- A description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP; the performance improvement projects to be implemented, including any interventions that the State proposes to improve access, quality, or timeliness of care.
- Arrangements for annual, external independent reviews of the quality outcome and timeliness of and access to, the covered services.
- A description of the State's transition of care policy.
- The State's plan to identify, evaluate, and reduce health disparities based on age, race, ethnicity, sex, primary language, and disability status, to the extent practicable.
- Appropriate use of intermediate sanctions for MCOs.
- A description of how the State will assess the performance and quality outcomes achieved by each primary care case management (PCCM) entity.
- The mechanisms implemented by the State to comply with requirements relating to the identification of persons who need long-term services and supports or persons with special healthcare needs.
- Information relating to non-duplication of EQR activities.
- The State's definition of "significant change" related to instances in which significant changes are made to the quality strategy or occur in the State Medicaid program.

AHCCCS has had a formal quality assessment and performance improvement (QAPI) plan in place since 1994, established and submitted an initial quality strategy to CMS in 2003, and has continued to update and submit revisions as needed to CMS. AHCCCS' QAPI strategy was last revised in December 2014. The AHCCCS quality strategy was set for revision in CYE 2017. However, due to the introduction of proposed changes to the managed care regulations, AHCCCS elected to delay this revision until final publication was posted by the Centers for Medicare & Medicaid Services (CMS). AHCCCS has established an internal workgroup to head the expansive revisions that incorporate AHCCCS goals and initiatives, Contractor oversight, and the new requirements found within the managed care regulations. The revised quality strategy is anticipated to be completed, submitted to CMS for review and approval, and posted to the AHCCCS website by July 1, 2018.

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

AHCCCS ensures 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 particular conditions, 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 efficiency.
- Solicits Contractor input when prioritizing areas for targeting improvement resources.

## ***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.

## ***Performance Measure Requirements and Targets***

AHCCCS establishes performance measures based on the CMS Core Measure sets and the National Committee for Quality Assurance (NCQA) HEDIS measures as well as on measures unique to Arizona's Medicaid program. AHCCCS establishes minimum performance standards and goals for each performance measure based on national standards, such as the NCQA National Medicaid means, whenever possible. AHCCCS uses the Consumer Assessment of Healthcare Providers and Systems (CAHPS). This survey tool was created by the Agency for Healthcare Research and Quality (AHRQ) to support and promote the assessment of members' experiences with healthcare.

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



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.

### ***Performance Improvement Project Requirements and Targets***

AHCCCS Contractors are expected to conduct PIPs in clinical care and non-clinical areas anticipated to have favorable impacts on health outcomes and member satisfaction. The health and safety of members receiving covered services remains a focus for AHCCCS. AHCCCS uses a multi-agency and Contractor approach in implementing health and safety oversight requirements.

AHCCCS requires that Contractors conduct PIPs, which AHCCCS defines 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, then sustain the improvement over at least one subsequent remeasurement cycle. AHCCCS requires Contractors to submit reports evaluating their data and interventions and propose new or revised interventions, if necessary.

## 3. Description of EQR Activities

### Mandatory Activities

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

- Validate Contractors’ PIP—validation performed by AHCCCS.
- Validate Contractor performance measures—validation performed by AHCCCS.
- Summary and findings of Contractor's performance in complying with the AHCCCS contract requirements and the federal Medicaid managed care regulations cited at 42 CFR §438.358—Review performed by AHCCCS.

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

### Optional Activities

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

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

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



## 4. AHCCCS Quality Initiatives

### AHCCCS Quality Initiatives

AHCCCS continued to demonstrate innovative and collaborative approaches to managing costs while improving the quality of systems, care, and services. Its documentation, including the Quarterly Quality Assurance/Monitoring Activity Reports, the 2017–2022 Strategic Plan, and the October 2012 Quality Assessment and Performance Improvement (QAPI) Strategy, demonstrated compelling evidence of AHCCCS’ vision and leadership in identifying and proactively pursuing opportunities to improve access to, and the quality and timeliness of, care and services; as well as member health outcomes.

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

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

### Key Accomplishments for AHCCCS

The following are the key accomplishments that AHCCCS highlighted in the AHCCCS Strategic Plan, State Fiscal Years 2017–2022:

- Successfully obtained approval for a new 1115 Demonstration Waiver. Included in the new waiver is the innovative new AHCCCS CARE program which contains the AHCCCS CARE account, Healthy Living Targets, and AHCCCS Works to connect members to employment opportunities. The waiver approval also includes an extension of existing authorities such as mandatory managed care and use of home- and community-based services for members with long-term care needs as well as a new \$1,000 dental benefit for long-term care members on ALTCS.
- Ranked number one nationally among state Medicaid programs for its individuals with developmental disabilities program in the 2016 United Cerebral Palsy Report.
- Successfully completed the merger with the Department of Behavioral Health Services in 2016. This merger will allow AHCCCS to implement policies and systems of care that better focus on whole person health, reduced stigma, enhanced service delivery for all members, and stronger member and family engagement.

- Committed to helping foster families and in 2016 implemented Jacob’s Law. Through this implementation AHCCCS has simplified access to needed behavioral health services, improved monitoring systems to ensure timely access to services, and engaged with foster families throughout the process.
- Released a report with recommendations to strengthen the healthcare system’s ability to respond to the needs of members with or at risk for autism spectrum disorder (ASD), including those with co-occurring diagnoses.
- Released a comprehensive report: *Behavioral Health Needs of Children Involved with the Department of Child Safety: Psychotropic Prescribing Update*. This report analyzed psychotropic prescribing for children in Arizona’s foster care system. The report detailed “the percentage of children in foster care receiving psychotropic medications decreased by 26 percent from 2008 to 2014, from 20.3 percent to 14.9 percent respectively. The percentage of children in foster care receiving antipsychotic medication decreased by 43 percent, from 10.9 percent to 6.2 percent”.
- Reopened enrollment for the KidsCare program providing high quality healthcare coverage for children of working families.
- Restored podiatry services provided by a licensed podiatrist and provided a \$1,000 dental benefit to all members in the ALTCS program.
- Continues to expand the external contract for determinations for persons with serious mental illness (SMI) to all Arizona counties, including several American Indian tribes, to ensure consistency and equity in the determination process.
- Worked with the Arizona Department of Corrections to establish a Justice System Transition program which allows eligible individuals to be enrolled with AHCCCS immediately upon release.
- Continues to pursue long-term strategies to reduce fragmentation in the healthcare delivery system through integration:
- Experienced a capitation rate increase of 1.7 percent. This is in line with the previous four-year average of just 2.1 percent. This is well above the Great Recession period where rates averaged a decrease of (4.6 percent) and much more sustainable than the 2005 through 2009 period wherein rates averaged a 6.6 percent increase.
- Continued care delivery and payment reform efforts, with a focus on transitioning from paying for the volume of care to the value of care provided. Contracted managed care organizations were required to have an increased percentage of their provider payments in value-based arrangements, in which payments are related to quality outcomes.
- Met most program integrity goals established in its annual plan. AHCCCS worked successfully with prosecutors on 39 different cases resulting in 62 convictions—a program record. AHCCCS recouped over \$1 billion due to coordination of benefits, third party recoveries, and the Office of Inspector General activities, and then began pursuing leveraging private sector expertise on data analyses.
- Registered, validated, and paid 3,600 eligible professionals and 75 acute care and critical access hospitals since the electronic health record program opened in July 2011. These payments total over \$666 million. AHCCCS continues to serve on the Health Current (formerly known as Health-E Connection) board, the Health Information Network of Arizona (HINAZ) board, and the Network Leadership Council. This July 2016, AHCCCS became an official participant in the network when

the Division of Fee-for-Service Management began receiving information from the network about its patient population.

- Continued to pursue an improved partnership with tribal stakeholders while continuing to engage in strategies that improve the health system for tribal members. AHCCCS conducted eight tribal consultation meetings in 2016. AHCCCS also had over 190 American Indians enrolled in active care coordination by the end of calendar year 2016.
- Conducted a 2016 employee survey the results of which indicated strong, positive feelings among staff. A total of 97 percent of staff value members of their team; 96 percent believe in the AHCCCS mission; 90 percent understand clearly what is expected from them; and 87 percent are proud to be AHCCCS employees. In addition, AHCCCS has achieved a world-class level of employee engagement, with nine engaged employees for every one disengaged employee. This is compared to the statewide average of 2.3 engaged employees for everyone disengaged employee.

## 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 impact improvement, and whether the areas are current priorities of CMS or State leadership and/or can be combined with existing initiatives. AHCCCS also seeks Contractor input in prioritizing areas for improvement.

In selecting and initiating new quality improvement initiatives, AHCCCS:

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

## Collaboratives/Initiatives

### *Administrative Simplification and the Integrated Model*

The Division of Behavioral Health Services (DBHS), as part of the Arizona Department of Health Services' (ADHS) has transitioned, along with the programs it manages, to AHCCCS, effective July 1, 2016. The behavioral health services were “carved out” benefits administered by DBHS through contracts with the RBHAs. Not only was this transition part of a more efficient government operation, it also coincides with a large integration effort for the seriously mentally ill population in Arizona. Before the integration of services, a member with a serious mental illness (SMI) had to coordinate with several healthcare systems to obtain services. As such, the physical health services were provided through the acute health plan; the behavioral health services through the RBHA; and the Medicare system, if the member was also eligible for Medicaid and Medicare; and Medicare Part D for medications.

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

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

Starting on October 1, 2018, AHCCCS proposes to offer fully integrated contracts to manage behavioral health and physical health services to children (including children with CRS conditions) and adult AHCCCS members not determined to have SMI. AHCCCS is also proposing to preserve the RBHAs as a choice option and to provide a mechanism for affiliated contractors to hold a single contract with AHCCCS for non-ALTCS members.

### *AHCCCS CARE: Choice, Accountability, Responsibility, Engagement*

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

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

- **Giving Citizens Tools to Manage Their Own Health:** Member premium contributions go into their AHCCCS CARE accounts, which work like flexible health savings accounts. These funds can be withdrawn by members and used for non-covered services, including dental, vision, chiropractic care, recognized weight loss programs, nutrition counseling, gym membership, and sunscreen.
- **Enforcing Member Contribution Requirements:** Members will be disenrolled for failure to pay their monthly premium requirements.
- **Engaging the Business and Philanthropic Community:** Employers and charitable organizations may contribute funds into the AHCCCS CARE Account to support a healthy workforce and to support members achieving health goals.
- **Promoting Healthy Behaviors:** The AHCCCS CARE program includes incentives to promote healthy behaviors. Members may defer their premium payments for six months if they meet healthy targets that include: meeting preventive health targets like getting a wellness exam, flu shot, mammogram, or cholesterol screening; or managing chronic illnesses like diabetes, asthma, or tobacco cessation. Meeting these healthy targets allows members to roll unused funds over into the next year and unlock funds available in the AHCCCS CARE account to be used for non-covered services.
- **Supporting the Medical Home Through Strategic Coinsurance:** The AHCCCS CARE program uses a strategic coinsurance strategy that only assesses payment requirements retrospectively so that members are not denied services and providers are not burdened with uncompensated care and administrative hassle. Strategic coinsurance only applies to: opioid use, use of brand-name drugs when a generic is available, non-emergency use of the emergency department (ED), and seeing a specialist without a primary care provider's referral.
- **Connecting to Employment Opportunities:** Through an innovative partnership with the Arizona Department of Economic Security, all AHCCCS CARE members will be automatically enrolled in job-seeking programs.

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

Some members will have to pay premiums as contributions into their AHCCCS Care account. The payment will be the lesser of 2 percent of household income or \$25.

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

## ***Executive Order 2016-06—Prescription of Opioids***

On October 24, 2016, the Governor of Arizona, Douglas Ducey, signed Executive Order 2016-06 to address the opioid crisis affecting the nation and, in particular, the state of Arizona. Even though this executive order occurred outside the review period for the annual report, this information is included as it directly addresses the issues of the opioid crisis. In this order, the Governor indicates that Arizona has the ninth highest rate of opioid deaths in the nation, and that approximately 404 people in the state died of prescribed-opioid overdoses in 2015. The state presented alarming statistics showing that during 2013 enough prescription pain medications were dispensed to medicate every adult in Arizona around the clock for two weeks.

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

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

## ***CMS Waiver***

On September 30, 2016, CMS approved a new waiver for AHCCCS for a five-year period from October 1, 2016, to September 30, 2021, to reform its Medicaid program. The approved waiver permits Arizona to continue to administer the mandatory managed care, the ALTCS program, the administrative simplification initiatives, integrated care for persons with SMI and children with special healthcare needs, the safety net care pool payments to the Phoenix Children's Hospital through 2017, and the payment of Indian Health Services and Public Law 93-638 (tribal) facilities for emergency dental services.

The waiver also discontinued AHCCCS' authority to charge premiums to parents of ALTCS children with a disability when the parents' annual adjusted gross income exceeds 400 percent of the FPL, but granted approval to add a new \$1,000 per year/per member dental benefit for ALTCS members.

## ***Targeted Investments Program***

Another important initiative for the state is the CMS approved Targeted Investments Program, to be implemented by AHCCCS. This program will support physical and behavioral healthcare integration and coordination initiatives for members, including those who have transitioned to the community from criminal justice facilities.

Pursuant to 42 CFR §438.6 (c), AHCCCS will incorporate specific payments to certain providers into the actuarially sound capitation rates to enhance service and promote performance improvement. The targeted investments program is expected to:

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

## Other Collaboratives/Initiatives

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

- 2016 United Cerebral Palsy Report: AHCCCS received national recognition for its *2016 United Cerebral Palsy Report* as it ranked number one nationally among Medicaid state programs for individuals with disabilities programs.
- *Behavioral Health Needs of Children Involved with the Department of Child Safety: Psychotropic Prescribing Update*: On May 27, 2016, the agency released this comprehensive report, which analyzed psychotropic prescribing among children in Arizona's foster care system. The report indicates that "The percentage of children in foster care receiving antipsychotic medication decreased by 43 percent, from 10.9 percent to 6.2 percent. The percentage of children receiving prescriptions in each of the other categories of medication declined, except for the percentage of children receiving ADHD medication, which remained the same."
- Recommendations to Office of the Arizona Governor Policy Advisor for Health and Human Services on Autism Spectrum Disorder: The ASD Advisory Committee (Committee) was appointed in spring 2015 by the Office of the Arizona Governor. The Committee was charged with articulating a series of recommendations to the State for strengthening the healthcare system's ability to respond to the needs of AHCCCS members with or at risk for ASD, including those with co-morbid diagnoses. The charge included focusing on individuals with varying levels of needs across the spectrum, including those able to live on their own and those who may require institutional levels of care, and addressing both the early identification of ASD and the development of person-centered care plans. The Committee's recommendations include both systems-level changes that will take time to implement and are expected to ameliorate the root causes of many of the current problems as well as short-term activities that could more quickly enhance an understanding of the current system by the full range of stakeholders and improve access for AHCCCS members with ASD. The systems-level changes include integration of physical and behavioral healthcare; delivering all Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services through acute health plans, with multiple plans available to ensure consumer choice; access to care coordination; and value-based purchasing.
- Summary of Activities Designed to Enhance the Credentialing/Recredentialing Process: AHCCCS previously worked collaboratively with the Arizona Association of Health Plans (AzAHP), representing the MCOs that contract with AHCCCS, to create a credentialing alliance (CA) aimed at

making the credentialing and recredentialing process easier for providers through the elimination of duplicative efforts and reduction of 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. During CYE 2016, requirements were added to set the time frame from beginning to end of the credentialing process.

- Summary of Activities Designed to Enhance the Medical Record Review (MRR) Process: AHCCCS created policy and worked collaboratively with the Arizona Association of Health Plans (AzAHP), the association that represented the Contractors to create a newly aligned MRR process aimed at making the process easier for providers through the elimination of duplicative efforts and reduction of administrative burdens. Prior to establishing this process, each Contractor conducted these MRRs for their specific in-network providers independently, leading to multiple reviews by multiple Contractors at different times.
- AHCCCS Quarterly Contractors' Quality Management/Maternal Child Health Meeting: To further promote the integration of medical and behavioral health services, targeted education is included within the AHCCCS Quarterly Contractor's Quality Management/Maternal Child Health Meeting. For example, during the meeting, AHCCCS included a PowerPoint presentation of the Arizona's Children's Behavioral Health System that focused on use of specific sections of EPSDT forms ("Developmental Surveillance," "Anticipatory Guidance," and "Social/Emotional Health") to demonstrate the connections between the physical and behavioral health systems.
- Centers of Excellence: AHCCCS requires Contractors to identify centers of excellence to improve standards of quality, care, and service. Contractors are required to submit a value-based providers (VBP)/centers of excellence report. The report incorporates the CYE 2017 implementation of one to two contracts with either the centers of excellence identified in the CYE 2016 executive summary and/or other existing centers of excellence. Contractors identify the centers of excellence under contract in CYE 2017 and, if different from those identified in the CYE 2016 executive summary, include a description as to how these centers were selected. The report includes a thorough description of the Contractors' initiatives to encourage member utilization, goals and outcome measures for the contract year, a description of the monitoring activities throughout the year, an evaluation of the effectiveness of the previous year's initiatives, a summary of lessons learned and any implemented changes, a description of the most significant barriers, any plans to encourage providers that have been determined to offer high value but are not participating in VBP arrangements (if any) to participate in VBP contracts, and a plan for next contract year. (Although this initiative occurred partially outside the review period, it is significant and therefore is included in this report.)
- Prenatal Exposure to Alcohol and Other Drugs: AHCCCS and the Contractors, including the RBHAs, participated in the Arizona Statewide Task Force on Preventing Prenatal Exposure to Alcohol and Other Drugs. This task force reviewed and developed publications and toolkits for members and providers. For providers, publications included the *Guidelines for Identifying Substance-Exposed Newborns*, while members' publications included information that related to the exposure/use of all drugs (prescription, opioids, alcohol, etc.) and neonatal abstinence syndrome (NAS). Mercy Care Plan-Long Term Care (MCP-LTC) and Mercy Maricopa Integrated Care (MMIC) both worked out processes to refer infants with NAS to Southwest Human Development,



and MMIC had a perinatal care manager for pregnant members with a designation of SMI. All pregnancies in women with SMI were considered high-risk and were provided integrated care management via MMIC care managers. When additional medical risks to the pregnancy were identified, they were flagged (i.e., substance use or abuse) and a referral was made to Mercy Maricopa Perinatal Care Management for care coordination and support.

- Arizona Health Plans Best Practice Guidelines: AHCCCS and most Contractors worked collaboratively with the Arizona Task Force on Preventing Prenatal Exposure to Alcohol and Other Drugs to establish Arizona Health Plan Best Practice Guidelines.
- Involvement of Stakeholders and Community Subject Matter Experts: Throughout 2016, AHCCCS continually involved stakeholders and community subject matter experts as members of AHCCCS committees, quality meetings, policy workgroups and advisory councils. Subject matter experts provided technical assistance, guidance, and advisement related to various areas and issues (e.g., special needs populations, consumer advocacy, ASD, early intervention, trauma-informed care, behavioral health system best practices, integrated care).
- Medical Director Meetings: AHCCCS involves medical directors from Contractors in quarterly meetings. These meetings are designed to inform medical directors of changes in policy, regulation, billing practices, and current or future system updates. Additionally, these quarterly medical director meetings are designed to provide information on best practices in medical, behavioral care, and/or prescribing practices.
- Interventions for Members with Alzheimer's 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.
- 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.
- The Arizona Partnership for Immunization (TAPI): Quality management staff attend TAPI Steering Committee meetings and subcommittee meetings concerning community awareness, provider issues, and adult immunizations. TAPI regularly communicates immunization trends and best practices with AHCCCS and its Contractors. TAPI's Provider Awareness and Adult and Community Awareness committees continue to focus on long-term projects such as updating the TAPI website with the most current information for providers, parents, and the community at large. In addition to the website, TAPI vaccination handouts have been updated with new color and formats. TAPI has launched a new teen vaccination campaign (Tdap, meningococcal, and human papillomavirus [HPV] vaccines) targeting provider education as well as parent and teen outreach. The parent-focused campaign is Protect Me with 3, reminding parents that their children still need them to protect them and help with healthy decisions. The teen campaign is Take Control and addresses teen vaccinations required to maintain health as teens begin to take control of their lives in the realms of college, driving, and even health decisions.

- **Health Current:** Formerly Arizona Health-e Connection, this non-profit organization is a health information exchange organization (HIO) and is the single statewide Health Information Exchange (HIE). Health Current currently has 347 unique participants, which include hospitals, accountable care organizations, health plans, behavioral health providers, laboratories, ambulatory practices, long-term care providers, and more. (For a complete list of participants, Health Current maintains a count on their website: <https://healthcurrent.org/hie/the-network-participants/>). To improve care coordination, AHCCCS requires all managed care contractors to join the HIE.

Health Current has recently completed an agreement to electronically share hospital data with several other out-of-state HIEs through a project called the Patient-Centered Data Home (PCDH). The PCDH project provides the technical and legal agreements to support cross-state data sharing for the purpose of care coordination. Launched in early 2017, Southern Colorado, Arizona, Utah and now Santa Cruz and San Diego HIEs are capable of sharing hospital admission, discharge, or transfer information with a Medicaid member's home HIE if they seek care outside of their Arizona or "home" HIE.

- **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 Partnership (TEPP) smoking cessation support programs such as "ASHLine" and/or counseling in addition to seeking assistance from their PCPs. Additional efforts have been focused on the integrated SMI population in connecting members to smoking cessation and nicotine replacement programs.
- **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 ED 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 ED 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 the situation does not warrant an ED visit, the EMS teams can make a recommendation for home care and timely follow-up with member's primary care physician.
- **Value-Based Purchasing (VBP) Initiatives:** AHCCCS is promoting numerous 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.
- **Early Reach-In:** Contractors are required to participate in criminal justice system "reach-in" care coordination efforts through collaboration with criminal justice partners (e.g., jails; sheriff's office; Correctional Health Services; and Arizona Department of Corrections, including community supervision, and probation courts). AHCCCS is engaged in a data exchange process that allows AHCCCS to suspend eligibility upon incarceration rather than terminate coverage. Upon the member's release, the member's AHCCCS eligibility is un-suspended allowing for immediate care

coordination activities. Using the 834 data to identify incarcerated members who have been incarcerated for 30 days or longer and who have anticipated release dates, the Contractor conducts reach-in care coordination for members with chronic and/or complex care needs, including assessment and identification of medication assisted treatment (MAT)-eligible members. The Contractors, with the criminal justice partners, facilitate the transition of members out of jails and prisons and into communities. Members are provided with education regarding care, services, resources, appointment information, and health plan case management contact information. Post-release initial physical and behavioral health appointments are scheduled within seven days of member release. Ongoing follow-up occurs with the member to assist with accessing and scheduling necessary services as identified in the member's care plan, including access to all three U.S. Food and Drug Administration (FDA)-approved MAT options covered under the AHCCCS Behavioral Health Drug List and assignment to peer support services to help navigate and retain the member in MAT when appropriate.

- **Foster Care Initiative:** AHCCCS is committed to providing comprehensive, quality healthcare for children in foster, kinship, or adoptive care. Foster children are eligible for medical and dental care, inpatient, outpatient, behavioral health, and other services through the Comprehensive Medical and Dental Program (CMDP) and the Regional Behavioral Health Authorities (RBHAs) or through CRS. Adoptive children are typically AHCCCS eligible and enroll in a health plan/RBHA or CRS like any Medicaid-eligible child. AHCCCS holds a variety of meetings related to improving service delivery for children in foster care. Monthly collaborative meetings with the Department of Children's Services (DCS)/CMDP occur to continue efforts to improve service delivery for children in the foster care system and to ensure that services identified as medically necessary are available. AHCCCS hosts monthly cross-divisional operational team meetings to continue efforts and quarterly meetings with RBHA and CRS leadership to review data and discuss system changes and best practices. System improvements include documenting frequently asked questions, developing behavioral health and crisis services flyers for foster and kinship caregivers, and streamlining health plan deliverables. Additionally, AHCCCS created a dashboard to track and trend utilization for children in foster care.

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

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

- **Agency with Choice:** AHCCCS has developed and implemented a member-directed option, Agency with Choice. This option is available to ALTCS members who prefer to reside in their own homes. The member and provider agency enter a formal partnership agreement that allows the provider agency to act as the legal employer of a direct care worker (DCW), with the member serving as the day-to-day managing employer. During CYE 2012, to progress with the implementation of the Agency with Choice member-directed option, AHCCCS worked in collaboration with a Development and Implementation Council comprised of ALTCS members, providers, community stakeholders, and Contractors—the primary function being to provide input on programmatic

changes that AHCCCS needed to make in order to implement the Agency with Choice member-directed option. In CYE 2013, the primary focus was on supporting Contractors to educate members/individual representatives (IRs) about the available service model options, including member-directed options. In CYE 2014, AHCCCS prioritized the development of tools for the purpose of assessing members' support needs for directing their care under this option. AHCCCS planned to work in collaboration with Contractors to implement the use of these specific tools in CYE 2015, but implementation was postponed to CYE 2016 to align with other program development activities. Currently, AHCCCS is planning to develop and implement a case manager refresher training program to ensure that case managers are able to support members making informed choices about the member-directed option as well as a provider assessment tool to help providers and Contractors assess whether or not the provider agency is fulfilling its roles and responsibilities. AHCCCS is also developing performance indicators for Contractors.

- **Direct Care Workforce Development:** Significant activities continue regarding the growing challenges related to ensuring the establishment of an adequate direct care (caregiver) workforce. The foundation for current activities began in March of 2004 when former Governor Napolitano formed the Citizens' Workgroup on the Long Term Care Workforce. The purpose of the Workgroup was to study the issue of the direct care workforce and provide recommendations regarding potential strategies to improve the workforce. As a direct result, the Direct Care Workforce Committee was formed and established training and competency standards for all in-home caregivers providing homemaker, personal care, and/or attendant care services.

Beginning October 1, 2012, AHCCCS formally incorporated the competency standards, training curriculum, and testing protocol into its service specifications for attendant care, personal care, and homemaker services. All in-home caregivers are now required to pass standardized examinations based upon the competency standards established by the Committee in order to provide care to ALTCS members in their homes. AHCCCS continues to continually monitor and improve the Direct Care Worker Training and Testing Program.

- Implemented and continually monitors an online database that serves as a tool to support the portability or transferability of DCW testing records from one employer to another employer.
- Created online computer-based training (CBT) modules to support users in learning how to set up the accounts and enter and access data within the online database.
- In 2016, AHCCCS initiated a cross-divisional project with the Division of Health Care Management and Provider Registration to identify and develop the following enhancements to the online database scheduled for release in CYE 2017:
  - Institute a crosscheck of DCWs in the database with provider registration databases to conduct Medicare and Medicaid exclusion checks.
  - Distinguish DCWs in the database based upon employment or contracting status with the DCW agency.
  - Incorporate an auditor role within the database to streamline tracking and documentation of training program audits by the Contractors and AHCCCS.
  - Develop new tracking practices and attestations to ensure the information remains up-to-date and accurate.

- **Testing Experience and Functional Tools (TEFT) Experience of Care Survey for ALTCS Populations:** As one of nine states participating in the TEFT grant from CMS, Arizona participated in the first round of the Experience of Care Survey, which was tested as a member satisfaction tool. Arizona believes that this innovative tool will provide valuable insight on member perspectives for those receiving home- and community-based services (HCBS). AHCCCS will conduct a second-round survey in 2018.
- **Heightened Scrutiny:** On January 16, 2014, the Centers for Medicare and Medicaid Services (CMS) released final rules regarding requirements for HCBS operated under section 1915 of the Social Security Act. The rules mandate certain requirements for residential and non-residential settings in which Medicaid members receive long-term care services and supports. Specifically, the Rules establish requirements for settings to ensure that individuals receiving services are integrated into their communities and have full access to the benefits of community living.

In CYE 2016, AHCCCS prioritized the “heightened scrutiny” process that CMS has instituted to allow states to preserve settings that are presumed to have institutional qualities and presumed not to be compliant with the HCBS rules. AHCCCS is responsible for identifying such settings and gathering and submitting evidence for CMS to make a determination as to whether or not the setting is or can become compliant by the end of the transition period. AHCCCS identified the following settings for the heightened scrutiny process:

- **Farmstead Community:** Working ranches in rural areas on large parcels of land. One licensed farmstead community in Arizona exists, serving eight members.
- **Memory/Dementia Care Units/Communities:** Settings that provide supervisory and personal care services to persons incapable of recognizing danger, summoning assistance, expressing need, or making basic care decisions. Seventy-nine such memory/dementia care units/communities exist in Arizona, serving approximately 1000 members. A statistically significant number of settings statewide were randomly selected to participate in the assessment process.

AHCCCS worked in collaboration with a multi-stakeholder/multi-disciplinary workgroup to create the assessment process and tools. Multi-disciplinary teams created to conduct the assessments included representatives from case management, quality management, and provider relations. In some instances, community members volunteered to participate in assessment activities in accordance with federal privacy guidelines.

The assessment tools are available on the AHCCCS website and include the following:

- Facility Self-Assessment Tool
- Member Interviews and File Review Tool
- Observation and Community Interviews Tool

The assessments occurred in the months of October through December 2016. AHCCCS is currently in the process of drafting a report to CMS to prepare for a public comment period followed by the final report submission to CMS tentatively planned for 2017.

Detailed information on all of AHCCCS’ activities to comply with the HCBS rules can be found on the AHCCCS website.

- Medicare and Medicaid Alignment for Duals: Arizona leads the nation with the highest percentage of dual-eligible members aligned in the same plan for Medicaid and Medicare outside the demonstration authority. Arizona has over 65,000 members enrolled in the same plan for Medicare and Medicaid. AHCCCS conducted a study to determine the impact that plan alignment has for dual-eligible members. The study compared national data for dual members enrolled in traditional Medicare fee-for-service to aligned dual-eligible members served by one of the AHCCCS health plans. The study found that the aligned AHCCCS dual-eligible members exhibited a 31 percent lower rate of hospitalization, a 43 percent lower rate of days spent in a hospital, a 9 percent lower rate of ED use, and a 21 percent lower readmission rate.

## 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.

### Bridgeway Health Solutions (BWY)

- **Increase E-Prescribing:** BWY uses a mobile application for PCP providers so that they can submit prescriptions electronically. Bridgeway care managers and pharmacy staff review pharmacy reports to identify members over-utilizing opioids or non-adherent to chronic medications and notify providers of member utilization patterns.

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

- **Hospital Readmissions:** MCP-LTC attributes the decrease in readmissions to improvement in coding for transfers versus readmissions, work surrounding discharge medications, and concurrent review staff processing prior authorizations for services prior to discharge. Data analysis and trending reports are used to improve communication with providers, monitor use of generic medications, and provide feedback to providers in order to change practice patterns as well as to identify patterns that influence credentialing or recredentialing activities. In addition, MCP-LTC identifies potential quality of care concerns, including opportunities for improvement in areas such as hospital discharge planning and case management activities. Data from activities are analyzed and reviewed by, at a minimum, the chief medical officer, head of medical management, and medical management (MM) administrator and presented to the MM committee for analysis of outcomes and recommendations. MCP-LTC acts upon variances that are untoward by changing interventions and re-evaluating new interventions for effectiveness and outcomes.
- **Reduce Avoidable Hospital Admissions:** MCP-LTC reviews enrollees' acute hospitalizations or observation stays daily, either on-site or by telephone or facsimile. The review may occur up to seven days a week on a schedule dictated by the enrollee's diagnosis or condition or contractual obligation. The initial review is completed within one business day of MCP-LTC's notification of admission. The concurrent review nurse begins discharge planning upon admission. Members who meet care management criteria are referred to care management, and readmission rates and avoidable admissions are monitored. MCP-LTC uses nationally recognized, evidence-based medical and behavioral health review criteria, which are applied based on the needs of individual enrollees and characteristics of the local delivery system. MCP-LTC has monthly joint operating meetings with all acute care facilities to review the facilities' outcomes, for example observation days, avoidable admissions, length of stay, or any relevant data found by reviewing the outcomes. Actions are planned in accordance with findings. Criteria sets are reviewed annually for appropriateness to the health plan's needs and changed as

applicable. All medical director discussions and activities, including discussions between medical directors and treating practitioners, are to be documented in the file.

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

- **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 HEDIS and the AHCCCS clinical performance measures. The CPC program staff members partner with providers in the management of their member panels by completing on-site visits and providing quarterly reports listing members due for preventive care or disease management services per HEDIS and AHCCCS performance measures as evidenced by claim submission, HEDIS educational material and resources, assistance in reassignment of members with confirmed history of receiving care elsewhere, and education on the use of the provider portal to assist with panel management. The CPC staff meet with providers regularly to discuss expectations about the delivery of preventive services to members. Focus is on the quality metrics important for the individual. In addition, the CPC staff members work with providers to ensure that all appropriate services are billed for, ensuring that all care provided 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 emergency room (ER) use and admissions by providing practices with real-time actionable data on access to care, ER utilization, admissions, discharges, care opportunities, and timely PCP follow-up.
- **National Medical Technology Assessment Committee (MTAC):** MTAC is responsible for the development and review of evidence-based position statements on selected medical technologies; assessments of the evidence supporting new and emerging technologies as well as new indications for existing technologies; review and approval of externally licensed criteria and references; review, evaluation, and recommendation for approval of Clinical Practice Guidelines (CPGs) for company-wide implementation; the consideration and incorporation of nationally accepted consensus statements and expert opinions into the establishment of national standards for UnitedHealth Group; and ensuring that clinical decisions about the safety and efficacy of medical care are consistent across all products and businesses. Membership of the MTAC may include the national medical director, UnitedHealth Health Services (chair), Health Plan and Health Services medical management, medical directors with diverse specialty backgrounds, and medical policy staff.



- **Reduce ED Utilization:** UHCCP conducts a monthly review and analysis of the census report, claims data, and high need/high cost reports. The plan identifies members with ED visits and provides education about available urgent care centers, primary care physician availability, and Nurse Line services. Case management and medical management staff conduct member outreach, assessment, and education. Members are assisted with scheduling 7-day PCP or specialist follow-up appointments and transportation arrangements.

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

- **Discharge Planning to the Community or Skilled Nursing Facility (SNF):** DDD's prior authorization staff members complete hospital notification forms and notify by email both the district nurse and support coordinator for every member notification of hospitalization. The district nurses triage every admission for complex medical issues, diabetes, pneumonia, or constipation, and identify if an intervention/prevention plan is needed. The district nurses are to follow up for appointments, gaps in medications or barriers to discharge, and DME within 7 days ideally and 30 days at the most. The district nurses encourage referrals to pulmonologists or gastroenterologists for chronic pulmonary and/or dysphasia/aspiration issues and neurologists for seizures. Inpatient hospitalization rates, average length of stay, and readmissions are reviewed at each subcontracted health plan individual meeting and at the medical management meeting. DDD conducts ongoing monthly subcontracted health plan telephonic meetings to discuss SNF discharges and other issues.

## 6. Organizational Assessment and Structure Performance

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

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

CYE 2016 commenced a new review cycle of ORs for which AHCCCS conducted a comprehensive OR for the ALTCS Contractors, including monitoring the progress of Contractors implementing CAPs for the recommendations from the 2016 OR.

The results of the OR for the four Contractors, the CAPs and CAP responses, and challenges (if applicable) are described in this section of the annual EQR report.

### Conducting the Review

For the CYE 2016 OR, AHCCCS reviewed 12 standards in various categories for each Contractor. Details regarding the standards reviewed for each Contractor are included in the findings.

### Objectives for Conducting the Review

AHCCCS' objectives for conducting ORs are to:

- Determine if the Contractor satisfactorily met AHCCCS' requirements as specified in its contract, AHCCCS policies, Arizona Revised Statutes, the Arizona Administrative Code (AAC), and Medicaid managed care regulations (42 CFR §438).
- Increase AHCCCS' knowledge of the Contractor's operational encounter processing procedures.
- Provide technical assistance and identify areas in which the Contractor can improve as well as areas of noteworthy performance and accomplishments.

- Review the Contractor's progress in implementing recommendations that AHCCCS made during prior ORs.
- Determine if the Contractor complied with its own policies and evaluate the effectiveness of those policies and procedures.
- Perform oversight of the Contractor as required by CMS in accordance with AHCCCS' 1115 waiver.
- Provide information to HSAG as AHCCCS' EQRO to use in preparing this report as described in 42 CFR §438.364.

### **Methodology for Conducting the Review**

While AHCCCS reviews the operational and financial performance of the Contractors throughout the year, it also conducts formal reviews on a schedule that ensures it monitors all applicable CMS and AHCCCS contract requirements at least once every three years. AHCCCS follows a CMS-approved process to conduct the ORs that is also consistent with CMS' protocol for EQROs that conduct the reviews.<sup>6-1</sup>

AHCCCS' methodology for conducting the OR included the following:

- Reviewing 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.

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

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

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

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<sup>6-1</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-1.pdf>. Accessed on: April 11, 2017.

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

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

## **Standards**

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

- Case Management (CM), 20 elements
- Corporate Compliance (CC), five elements
- Claims and Information Systems (CIS), 12 elements
- Delivery Systems (DS), 10 elements
- General Administration (GA), three elements
- Grievance Systems (GS), 17 elements
- Adult, EPSDT, and Maternal Child Health (MCH), 15 elements
- Medical Management (MM), 25 elements
- Member Information (MI), nine elements
- Quality Management (QM), 31 elements
- Reinsurance (RI), four elements
- Third-Party Liability (TPL), seven elements

## **Scoring Methodology**

Each standard area contains elements designed to measure the Contractor's performance and compliance with the federal managed care rules and the AHCCCS ALTCS contract provisions. A Contractor may receive up to a maximum possible score of 100 percent for each standard measured in the CYE 2016 OR. Within each standard are specific scoring detail criteria worth defined percentages of the total possible score.

AHCCCS includes the percentages awarded for each scoring detail in the standard's total score. Using the sum of all applicable standard total scores, AHCCCS then develops an overall standard area score. In

addition, a standard is scored Not Applicable (N/A) if it does not apply to the Contractor and/or no instances exist in which the requirement is applied.

Contractors are required to complete a corrective action plan (CAP) for any standard for which the total score is less than 95 percent.

### **Corrective Action Statements**

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

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

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

### **Contractor-Specific Results**

For CYE 2016 AHCCCS conducted 12 standards for each Contractor. Contractor specific results are presented below.

#### **Bridgeway Health Solutions (BWY)**

AHCCCS conducted an on-site review of BWY from April 4, 2016, through April 6, 2016. A copy of the draft version of the report was provided to the Contractor on May 18, 2016. BWY was given a period of one week in which to file a challenge to any findings that the health plan considered inaccurate, based on the evidence available at the time of review.

## Findings

For CYE 2016 AHCCCS conducted a comprehensive OR considering 12 standards. Table 6-1 presents the total number of elements, the standard area scores, and the number, if any, of required corrective actions for each standard area reviewed.

**Table 6-1—Standards and Compliance Scores for BWY**

| Standard Area                           | Total Number of Elements | Standard Area Score | Required Corrective Actions |
|---|--------------------------|---------------------|-----------------------------|
| Case Management                         | 18                       | 98%                 | 1                           |
| Corporate Compliance                    | 5                        | 95%                 | 1                           |
| Claims and Information Systems          | 12                       | 92%                 | 5                           |
| Delivery Systems                        | 9                        | 100%                | 0                           |
| General Administration                  | 3                        | 100%                | 0                           |
| Grievance Systems                       | 17                       | 100%                | 0                           |
| Adult, EPSDT, and Maternal Child Health | 14                       | 100%                | 0                           |
| Medical Management                      | 20                       | 99%                 | 0                           |
| Member Information                      | 9                        | 97%                 | 1                           |
| Quality Management                      | 28                       | 96%                 | 4                           |
| Reinsurance                             | 4                        | 100%                | 0                           |
| Third-Party Liability                   | 7                        | 100%                | 0                           |

Table 6-1 illustrates the following compliance results for the 12 standards reviewed for the BWY OR:

- Case Management (CM): For the 18 elements within this standard, the Contractor received a score of 98 percent (1,758 out of 1,800).
- Corporate Compliance (CC): For the five elements within this standard, the Contractor received score of 95 percent (out of 500).
- Claims and Information Systems (CIS): For the 12 elements within this standard, the Contractor received a score of 92 percent (1,103 out of 1,200).
- Delivery Systems (DS): For the nine elements within this standard, the Contractor received a score of 100 percent (900 out of 900).
- General Administration (GA): For the three elements within this standard, the Contractor received a score of 100 percent (300 out of 300).
- Grievance Systems (GS): For the 17 elements within this standard, the Contractor received a score of 100 percent (1,700 out of 1,700).
- Adult, EPSDT, and Maternal Child Health (MCH): For the 14 elements within this standard, the Contractor received a score of 100 percent (1,400 out of 1,400).

- **Medical Management (MM):** For the 20 elements within this standard, the Contractor received a score of 99 percent (1,991 out of 2,000).
- **Member Information (MI):** For the nine elements within this standard, the Contractor received a score of 97 percent (875 out of 900).
- **Quality Management (QM):** For the 28 elements within this standard, the Contractor received a score of 96 percent (2,687 out of 2,800).
- **Reinsurance (RI):** For the four elements within this standard, the Contractor received a score of 100 percent (400 out of 400).
- **Third-Party Liability (TPL):** For the seven elements within this standard, the Contractor received a score of 100 percent (700 out of 700).

### Strengths

For this OR, AHCCCS reviewed a total of 12 standards. BWY was fully compliant (100 percent scores) with six of the 12 standards reviewed (DS, GA, GS, MCH, RI, and TPL). The Contractor also demonstrated strong performance in the CM, CC, MM, MI, and QM standards, with compliance scores between 95 and 99 percent.

BWY performed exceptionally well within six standards (DS, GA, GS, MCH, RI, and TPL), obtaining 100 percent scores, and performed within the compliance threshold in the remaining five standards (CM, CC, MM, MI, and QM). However, because BWY obtained less than 100 percent for those standards CAPs were required for some elements. These are still highlighted as strengths for the Contractor as the scores surpassed the 95 percent threshold required by AHCCCS for compliance.

The Contractor received a 98 percent score within the CM standard; and AHCCCS found that BWY performed equally well within the MM standard, with a 99 percent score. Likewise, the Contractor received a 97 percent score for its performance within the MI standard. Most elements for the QM standards were in compliance, and AHCCCS scored BWY 96 percent overall.

### Opportunities for Improvement and Recommendations

The results of the OR demonstrated opportunities for improvement as BWY was less than fully compliant within six standards of the 12 standards reviewed. BWY underperformed in the CIS standard, being found noncompliant with several elements and receiving a 92 percent score. AHCCCS established several issues during the OR for which the Contractor was required to submit various CAPs. For the CM standard, the Contractor was found noncompliant with some requirements and received a score of 98 percent. For the CC standard, BWY was scored 95 percent. For the MM, MI, and QM standards the Contractor received scores of 99, 97, 98 percent respectively.

For each element found noncompliant within each standard, the Contractor was required to present CAPs for AHCCCS approval in accordance with the compliance review schedule.

For the CM standard, BWY must ensure that needs assessments and care planning processes are completed as required, to include member specific goals that are attainable and measurable, and that a plan of action and/or interventions to be used to meet the goals are identified in the member's file.

For the CC standard, BWY must enhance its current training to ensure that the elements required under the contract are sufficiently covered. The Contractor must update its training curriculum to include the 5 elements as required in the AHCCCS' contract and the reporting of fraud, waste, and abuse (FWA) to AHCCCS/OIG and include this in all FWA trainings for new and existing employees.

For the CIS standard, BWY and its subcontractors' remits must include detailed and accurate explanations as well as descriptions of payments less than billed charges, denials, and adjustments. The Contractor must ensure that its subcontractors' remits include the amount billed, complete and accurate provider rights for claim disputes, instructions and time frames for the submission of claim disputes, and instructions and time frames for the submission of corrected claims.

BWY must ensure that it pays non-hospital claims at the rate of 10 percent per annum (calculated daily) on claims paid more than 45 days after the date of receipt of the clean claim submission. The Contractor must ensure that it pays interest on all claim disputes as appropriate based on the date of the receipt of the original clean claim submission. In addition, BWY must ensure that it accurately applies quick pay discounts and that it pays, and that its delegated subcontractors pay, providers the correct contracted rates. The Contractor must ensure that it processes and pays all overturned claims disputes in a manner consistent with the decision within 15 days of the decision.

For the MI standard, AHCCCS included only one recommendation: that BWY must ensure it notifies affected members of material changes to network and operations at least 30 days before the effective date of the change.

For the QM standard, AHCCCS required that BWY develop a process for clearly documenting review of grievance and appeal information, adverse events, utilization management information, performance improvement information, and quality issues during the credentialing process. These elements must be addressed for each credentialing, recredentialing, and provisional credentialing file reviewed by the Credentialing Committee. BWY must identify how it will perform provisional credentialing for providers working at federally qualified health centers (FQHCs); FQHC look-alikes; and, in rural or medically underserved areas, in accordance with contract requirements and its own policy.

In addition, BWY must demonstrate evidence of maintaining for each credentialed provider an individual credentialing and recredentialing file that includes the initial credentialing and all subsequent recredentialing applications, including attestations by the applicant of the correctness and completeness of the application as demonstrated by the signature on the application; primary source verification; if a prescriber, Drug Enforcement Agency (DEA) or controlled dangerous substance (CDS) information; information gained through credentialing and recredentialing queries; and review of grievance and appeal information, adverse events, utilization management information, performance improvement information, and quality issues during the credentialing process.



AHCCCS required that BWY incorporate the requirements of the AHCCCS Medical Policy Manual (AMPM) Policy 950—Credentialing and Recredentialing Processes into its Organizational Credentialing Policy and submit evidence of compliance in its credentialing processes.

### Summary

BWY was fully compliant (100 percent scores) for six of the 12 standards reviewed (DS, GA, GS, MCH, RI, and TPL) during the comprehensive OR. The Contractor was not required to submit CAPs for any of those standards because no element within those standards was found non-compliant. However, although the Contractor scored at or above 95 percent for the CM, CC, MM, MI, and QM standards, some elements within those standards were found non-compliant, and CAPs were required to address these findings.

BWY obtained a score of 92 percent for the CIS standard, below the required threshold; and AHCCCS found the Contractor out of compliance with several elements also identified during the previous OR. For instance, the element that requires Contractors to ensure that the remittance advice to providers contains the minimum required information was found noncompliant.

BWY obtained a score of 96 percent for the QM standard. The Contractor was found non-compliant with four of the elements within the standard and was required to submit a CAP addressing the AHCCCS' findings. On September 2, 2016, AHCCCS, Division of Health Care Management (DHCM) approved the Contractor's second submission of the proposed CAP for the CYE 2016 OR, which included all findings and recommendations identified during the OR. AHCCCS agreed with all proposed steps in the CAP, indicating that the Contractor had six months from the date of approval to complete all actions as proposed in the CAP.

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

AHCCCS conducted an on-site review of MCP-LTC from May 16, 2016, through May 19, 2016. A copy of the draft version of the report was provided to the Contractor on July 1, 2016. MCP-LTC was given a period of one week in which to file a challenge to any findings that the health plan considered in accurate, based on the evidence available at the time of review.

### Findings

For CYE 2016, AHCCCS conducted a comprehensive OR considering 12 standards. Table 6-2 presents the total number of elements, the standard area scores, and the number, if any, of required corrective actions for each standard area reviewed.

**Table 6-2—Standards and Compliance Scores for MCP-LTC**

| Standard Area                           | Total Number of Elements | Standard Area Score | Required Corrective Actions |
|---|--------------------------|---------------------|-----------------------------|
| Case Management                         | 18                       | 94%                 | 2                           |
| Corporate Compliance                    | 5                        | 93%                 | 1                           |
| Claims and Information Systems          | 12                       | 96%                 | 1                           |
| Delivery Systems                        | 9                        | 98%                 | 1                           |
| General Administration                  | 3                        | 100%                | 0                           |
| Grievance Systems                       | 17                       | 96%                 | 1                           |
| Adult, EPSDT, and Maternal Child Health | 14                       | 100%                | 0                           |
| Medical Management                      | 20                       | 96%                 | 2                           |
| Member Information                      | 9                        | 100%                | 0                           |
| Quality Management                      | 28                       | 97%                 | 2                           |
| Reinsurance                             | 4                        | 100%                | 0                           |
| Third-Party Liability                   | 7                        | 100%                | 0                           |

Table 6-2 illustrates the following compliance results for the 12 standards reviewed for the MCP-LTC OR:

- Case Management (CM): For the 18 elements within this standard, the Contractor received a standard area score of 94 percent (1,693 out of 1,800).
- Corporate Compliance (CC): For the five elements within this standard, the Contractor received a standard area score of 93 percent (466 out of 500).
- Claims and Information Systems (CIS): For the 12 elements within this standard, the Contractor received a score of 96 percent (1,146 out of 1,200).
- Delivery Systems (DS): For the nine elements within this standard, the Contractor received a score of 98 percent (880 out of 900).
- General Administration (GA): For the three elements within this standard, the Contractor received a score of 100 percent (300 out of 300).
- Grievance Systems (GS): For the 17 elements within this standard, the Contractor received a score of 96 percent (1,624 out of 1,700).
- Adult, EPSDT, and Maternal Child Health (MCH): For the 14 elements within this standard, the Contractor received a score of 100 percent (1,400 out of 1,400).
- Medical Management (MM): For the 20 elements within this standard, the Contractor received a score of 96 percent (1,928 out of 2,000).
- Member Information (MI): For the nine elements within this standard, the Contractor received a score of 100 percent (900 out of 900).

- **Quality Management (QM):** For the 28 elements within this standard, the Contractor received a score of 97 percent (2,728 out of 2,800).
- **Reinsurance (RI):** For the four elements within this standard, the Contractor received a score of 100 percent (400 out of 400).
- **Third-Party Liability (TPL):** For the seven elements within this standard, the Contractor received a score of 100 percent (700 out of 700).

### Strengths

For this OR, AHCCCS reviewed a total of 12 standards. MCP-LTC was fully compliant with five of the standards reviewed (GA, MCH, MI, RI, and TPL). The Contractor also demonstrated strong performance for the CIS, DS, GS, MM, and QM standards; although MCP-LTC did not obtain full compliance scores of 100 percent for those.

MCP-LTC received 100 percent scores for five standards and received scores between 96 percent and 98 percent for an additional five standards, obtaining a high overall performance result. The Contractor performed below the 95 percent threshold for only two of the 12 standards reviewed.

### Opportunities for Improvement and Recommendations

The results of the OR demonstrated opportunities for improvement as MCP-LTC was less than fully compliant in seven of the 12 standards reviewed by AHCCCS. For the CM standard, MCP-LTC received 94 percent and was required to provide a CAP for the elements identified as noncompliant by AHCCCS. For the CC standard, MCP-LTC received 93 percent and at least one of the elements reviewed was found noncompliant during the review.

The CIS standard received a score of 96 percent, with various issues identified and later addressed in a CAP. MCP-LTC received a 98 percent for the DS standard, with one element requiring corrective action. For the GS standard, MCP-LTC received a 96 percent score; however, AHCCCS required some corrective actions to achieve compliance. For the MM standard, AHCCCS scored the Contractor with 96 percent, discovering various issues for which MCP-LTC provided a CAP. For the QM standard, MCP-LTC received a 97 percent score.

For each element found noncompliant within each standard, the Contractor was required to present CAPs for AHCCCS' approval in accordance with the compliance review schedule.

For the CM standard, AHCCCS required MCP-LTC to develop a CAP to ensure that specific member goals are identified, documented, and monitored for progress when conducting needs assessment and care/service planning, to include the most recent Case Manager Caseload Report.

For the CC standard, AHCCCS required MCP-LTC to add language and content regarding reporting of FWA directly to AHCCCS—OIG. Information on how to report fraud, waste, or abuse of the program online, by phone or letter, and via fax is available on the AHCCCS website.

For the CIS standard, MCP-LTC's remits must include the reasons for all denials and adjustments as well as a detailed explanation/description of payments less than billed charges, denials, and adjustments. The Contractor's letters denying a claim when the provider is not registered with AHCCCS must include instructions and time frames for the submission of claim disputes and instructions and time frames for the submission of corrected claims. The dental subcontractor's remits must include the reasons and a detailed description for all denials and adjustments as well as instructions and time frames for the submission of claim disputes and corrected claims.

For the DS standard, AHCCCS required MCP-LTC to have a mechanism for tracking and trending provider inquiries that includes timely acknowledgement and resolution and which takes systemic action as appropriate.

For the GS standard, the Contractor is required to comply with the requirement of issuing written acknowledgement letters within five business days of receipt for all claim disputes.

For the MM standard, AHCCCS required MCP-LTC to consider having a separate policy for discharge planning. In either case, the proactive discharge planning policy language must contain the required elements in Chapter 1000, including the arrangement of follow-up appointments with the PCP or specialist; coordination of prescription medications, therapies, and durable medical equipment (DME) as medically necessary; occurrence of post-discharge telephone calls; confirmation within seven days of discharge that discharge needs were met; and referral to the appropriate contractor case management (CM), disease management (DM), or community resources. In addition, MCP-LTC must address each field on the Electronic Transformation of Information (ETI) form.

For the QM standard, AHCCCS required MCP-LTC to develop a policy and procedure that outlines the process for correcting identified issues with the health information system and related data. Additionally, the Contractor must document the process for notifying AHCCCS when data discrepancies or health information system issues are identified. MCP-LTC must provide evidence of ensuring behavioral health services are provided and clearly documented in the member's individual treatment plan.

## Summary

MCP-LTC was fully compliant with five standards reviewed by AHCCCS (GA, MCH, MI, RI, and TPL). Although the Contractor did not achieve full compliance for the CIS, DS, GS, MM, and QM standards, the scores were between the 96 and 98 percent. AHCCCS required CAPs for all elements found noncompliant, regardless of percentage of compliance below 100 percent.

MCP-LTC was not fully compliant with seven standards reviewed. MCP-LTC submitted CAPs to AHCCCS for all elements within the seven standards for which AHCCCS identified deficiencies. On October 25, 2016, AHCCCS approved all proposed CAPs from the Contractor, with the acceptance of all proposed CAPs. MCP-LTC must demonstrate progress in each proposed step until AHCCCS agrees that MCP-LTC has addressed the findings for each CAP.

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

AHCCCS conducted an on-site review of UHCCP-LTC from February 22, 2016, to February 24, 2016. A copy of the draft version of the report was provided to the Contractor on April 6, 2016. UHCCP-LTC was given a period of one week in which to file a challenge to any findings that the health plan considered to be inaccurate, based on the evidence available at the time of review

#### Findings

For CYE 2016, AHCCCS conducted the OR considering 12 standards. Table 6-3 presents the total number of elements, the standard area scores, and the number, if any, of required corrective actions for each standard area reviewed.

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

| Standard Area                           | Total Number of Elements | Standard Area Score | Required Corrective Actions |
|---|--------------------------|---------------------|-----------------------------|
| Case Management                         | 18                       | 97%                 | 3                           |
| Corporate Compliance                    | 5                        | 92%                 | 1                           |
| Claims and Information Systems          | 12                       | 88%                 | 2                           |
| Delivery Systems                        | 9                        | 92%                 | 2                           |
| General Administration                  | 3                        | 100%                | 0                           |
| Grievance Systems                       | 17                       | 100%                | 0                           |
| Adult, EPSDT, and Maternal Child Health | 14                       | 100%                | 0                           |
| Medical Management                      | 20                       | 97%                 | 5                           |
| Member Information                      | 9                        | 100%                | 0                           |
| Quality Management                      | 28                       | 98%                 | 1                           |
| Reinsurance                             | 4                        | 100%                | 0                           |
| Third-Party Liability                   | 7                        | 100%                | 0                           |

Table 6-3 illustrates the following compliance result for the standards reviewed for the UHCCP-LTC OR:

- Case Management (CM): For the 18 elements within this standard, the Contractor received a score of 97 percent (1,753 out of 1,800).
- Corporate Compliance (CC): For the five elements within this standard, the Contractor received a score of 92 percent (460 out of 500).
- Claims and Information Systems (CIS): For the 12 elements within this standard, the Contractor received a score of 88 percent (1,051 out of 1,200).

- **Delivery Systems (DS):** For the nine elements within this standard, the Contractor received a score of 92 percent (830 out of 900).
- **General Administration (GA):** For the three elements within this standard, the Contractor received a score of 100 percent (300 out of 300).
- **Grievance Systems (GS):** For the 17 elements within this standard, the Contractor received a score of 100 percent (1,700 out of 1,700).
- **Adult, EPSDT, and Maternal Child Health (MCH):** For the 14 elements within this standard, the Contractor received a score of 100 percent (1,400 out of 1,400).
- **Medical Management (MM):** For the 20 elements within this standard, the Contractor received a score of 97 percent (1,936 out of 2,000).
- **Member Information (MI):** For the nine elements within this standard, the Contractor received a score of 100 percent (900 out of 900).
- **Quality Management (QM):** For the 28 elements within this standard, the Contractor received a score of 98 percent (2,744 out of 2,800).
- **Reinsurance (RI):** For the four elements within this standard, the Contractor received a score of 100 percent (400 out of 400).
- **Third-Party Liability (TPL):** For the seven elements within this standard, the Contractor received a score of 100 percent (700 out of 700).

## Strengths

UHCCP-LTC was in full compliance with six of the 12 standards reviewed (GA, GS, MCH, MI, RI, and TPL). The Contractor received a score of 100 percent for each of these six standards, and no CAP was required. UHCCP-LTC also had strong performance within three of the standards (CM, MM, and QM), with scores between the 97 and 98 percent.

## Opportunities for Improvement and Recommendations

The results of the OR demonstrated opportunities for improvement as UHCCP-LTC was less than fully compliant in six of the 12 standards reviewed. In the report generated from UHCCP-LTC's OR, AHCCCS included recommendations for UHCCP-LTC, including which standards required CAPs. AHCCCS included the following recommendations in the final OR report to UHCCP-LTC.

For the CM standard, UHCCP-LTC must develop policies and procedures for placement and service planning to ensure that service planning is complete. The Contractor must develop policies and procedures for the Client Assessment Tracking System (CATS) to ensure that the CATS screens are accurately completed in a timely manner. The Contractor must develop a CAP to ensure that the case managers' (CMs') caseloads do not exceed the standard weighted value of 96. In addition, the Contractor must develop policies and procedures for monitoring case management caseloads for compliance with AHCCCS standards to ensure that the CMs' caseloads do not exceed the standard weighted value of 96.

For the CC standard, UHCCCP-LTC must demonstrate that it regularly checks the exclusion databases for excluded individuals and vendors. For the CIS standard, UHCCCP-LTC must ensure that all remits include a detailed description of denials and adjustments, the accurate amount billed, the application of coordination of benefits and copays, provider rights, instructions and time frames for claims disputes, as well as the resubmission of corrected claims. In addition, the Contractor must ensure that it pays interest on hospital claims at the rate of one percent per month for each month or portion of a month following the 60th day of receipt of the clean claim until the date of payment. AHCCCS requires that non-hospital claims be paid at the rate of 10 percent per annum (calculated daily) on claims paid more than 45 days after the date of receipt of the clean claim submission. The Contractor must ensure that it pays interest on clean claims at the rate of one percent per month from the date the claim is submitted for ALTCS services not paid within 30 calendar days after the claim is received. UHCCP-LTC must ensure that it pays interest on all claim disputes as appropriate based on the date of the receipt of the original clean claim submission.

For the DS standard, UHCCP-LTC must amend all subcontracts on their regular renewal schedule or within six calendar months of AHCCCS making changes to the minimum subcontract provisions. The Contractor must notify contracted providers when a material change in the network occurs 30 days in advance of the material change. AHCCCS requires that the Contractor ensure that all requirements in AHCCCS Contractors' Operations Manual (ACOM) 416 are not just documented in policy, but are also present in the provider manual itself.

For the MM standard, UHCCP-LTC must identify the barriers that prevent concurrent review from being conducted within one business day of notification and implement actions to ensure compliance. The Contractor must implement actions to ensure compliance with proactive discharge planning including post-discharge contact with the member as well as a physician follow-up appointment when the member is discharged to home. To ensure that UHCCP-LTC facilitates coordination of all services being provided to a member when the member is transitioning between Contractors, AHCCCS requires that ETI forms be complete and comprehensive; this allows provision of seamless and gap-free transitions for members. To ensure that UHCCP-LTC does not deny emergency services, the policy must be updated to include that payment is not denied when a representative of the Contractor instructs the enrollee to seek emergency services. Finally, to ensure that UHCCP-LTC identifies, monitors, and implements interventions to prevent the misuse of controlled and non-controlled medications, UHCCP-LTC must develop processes and include in policy how specific instructions are given to members, the assigned exclusive pharmacy and/or exclusive provider, and their pharmacy benefit manager (PBM) on how to address emergencies, out-of-stock medication, and what to do when the exclusive pharmacy is closed.

For the QM standard, UHCCP-LTC needs to provide proof that advance directive activities have been implemented for members. The Contractor needs to demonstrate that medical records and Do Not Resuscitate (DNR) orders are kept in easily accessible areas, while still protecting them in some confidential manner.

**Summary**

For this OR, AHCCCS reviewed 12 standards. UHCCP-LTC was fully compliant with six of 12 of the standards reviewed. AHCCCS required CAPs for the remaining six standards.

UHCCP-LTC was not fully compliant with six standards reviewed. UHCCP-LTC submitted CAPs to AHCCCS for all elements for which AHCCCS identified deficiencies within the six standards. On July 21, 2016, AHCCCS approved all proposed CAPs from the Contractor, excepting two—one was partially accepted, and one was accepted with contingencies. UHCCP-LTC had to demonstrate progress in each proposed step before AHCCCS agreed that UHCCP-LTC had addressed the findings for each CAP. UHCCP-LTC’s CAP update was due January 21, 2017.

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

AHCCCS conducted an on-site review of DES/DDD from June 27, 2016, to June 29, 2016. A copy of the draft version of the report was provided to the Contractor on August 10, 2016. DES/DDD was given a period of one week in which to file a challenge to any findings that the health plan considered inaccurate, based on the evidence available at the time of review.

**Findings**

For CYE 2016 AHCCCS conducted an OR considering 12 standards. Table 6-4 presents the total number of elements, the standard area scores, and the required corrective actions for each standard area reviewed.

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

| Standard Area                           | Total Number of Elements | Standard Area Score | Required Corrective Actions |
|---|--------------------------|---------------------|-----------------------------|
| Case Management                         | 20                       | 93%                 | 5                           |
| Corporate Compliance                    | 5                        | 87%                 | 1                           |
| Claims and Information Systems          | 12                       | 73%                 | 5                           |
| Delivery Systems                        | 9                        | 93%                 | 2                           |
| General Administration                  | 3                        | 100%                | 0                           |
| Grievance Systems                       | 17                       | 100%                | 0                           |
| Adult, EPSDT, and Maternal Child Health | 15                       | 100%                | 0                           |
| Medical Management                      | 22                       | 92%                 | 4                           |
| Member Information                      | 9                        | 100%                | 0                           |
| Quality Management                      | 28                       | 97%                 | 4                           |



| Standard Area         | Total Number of Elements | Standard Area Score | Required Corrective Actions |
|-----------------------|--------------------------|---------------------|-----------------------------|
| Reinsurance           | 4                        | 63%                 | 3                           |
| Third-Party Liability | 7                        | 57%                 | 3                           |

Table 6-4 illustrates the following compliance results for the 12 standards reviewed for the DES/DDD comprehensive OR:

- Case Management (CM): For the 20 elements within this standard, the Contractor received a standard area score of 93 percent (1,867 out of 2,000).
- Corporate Compliance (CC): For the five elements within this standard, the Contractor received a standard area score of 87 percent (434 out of 500).
- Claims and Information Systems (CIS): For the 12 elements within this standard, the Contractor received a score of 73 percent (880 out of 1,200).
- Delivery Systems (DS): For the nine elements within this standard, the Contractor received a score of 93 percent (841 out of 900).
- General Administration (GA): For the three elements within this standard, the Contractor received a score of 100 percent (300 out of 300).
- Grievance Systems (GS): For the 17 elements within this standard, the Contractor received a score of 100 percent (1,700 out of 1,700).
- Adult, EPSDT, and Maternal Child Health (MCH): For the 15 elements within this standard, the Contractor received a score of 100 percent (1,500 out of 1,500).
- Medical Management (MM): For the 22 elements within this standard, the Contractor received a score of 92 percent (2,028 out of 2,200).
- Member Information (MI): For the nine elements within this standard, the Contractor received a score of 100 percent (900 out of 900).
- Quality Management (QM): For the 28 elements within this standard, the Contractor received a score of 97 percent (2,710 out of 2,800).
- Reinsurance (RI): For the four elements within this standard, the Contractor received a score of 63 percent (250 out of 400).
- Third-Party Liability (TPL): For the seven elements within this standard, the Contractor received a score of 57 percent (400 out of 700).

### Strengths

For this OR, AHCCCS reviewed a total of 12 standards for which DES/DDD was fully compliant (100 percent scores) in the following four standards: GA, GS, MCH, and MI.

## Opportunities for Improvement and Recommendations

The results of the OR demonstrated opportunities for improvement as DES/DDD was not in full compliance with eight of the 12 standards reviewed. In the report generated from the DES/DDD OR, AHCCCS identified deficiencies and opportunities for improvement which the Contractor presented in CAPs for each element identified. AHCCCS included the following recommendations in the final OR report to DES/DDD.

For the CM standard, DES/DDD must develop a corrective action plan to ensure the service planning process, including the completion of accurate and comprehensive member contingency plan and back-up plans for members receiving critical services and the facilitation of member emergency or disaster plans, as applicable. The Contractor must develop a corrective action plan to ensure that that Client Assessment Tracking System (CATS) screen CA162 is completed and updated accordingly. In addition, AHCCCS required DES/DDD to develop a plan to ensure that member placement and services, including any change in placement, are assessed within the required time frames and, when appropriate, that acceptable reasons are documented for any instances of not conducting review assessments in a timely manner. AHCCCS also required the Contractor to develop a plan to ensure that all districts have average caseloads at or below the AHCCCS standard of 1:40. Finally, DES/DDD must ensure that annual interrater reliability (IRR) testing is done for all staff conducting member assessments and service authorizations.

For the CC standard, DES/DDD must revise its policies and procedures to specify that referrals about fraud are to be submitted electronically on the AHCCCS website. In addition, any internally resolved allegations that did not result in FWA must be reported with accompanying information which clearly includes the outcomes of any internal investigation or review.

For the CIS standard, DES/DDD must include the correct paid amount on its ALTCS billing detail reports and ensure that its fee-for-service remits include the reason(s) for denials and adjustments, a detailed explanation/description of payments less than billed charges, denials and adjustments, and instructions and time frames for the submission of corrected claims. DES/DDD must ensure that it pays applicable interest on all claims, including overturned claim disputes. While the Contractor has a process in place to ensure its Acute Care subcontractors accurately apply quick pay discounts, it does not and must have a process in place to apply quick pay discounts on the hospital claims it pays through its Fee for Service (FFS) population. The Contractor provided policies and procedures showing that they require claims resulting from an overturned claims dispute to be paid within 15 days of the decision. The Contractor must develop policies and procedures auditing the contract-loading process for accuracy of payment against hard copy contracts that include provisions for auditing periodicity for its American Indian Health Program (AIHP) and ALTC services. The Contractor must ensure that all claims paid to contracted providers are paid according to each provider's agreed-upon rate.

For the DS standard, DES/DDD must ensure that its provider services representatives are adequately trained on claim dispute and appeal procedures and that its provider manual contains all requirements listed in AHCCCS ACOM 416.

For the MM standard, DES/DDD must develop a process for conducting concurrent review that clearly identifies the date of the initial and subsequent reviews and the name and title of the reviewer. The Contractor must implement a process for proactive discharge planning for members admitted into acute care facilities that includes but is not limited to a discharge needs assessment while the member is in the facility and the AHCCCS requirements for discharge planning and post-discharge follow-up. DES/DDD must develop a process to ensure that ETI forms are complete and accurate. The Contractor must develop a process to ensure that notices of action (NOAs) and notices of exception (NOEs) are written in compliance with State and federal regulations and as outlined in AHCCCS ACOM Policy 414.

For the QM standard, DES/DDD reported that an on-site health and safety visit is conducted within twenty-four hours for abuse and neglect allegations. This must be completed and clearly documented in the quality of care file. The Contractor also is required to monitor and document the success of actions taken or implement new actions when necessary. This also must be clearly documented. In addition, the Contractor must monitor the actions and interventions taken to correct deficiencies. The success of these interventions must be documented or new interventions implemented.

For the RI standard, DES/DDD must demonstrate improved communication with subcontractors regarding transplant-related encounters and cases. The Contractor must include in policy and desktop procedures corrections and missing information; including the All Patient Refined-Diagnostic Related Group (APR-DRG) Encounter rules regarding reinsurance—namely, that interim inpatient bills are not reinsured, that the only form type reinsured on DES cases is Form I, that Developmental Disability Catastrophic (DDC) is the case type for special DES cases which exceed \$650,000.00; and the Contractor must omit information regarding case types that do not apply to the Contractor. Finally, DES/DDD must advise AHCCCS Reinsurance of overpayments per the reinsurance contract.

For the Third-Party Liability standard, DES/DDD must demonstrate that it has a process in place to identify the existence of potentially liable third parties using trauma code edits. The Contractor must demonstrate that it has a process to review reinsurance payments regularly to identify any payments related to a total plan third-party liability case and to report that information to AHCCCS' authorized representative. In addition, DES/DDD must demonstrate that it is filing liens on all total plan case exceeding \$250 and that it has a process in place to release liens when required.

## Summary

For this OR, AHCCCS reviewed a total of 12 standards for which DES/DDD was fully compliant with four of the total standards reviewed (GA, GS, MCH, and MI). The Contractor received a 97 percent score in the QM standard, above the 95 percent threshold for compliance. DES/DDD also received scores between 92 percent and 93 percent for the CM, DS, and MM standards. The Contractor received low scoring percentages—between 57 percent and 87 percent—for the CC, CIS, TPL, and RI standards. All standards found in noncompliance or below 100 percent, and wherein AHCCCS identified elements that required corrective actions, were addressed by the Contractor through the CAP process.

## Overall Results for ALTCS Contractors

### Findings

AHCCCS conducted the comprehensive OR for the four ALTCS Contractors for CYE 2016. Table 6-5 details the percentage score for each Contractor for each of the 12 standards.

**Table 6-5—ALTCS Contractors and DES/DDD Standard Area Scores**

| Standard                                | BWY  | MCP-LTC | UHCCP-LTC | DES/DDD |
|---|------|---------|-----------|---------|
| Case Management                         | 98%  | 94%     | 97%       | 93%     |
| Corporate Compliance                    | 95%  | 93%     | 92%       | 87%     |
| Claims and Information Systems          | 92%  | 96%     | 88%       | 73%     |
| Delivery Systems                        | 100% | 98%     | 92%       | 93%     |
| General Administration                  | 100% | 100%    | 100%      | 100%    |
| Grievance Systems                       | 100% | 96%     | 100%      | 100%    |
| Adult, EPSDT, and Maternal Child Health | 100% | 100%    | 100%      | 100%    |
| Medical Management                      | 99%  | 96%     | 97%       | 92%     |
| Member Information                      | 97%  | 100%    | 100%      | 100%    |
| Quality Management                      | 96%  | 97%     | 98%       | 97%     |
| Reinsurance                             | 100% | 100%    | 100%      | 63%     |
| Third-Party Liability                   | 100% | 100%    | 100%      | 57%     |

### Case Management

BWY received a standard area score of 98 percent (1,758 out of possible points); MCP-LTC received 94 percent (1,693 out of 1,800 points), UHCCP-LTC received 97 percent (1,753 out of 1,800 points), and DES/DDD obtained 93 percent (1,867 out of 2,000 points). BWY achieved the highest score for this standard with 98 percent, followed by UHCCP-LTC with 97 percent; however, no Contractors achieved full compliance for this standard. AHCCCS identified opportunities for improvement for this standard, and all Contractors submitted CAPs. All Contractors were found deficient in relation to the needs assessment and care/service planning.

## Corporate Compliance

BWY received a standard area score of 95 percent (473 out of 500 points), MCP-LTC received 93 percent (466 out of 500 points), UHCCP-LTC received 92 percent (460 out of 500 possible points), DES/DDD scored 87 percent (434 out of 500 points) All Contractors performed below or at 95 percent, and none achieved full compliance (100 percent). All Contractors submitted CAPs for all elements identified by AHCCCS for improvement. Some elements identified by AHCCCS were related to training; reporting FWA, referrals; and checking exclusion databases.

## Claims and Information Systems

BWY achieved 92 percent (1,103 out of 1200 points). MCP-LTC scored 96 percent (1,146 out of 1,200 points). UHCCP-LTC scored 88 percent (1,051 out of 1,200 points). DES/DDD received 73 percent (880 out of 1,200 possible points). MCP-LTC obtained the highest score with 96 percent, followed by BWY with 92 percent; however, no Contractors obtained full compliance for this standard. AHCCCS found several deficiencies for which all Contractors submitted CAPs. One Contractor (BWY) was found deficient in some of the same elements as the previous year OR, indicating that the Contractor did not implement control systems to correct deficiencies previously identified by AHCCCS. Three Contractors (BWY, MCP-LTC, and UHCCP-LTC) were found noncompliant with the requirement for remits, which must include the reasons for all denials and adjustments as well as detailed explanation/description of payments less than billed charges, denials, and adjustments.

## Delivery Systems

BWY scored 100 percent (900 out of 900 points). MCP-LTC achieved a score of 98 percent (880 out of 900 points). UHCCP-LTC achieved 92 percent (830 out of 900 points). DES/DDD achieved 93 percent (841 out of 900 points). BWY was in full compliance for this standard, while MCP-LTC scored 98 percent score, above the compliance threshold, with just one element for corrective action. The other two Contractors received 92 percent and 93 percent. AHCCCS found various deficiencies within this standard. The findings identified by AHCCCS were different for each Contractor, and Contractors were required to provide CAPs for each element found noncompliant.

## General Administration

All Contractors received scores of 100 percent (300 out of 300points), indicating full compliance for this standard.

## Grievance Systems

BWY scored 100 percent (1,700 out of 1,700 points). MCP-LTC achieved a score of 96 percent (1,624 out of 1,700 points). UHCCP-LTC scored 100 percent (1,700 out of 1,700 points). DES/DDD scored 100 percent (1,700 out of 1,700points). As such, three of the four Contractors obtained full compliance in this standard. Only MCP-LTC, with a score of 96 percent was found noncompliant with one element and was required submit a CAP addressing the findings identified by AHCCCS. The element of noncompliance was related to the requirement to issue a written acknowledgement letter within five

business days of receipt on all claim disputes. The overall performance for this standard is outstanding considering that 15 elements were evaluated and only a single element for one Contractor was found noncompliant.

### **Adult, EPSDT, and Maternal Child Health**

All Contractors scored 100 percent (1500 out of 1500 points). The overall compliance for this standard is outstanding, with all Contractors having obtained 100 percent compliance. AHCCCS identified no elements out of compliance.

### **Medical Management**

BWY scored 99 percent (1,991 out of 2000 points). MCP-LTC scored 96 percent (1,928 out of 2,000 possible points). UHCCP-LTC scored 97 percent (1,936 out of 2,000 points). DES/DDD scored 92 percent (2,028 out of 2,200 points). The highest score was obtained by BWY, with 99 percent; and no corrective actions were imposed. The other three Contractors were found deficient in some elements within the standard, and all were required to submit CAPs to AHCCCS. MCP-LTC, UHCCP-LTC, and DES/DDD had deficiencies related to discharge planning and the ETI form.

### **Member Information**

BWY scored 97 percent (875 out of 900 points). MCP-LTC, UHCCP-LTC, and DES/DDD all received 100 percent (900 out of 900 points).

### **Quality Management**

BWY scored 96 percent (2,687 out of 2,800 points). MCP-LTC scored 97 percent (2,728 out of 2,800 points). UHCCP-LTC scored 98 percent (2,744 out of 2,800 points). DES/DDD scored 97 percent (2,710 out of 2,800 points). AHCCCS identified deficiencies that varied among Contractors, and all Contractors were required to submit CAPs.

### **Reinsurance**

BWY, UHCCP-LTC, and MCP-LTC each scored 100 percent (400 out of 400 points). DES/DDD scored 63 percent (250 out of 400 points), with several deficiencies identified by AHCCCS and requiring CAPs.

### **Third-Party Liability**

BWY, UHCCP-LTC, and MCP-LTC each scored 100 percent (700 out of 700 points). DES/DDD scored 57 percent (400 out of 700 points), with several deficiencies identified by AHCCCS and requiring CAPs.

## **Strengths**

All Contractors had two standards, MCH and GA, in which all related elements were scored as fully compliant. BWY received a 98 percent score for the CM standard and performed very well within the MM standard, with a 99 percent score. BWY received a 97 percent score for its performance within the MI standard. Most elements for the QM standards were in compliance, and AHCCCS scored BWY at 96 percent for that standard.

MCP-LTC achieved a 100 percent score for five standards and scores between 96 percent and 98 percent for another five standards, with a high overall performance result. The Contractor underperformed, below the threshold of the 95 percent, in only two of the 12 standards reviewed. UHCCP-LTC was in full compliance with six of the 12 standards reviewed (GA, GS, MCH, MI, RI, and TPL). UHCCP-LTC also had strong performance in three of the standards (CM, MM, and QM), with scores between 97 percent and 98 percent.

For this OR, AHCCCS reviewed a total of 12 standards, for which DES/DDD was fully compliant with four standards reviewed (GA, GS, MCH, and MI). The Contractor received a 97 percent score in the QM standard, above the 95 percent threshold for compliance. DES/DDD also received between 92 percent and 93 percent scores for the CM, DS, and MM standards. The Contractor received low scoring percentages, between 57 percent and 87 percent for the CC, CIS, TPL, and RI standards.

## **Opportunities for Improvement and Recommendations**

All Contractors made progress in meeting the standards; however, opportunities for improvement do exist. The results of the OR demonstrated opportunities for improvement as BWY was less than fully compliant in six standards of the 12 standards reviewed. BWY underperformed in the CIS standard and AHCCCS established several issues during the OR, for which the Contractor was required to submit various CAPs. The Contractor was found noncompliant with several elements and received a 92 percent score. For the CM standard, the Contractor was found noncompliant with some requirements and achieved a score of 98 percent. For the CC standard, BWY scored 95 percent. For the MM, MI, and QM standards the Contractor received scores of 96, 97, and 98 percent, respectively.

Results of the OR demonstrated opportunities for improvement for MCP-LTC, as the Contractor was less than fully compliant in seven of the 12 standards reviewed by AHCCCS. For the CM standard, the Contractor received 94 percent and was required to provide a CAP for some elements identified by AHCCCS as noncompliant. For the CC standard, MCP-LTC scored 93 percent, and at least one of the elements was found noncompliant during the review. The CIS standard received a score of 96 percent, with various issues identified and later addressed in a CAP.

MCP-LTC received a 98 percent for the DS standard, with one element requiring corrective action. For the GS standard, MCP-LTC scored 96 percent and AHCCCS required some corrective actions of MCP-LTC to achieve compliance. For the MM standard, AHCCCS scored the Contractor with 96 percent, discovering various issues for which the MCP-LTC provided a CAP. For the QM standard, MCP-LTC received a 97 percent score.

The results of the OR demonstrated opportunities for improvement as UHCCP-LTC was less than fully compliant in six of the 12 standards reviewed. In the report generated from UHCCP-LTC's OR, AHCCCS included recommendations for UHCCP-LTC, which required CAPs. UHCCP-LTC submitted CAPs to AHCCCS for all elements within the six standards for which AHCCCS identified deficiencies.

Results of the OR demonstrated opportunities for improvement as DES/DDD was not in full compliance with eight of the 12 standards reviewed. In the report generated from the DES/DDD's OR, AHCCCS identified deficiencies and opportunities for improvement, which the Contractor presented in CAPs for each element identified. AHCCCS included the following recommendations in the final OR report to DES/DDD.

Based on AHCCCS' review of ALTCS EPD Contractors' performance in CYE 2016 and the associated opportunities for improvement identified from the comprehensive OR, HSAG recommends the following for the Contractors:

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

Implement, as a proactive measure prior to the next OR, periodic risk assessments, including those elements reviewed by AHCCCS for which the Contractor was found deficient; assigning a level of compliance. Based on the highest number of CAPs, AHCCCS should concentrate improvement efforts on the following standard areas: CM, MM, and QM. AHCCCS should pay attention to the CIS standard as this is the standard within which most Contractors scored under 95 percent as well as the standard with the most CAPs.

## Summary

For AHCCCS' CYE 2016 OR, the four Contractors had positive results overall. All Contractors scored fully compliant in two standards (GA and MCH); and three Contractors (BWY, MCP-LTC and UHCCP-LTC) scored 100 percent in four standards (GA, MCH, RI, and TPL). DES/DDD scored below 95 percent for 58 percent of the standards; the Contractor has submitted CAPs for all elements recommended by AHCCCS.



The GA, GS, MCH, MI, and QM standards were strengths across the four Contractors. All Contractors scored at or above 95 percent on these standards. The CIS standard resulted in the highest number of scores below 95 percent, with DES/DDD scoring 73 percent.

## 7. Performance Measure Performance

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

As permitted by 42 CFR §438.358(a), AHCCCS elected to conduct the functions associated with the mandatory activity of validating performance measures. In accordance with and satisfying the requirements of 42 CFR §438.364(a)(1–5), AHCCCS contracted with HSAG as an EQRO to use the information that AHCCCS obtained from the performance measure calculations and data validation activities to prepare this CYE 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 calculated and approved the rates for inclusion in this report for the following performance measures for the ALTCS population for CYE 2015:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Ambulatory Care (per 1,000 Member Months)—Emergency Department (ED) Visits—Total*
- *Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (per 100,000 Member Months)*
- *Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)*
- *Heart Failure Admission Rate (per 100,000 Member Months)*
- *Plan All-Cause Readmissions—Total*

For DES/DDD, AHCCCS calculated and approved the rates for inclusion for the following performance measures for CYE 2015:

- *Adolescent Well-Care Visits*
- *Adults' Access to Preventive/Ambulatory Health Services*
- *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*
- *Annual Dental Visits—2–20 Years*
- *Breast Cancer Screening*

- *Cervical Cancer Screening*
- *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years*
- *COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)*
- *Chlamydia Screening in Women—Total*
- *Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)*
- *Follow-Up After Hospitalization—7-Day Follow-Up and 30-Day Follow-Up*
- *Heart Failure Admission Rate (per 100,000 Member Months)*
- *Plan All-Cause Readmissions—Total*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Using AHCCCS' results and statistical analysis of the Contractors' performance measure rates, HSAG organized, aggregated, and analyzed the CYE 2015 results. From the analysis, HSAG was able to draw conclusions about Contractor-specific and statewide aggregate performance related to the quality of, access to, and timeliness of care and services that the Contractors provided to AHCCCS members for CYE 2015.

### ***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 the performance measure rates.

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

- Determine Contractor performance on each AHCCCS-selected performance measure.
- Compare Contractor performance to AHCCCS' minimum performance standard (MPS) for each measure, if available.
- Draw conclusions about the quality of, access to, and timeliness of care and services furnished by individual Contractors and, statewide, by all Contractors.
- Aggregate and assess the AHCCCS-required Contractor CAPs, to provide an overall evaluation of performance for each Contractor and statewide.

## ***Methodology for Conducting the Review***

For the CYE 2015 review period (i.e., measurement year ending September 30, 2015), AHCCCS conducted the following activities:

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

CAPs, key components of the AHCCCS Quality Strategy, are used as foundational elements to improve performance rates that fall below contractual MPSs. At the time of the production of this report, AHCCCS had not yet formally required CAPs of Contractors for CYE 2015 data. As a result, no CAP data are included in the report for this year.

The Contractors' rates were calculated for AHCCCS-selected performance measures using administrative data collected from the automated managed care data system known as the Prepaid Medicaid Management Information System (PMMIS).

Performance measures used the Healthcare Effectiveness Data and Information Set (HEDIS®)<sup>7-1</sup> or a HEDIS-like methodology for rate calculation. The HEDIS administrative methodology used for data collection in the current measurement did not differ from the methodology used for the previous measurement period. NCQA updates its methodology annually to add new codes to better identify the eligible population and/or services being measured or to delete codes retired from standardized coding sets used by providers.

AHCCCS analyzed Contractors' results for each performance measure to determine if performance measure rates met or exceeded corresponding AHCCCS MPSs. Relative rate changes and statistical analyses are presented to show the magnitude and direction of any change in rates from the previous measurement period and whether or not the change was statistically significant.

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

The following sections describe HSAG's findings, conclusions, and recommendations for each Contractor as well as statewide comparative results for all Contractors for CYE 2015.

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<sup>7-1</sup> HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

## ALTCS Contractor-Specific Results

AHCCCS provided data to HSAG for the CYE 2015 performance measure rates for three ALTCS Contractors. The three CYE 2015 ALTCS Contractors were BWY, MCP-LTC, and UHCCP-LTC. The CYE 2015 performance measures reported for the ALTCS Contractors are listed in the “Conducting the Review” section preceding. No discussion of CAPs is included in the report this year for CYE 2015 data.

### Bridgeway Health Solutions (BWY)

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

#### Findings

Table 7-1 presents the performance measure rates for BWY. The table displays CYE 2014 performance; CYE 2015 performance; the relative percentage change between the CYE 2014 and CYE 2015 rates; the statistical significance of the relative percentage change; and the AHCCCS MPS, when applicable.

**Table 7-1—Performance Measurement Review for BWY**

| Performance Measure  | CYE 2014 Performance | CYE 2015 Performance | Relative Percentage Change | Significance Level (p value) <sup>1</sup> | Minimum Performance Standard |
|--|----------------------|----------------------|----------------------------|---|------------------------------|
| <b><i>Adults’ Access to Preventive/Ambulatory Health Services</i></b>                                  |                      |                      |                            |   |                              |
| <i>Adults’ Access to Preventive/Ambulatory Health Services</i>   | —                    | 90.3%                | —                          | —   | 75.0%                        |
| <b><i>Ambulatory Care (per 1,000 Member Months)<sup>2</sup></i></b>                                    |                      |                      |                            |   |                              |
| <i>ED Visits—Total</i>   | 64                   | 69                   | —                          | —   | —                            |
| <b><i>COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)<sup>2</sup></i></b>    |                      |                      |                            |   |                              |
| <i>COPD or Asthma in Older Adults Admission Rate</i>   | 114.3                | 138.9                | —                          | —   | —                            |
| <b><i>Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)<sup>2</sup></i></b> |                      |                      |                            |   |                              |
| <i>Diabetes Short-Term Complications Admission Rate</i>  | 12.9                 | 25.5                 | —                          | —   | —                            |
| <b><i>Heart Failure Admission Rate (per 100,000 Member Months)<sup>2</sup></i></b>                     |                      |                      |                            |   |                              |
| <i>Heart Failure Admission Rate</i>  | 90.1                 | 121.6                | —                          | —   | —                            |

| Performance Measure                            | CYE 2014 Performance | CYE 2015 Performance | Relative Percentage Change | Significance Level (p value) <sup>1</sup> | Minimum Performance Standard |
|--|----------------------|----------------------|----------------------------|---|------------------------------|
| <b>Plan All-Cause Readmissions<sup>2</sup></b> |                      |                      |                            |   |                              |
| Total  | 14.0%                | 11.6%                | -17.3%                     | P=.075                                    | —                            |

<sup>1</sup> Significance levels (p values) noted in the table were calculated by AHCCCS and HSAG and demonstrate whether the differences in performance between CYE 2014 and CYE 2015 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤ 0.05. Significance levels (p-values) in bold font indicate statistically significant values.

<sup>2</sup> A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance.

— Indicates either that comparison of performance between CYE 2014 and CYE 2015 is not possible or that an MPS has not yet been established by AHCCCS.

### CAPs

No discussion of CAPs is included in the report for CYE 2015 data.

### Strengths

BWY exceeded the CYE 2015 MPS for the *Adults’ Access to Preventive/Ambulatory Health Services* measure by 15.3 percentage points.

### Opportunities for Improvement

No opportunities for improvement were identified as the only performance measure rate compared to an MPS exceeded that MPS for CYE 2015.

### Summary

BWY’s performance measure rate for the *Adults’ Access to Preventive/Ambulatory Health Services* measure exceeded the MPS by more than 15 percentage points.

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

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

#### Findings

Table 7-2 presents the performance measure rates for MCP-LTC. The table displays CYE 2014 performance; CYE 2015 performance; the relative percentage change between the CYE 2014 and CYE 2015 rates; the statistical significance of the relative percentage change; and the AHCCCS MPS, when applicable.

**Table 7-2—Performance Measurement Review for MCP-LTC**

| Performance Measure   | CYE 2014 Performance | CYE 2015 Performance | Relative Percentage Change | Significance Level (p value) <sup>1</sup> | Minimum Performance Standard |
|---|----------------------|----------------------|----------------------------|---|------------------------------|
| <b>Adults' Access to Preventive/Ambulatory Health Services</b>                                  |                      |                      |                            |   |                              |
| Adults' Access to Preventive/Ambulatory Health Services   | —                    | 94.7%                | —                          | —   | 75.0%                        |
| <b>Ambulatory Care (per 1,000 Member Months)<sup>2</sup></b>                                    |                      |                      |                            |   |                              |
| ED Visits—Total   | 69                   | 75                   | —                          | —   | —                            |
| <b>COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)<sup>2</sup></b>    |                      |                      |                            |   |                              |
| COPD or Asthma in Older Adults Admission Rate   | 137.3                | 113.3                | —                          | —   | —                            |
| <b>Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)<sup>2</sup></b> |                      |                      |                            |   |                              |
| Diabetes Short-Term Complications Admission Rate  | 12.7                 | 7.9                  | —                          | —   | —                            |
| <b>Heart Failure Admission Rate (per 100,000 Member Months)<sup>2</sup></b>                     |                      |                      |                            |   |                              |
| Heart Failure Admission Rate  | 127.4                | 151.9                | —                          | —   | —                            |
| <b>Plan All-Cause Readmissions<sup>2</sup></b>  |                      |                      |                            |   |                              |
| Total   | 17.0%                | 16.3%                | -4.1%                      | <b>P=.449</b>                             | —                            |

<sup>1</sup> Significance levels (p values) noted in the table were calculated by AHCCCS and HSAG and demonstrate whether the differences in performance between CYE 2014 and CYE 2015 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤ 0.05. Significance levels (p-values) in bold font indicate statistically significant values.

<sup>2</sup> A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance.

— Indicates either that comparison of performance between CYE 2014 and CYE 2015 is not appropriate or that an MPS has not yet been established by AHCCCS.

#### CAPs

No discussion of CAPs is included in the report for CYE 2015 data.

## Strengths

MCP-LTC exceeded the CYE 2015 MPS for the *Adults' Access to Preventive/Ambulatory Health Services* measure by 19.7 percentage points.

## Opportunities for Improvement

No opportunities for improvement were identified as the only performance measure rate compared to an MPS exceeded that MPS for CYE 2015.

## Summary

MCP-LTC's performance measure rate for the *Adults' Access to Preventive/Ambulatory Health Services* measure exceeded the MPS by more than 19 percentage points.



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

UHCCP-LTC has contracted with AHCCCS since 1989.

### Findings

Table 7-3 presents the performance measure rates for UHCCP-LTC. The table displays CYE 2014 performance; CYE 2015 performance; the relative percentage change between the CYE 2014 and CYE 2015 rates; the statistical significance of the relative percentage change; and the AHCCCS MPS, when applicable.

**Table 7-3—Performance Measurement Review for UHCCP-LTC**

| Performance Measure   | CYE 2014 Performance | CYE 2015 Performance | Relative Percentage Change | Significance Level (p value) <sup>1</sup> | Minimum Performance Standard |
|---|----------------------|----------------------|----------------------------|---|------------------------------|
| <b>Adults' Access to Preventive/Ambulatory Health Services</b>                                  |                      |                      |                            |   |                              |
| Adults' Access to Preventive/Ambulatory Health Services   | —                    | 85.0%                | —                          | —   | 75.0%                        |
| <b>Ambulatory Care (per 1,000 Member Months)<sup>2</sup></b>                                    |                      |                      |                            |   |                              |
| ED Visits—Total   | 55                   | 59                   | —                          | —   | —                            |
| <b>COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)<sup>2</sup></b>    |                      |                      |                            |   |                              |
| COPD or Asthma in Older Adults Admission Rate   | 73.8                 | 78.6                 | —                          | —   | —                            |
| <b>Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)<sup>2</sup></b> |                      |                      |                            |   |                              |
| Diabetes Short-Term Complications Admission Rate  | 17.1                 | 7.8                  | —                          | —   | —                            |
| <b>Heart Failure Admission Rate (per 100,000 Member Months)<sup>2</sup></b>                     |                      |                      |                            |   |                              |
| Heart Failure Admission Rate  | 58.0                 | 87.2                 | —                          | —   | —                            |
| <b>Plan All-Cause Readmissions<sup>2</sup></b>  |                      |                      |                            |   |                              |
| Total   | 10.8%                | 7.3%                 | -33.1%                     | <b>P=.011</b>                             | —                            |

<sup>1</sup> Significance levels (p values) noted in the table were calculated by AHCCCS and HSAG and demonstrate whether the differences in performance between CYE 2014 and CYE 2015 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤ 0.05. Significance levels (p-values) in bold font indicate statistically significant values.

<sup>2</sup> A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance.

— Indicates either that comparison of performance between CYE 2014 and CYE 2015 is not appropriate or that an MPS has not yet been established by AHCCCS.

### CAPs

No discussion of CAPs is included in the report for CYE 2015 data.

## Strengths

UHCCP-LTC exceeded the CYE 2015 MPS for the *Adults' Access to Preventive/Ambulatory Health Services* measure by 10 percentage points. Additionally, as a lower rate indicates better performance for this measure, the *Plan All-Cause Readmissions* performance measure rate demonstrated statistically significant improvement from CYE 2014 to CYE 2015.

## Opportunities for Improvement

No opportunities for improvement were identified as the only performance measure rate compared to an MPS exceeded that MPS for CYE 2015.

## Summary

UHCCP-LTC's performance measure rate for the *Adults' Access to Preventive/Ambulatory Health Services* measure exceeded the MPS by 10 percentage points. Further, statistically significant improvement from CYE 2014 to CYE 2015 was noted for the *Plan All-Cause Readmissions* performance measure rate.

## Comparative Results for ALTCS Contractors—CYE 2015

### Findings

Table 7-4 presents the aggregate performance measure rates for all ALTCS Contractors. The table displays CYE 2014 performance; CYE 2015 performance; the relative percentage change between the CYE 2014 and CYE 2015 rates; the statistical significance of the relative percentage change; and the AHCCCS MPS, when applicable.

**Table 7-4—Performance Measurement Review for ALTCS Contractors**

| Performance Measure   | CYE 2014 Performance | CYE 2015 Performance | Relative Percentage Change | Significance Level (p value) <sup>1</sup> | Minimum Performance Standard |
|---|----------------------|----------------------|----------------------------|---|------------------------------|
| <b>Adults' Access to Preventive/Ambulatory Health Services</b>                                  |                      |                      |                            |   |                              |
| Adults' Access to Preventive/Ambulatory Health Services   | —                    | 90.5%                | —                          | —   | 75.0%                        |
| <b>Ambulatory Care (per 1,000 Member Months)<sup>2</sup></b>                                    |                      |                      |                            |   |                              |
| ED Visits—Total   | 63                   | 68                   | —                          | —   | —                            |
| <b>COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)<sup>2</sup></b>    |                      |                      |                            |   |                              |
| COPD or Asthma in Older Adults Admission Rate   | 110.8                | 106.2                | —                          | —   | —                            |
| <b>Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)<sup>2</sup></b> |                      |                      |                            |   |                              |
| Diabetes Short-Term Complications Admission Rate  | 14.2                 | 11.6                 | —                          | —   | —                            |
| <b>Heart Failure Admission Rate (per 100,000 Member Months)<sup>2</sup></b>                     |                      |                      |                            |   |                              |
| Heart Failure Admission Rate  | 96.1                 | 122.4                | —                          | —   | —                            |
| <b>Plan All-Cause Readmissions<sup>2</sup></b>  |                      |                      |                            |   |                              |
| Total   | 15.5%                | 13.7%                | -11.8%                     | <b>P=.006</b>                             | —                            |

<sup>1</sup> Significance levels (p values) noted in the table were calculated by AHCCCS and HSAG and demonstrate whether the differences in performance between CYE 2014 and CYE 2015 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤ 0.05. Significance levels (p-values) in bold font indicate statistically significant values.

<sup>2</sup> A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance. — Indicates either that comparison of performance between CYE 2014 and CYE 2015 is not appropriate or that an MPS has not yet been established by AHCCCS.

## **CAPs**

No discussion of CAPs is included in the report for CYE 2015 data.

## **Strengths**

The ALTCS Contractors' aggregate performance measure rate exceeded the CYE 2015 MPS for the *Adults' Access to Preventive/Ambulatory Health Services* measure by 15.5 percentage points. Additionally, as a lower rate indicates better performance for this measure, the *Plan All-Cause Readmissions* performance measure rate demonstrated statistically significant improvement from CYE 2014 to CYE 2015.

## **Opportunities for Improvement**

No opportunities for improvement were identified as the only performance measure rate compared to an MPS exceeded that MPS for CYE 2015.

## **Summary**

The performance measure rate for the *Adults' Access to Preventive/Ambulatory Health Services* measure exceeded the MPS by more than 15 percentage points for the ALTCS Contractors.

Five performance measure rates reported by the ALTCS Contractors do not have a CYE 2015 MPS; therefore, the rates were not compared to an MPS. Even though an MPS has not been established for some measures, the Contractors should monitor the performance of these rates.

## **DES/DDD Results**

DES/DDD has contracted with AHCCCS since 1989.

## **Findings**

Table 7-5 presents the performance measure rates for DES/DDD. The table displays CYE 2014 performance; CYE 2015 performance; the relative percentage change between the CYE 2014 and CYE 2015 rates; the statistical significance of the relative percentage change; and the AHCCCS MPS, when applicable.

Table 7-5—Performance Measurement Review for DES/DDD

| Performance Measure   | CYE 2014 Performance | CYE 2015 Performance | Relative Percentage Change | Significance Level ( $p$ value) <sup>1</sup> | Minimum Performance Standard |
|---|----------------------|----------------------|----------------------------|--|------------------------------|
| <b>Adolescent Well-Care Visits</b>  |                      |                      |                            |  |                              |
| Adolescent Well-Care Visits   | 35.8%                | 39.8%                | 11.4%                      | <b>P&lt;.001</b>                             | 41.0%                        |
| <b>Adults' Access to Preventive/Ambulatory Health Services</b>                                  |                      |                      |                            |  |                              |
| Adults' Access to Preventive/Ambulatory Health Services   | —                    | 85.2%                | —                          | —  | 75.0%                        |
| <b>Ambulatory Care (per 1,000 Member Months)<sup>3</sup></b>                                    |                      |                      |                            |  |                              |
| ED Visits—Total   | 41                   | 44                   | —                          | —  | —                            |
| <b>Annual Dental Visits<sup>2</sup></b>   |                      |                      |                            |  |                              |
| 2–20 Years  | 52.9%                | 55.7%                | 5.3%                       | <b>P&lt;.001</b>                             | 60.0%                        |
| <b>Breast Cancer Screening</b>  |                      |                      |                            |  |                              |
| Breast Cancer Screening   | —                    | 45.1%                | —                          | —  | 50.0%                        |
| <b>Cervical Cancer Screening</b>  |                      |                      |                            |  |                              |
| Cervical Cancer Screening   | —                    | 18.0%                | —                          | —  | 64.0%                        |
| <b>Children and Adolescents' Access to Primary Care Practitioners</b>                           |                      |                      |                            |  |                              |
| 12–24 Months  | 93.4%                | 98.3%                | 5.3%                       | P=.228                                       | 93.0%                        |
| 25 Months–6 Years   | 86.6%                | 90.1%                | 4.0%                       | <b>P&lt;.001</b>                             | 84.0%                        |
| 7–11 Years  | 90.1%                | 91.1%                | 1.1%                       | P=.114                                       | 83.0%                        |
| 12–19 Years   | 87.3%                | 88.4%                | 1.2%                       | P=.087                                       | 82.0%                        |
| <b>COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)<sup>3</sup></b>    |                      |                      |                            |  |                              |
| COPD or Asthma in Older Adults Admission Rate   | 8.3                  | 12.0                 | —                          | —  | —                            |
| <b>Chlamydia Screening in Women</b>   |                      |                      |                            |  |                              |
| Total   | —                    | 8.3%                 | —                          | —  | 63.0%                        |
| <b>Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)<sup>3</sup></b> |                      |                      |                            |  |                              |
| Diabetes Short-Term Complications Admission Rate  | 5.3                  | 3.2                  | —                          | —  | —                            |
| <b>Follow-Up After Hospitalization</b>  |                      |                      |                            |  |                              |
| 7-Day Follow-Up   | —                    | 37.8%                | —                          | —  | 50.0%                        |
| 30-Day Follow-Up  | —                    | 75.5%                | —                          | —  | 70.0%                        |
| <b>Heart Failure Admission Rate (per 100,000 Member Months)<sup>3</sup></b>                     |                      |                      |                            |  |                              |
| Heart Failure Admission Rate  | 4.0                  | 3.8                  | —                          | —  | —                            |
| <b>Plan All-Cause Readmissions<sup>3</sup></b>  |                      |                      |                            |  |                              |
| Total   | 11.5%                | 9.2%                 | -19.6%                     | P=.083                                       | —                            |

| Performance Measure   | CYE 2014 Performance | CYE 2015 Performance | Relative Percentage Change | Significance Level (p value) <sup>1</sup> | Minimum Performance Standard |
|---|----------------------|----------------------|----------------------------|---|------------------------------|
| <b>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</b> |                      |                      |                            |   |                              |
| <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i> | 48.0%                | 52.1%                | 8.5%                       | <b>P=.002</b>                             | 66.0%                        |

<sup>1</sup> Significance levels (p values) noted in the table were calculated by AHCCCS and HSAG and demonstrate whether the differences in performance between CYE 2014 and CYE 2015 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤ 0.05. Significance levels (p-values) in bold font indicate statistically significant values.

<sup>2</sup> Due to measure specification changes, exercise caution when comparing CYE 2015 performance measure rates for this measure to prior years' rates.

<sup>3</sup> A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance.

— Indicates either that the Contractor was not required to report the measure, that an MPS has not yet been established by AHCCCS, or that comparison of performance between CYE 2014 and CYE 2015 is not appropriate.

## CAPs

No discussion of CAPs is included in the report for CYE 2015 data.

## Strengths

DES/DDD exceeded the MPS for six of 13 performance measure rates (*Adults' Access to Preventive/Ambulatory Health Services; Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years; and Follow-Up After Hospitalization—30-Day Follow-Up*) with an MPS for CYE 2015. Of note, the performance measure rate for *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* also showed a statistically significant increase from CYE 2014 to CYE 2015.

## Opportunities for Improvement

Even though *Adolescent Well-Care Visits; Annual Dental Visits—2–20 Years; and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* demonstrated significant improvement from CYE 2014 to CYE 2015, these three performance measure rates fell below the corresponding established MPSs. Of note, the *Breast Cancer Screening, Cervical Cancer Screening, and Chlamydia Screening in Women—Total* performance measure rates performed below the respective MPSs for CYE 2015 by 4.9 percentage points, 46.0 percentage points, and 54.7 percentage points, respectively. In addition, the performance measure rate for the *Follow-Up After Hospitalization—7-Day Follow-Up* fell more than 12 percentage points below the established MPS.

## Summary

Six measure rates (*Adults' Access to Preventive/Ambulatory Health Services; Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years; and Follow-Up After Hospitalization—30-Day Follow-Up*) exceeded the established MPS for CYE 2015, while seven measure rates (*Adolescent Well-Care Visits; Annual Dental Visits—2–20 Years; Breast Cancer Screening; Cervical Cancer Screening; Chlamydia Screening in Women—Total; Follow-Up After Hospitalization—7-Day Follow-Up; and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) did not meet the MPSs. Further, four of these performance measure rates fell below the corresponding MPSs by more than 10 percentage points, suggesting that DES/DDD has opportunities to improve in women's screenings, well-child visits, and follow-up after hospitalization.

## 8. Performance Improvement Project Performance

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

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

42 CFR §438.330(d)(3) also requires each Contractor to report the status and results of each PIP not less than once per year.

### 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.
- Consider comprehensive aspects of 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 CYE 2015 qualitative analyses and 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.<sup>8-1</sup> 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 assists 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 the percentage of prescriptions submitted electronically, to improve patient safety. AHCCCS' goal is to demonstrate a statistically significant increase in the number of providers submitting prescriptions electronically and the number of prescriptions submitted electronically, followed by sustained improvement for one year.

### **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 system-wide 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.

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

- 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 as necessary. 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 their planned changes to interventions to AHCCCS.

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.<sup>8-2</sup> 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.

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

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<sup>8-2</sup> 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: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf> Accessed on September 21, 2017.

## Contractor-Specific Results

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

During CYE 2015, the *E-Prescribing* PIP was in its intervention phase. Baseline data were used to assist AHCCCS Contractors to identify and/or to implement strategies for increasing the number of providers ordering prescriptions electronically and for increasing the percentage of prescriptions submitted electronically. It is expected that Contractor, provider, and member education efforts during the intervention phase will result in rate increases for Indicators 1 and 2.

The following section includes Contractors' PIP qualitative analyses and interventions as submitted to AHCCCS for CYE 2015 (October 1, 2014, through September 30, 2015.) HSAG has made minimal edits to the analyses and interventions for grammar and punctuation.

### *Bridgeway Health Solutions (BWY)*

BWY submitted the following qualitative analysis:

- Since electronic prescribing began, the long-term care sector has lagged in terms of adoption and use of this technology. When electronic prescribing was added to the meaningful-use incentive created by CMS, the long-term care sector was excluded from this mandate and any subsequent grants to adopt the new technology. Additionally, the addition, for members requiring long-term care, to live outside of skilled nursing facilities exacerbated the fragmentation that already existed related to services in the sector.
- The largest barrier that providers face in the adoption of electronic prescribing technology in the long-term care sector is being mobile and relying on the facility or parent company to provide them with electronic prescribing tools. Although some facilities are large national providers, most are independently owned by small business providers that cannot afford the upgrade in medical record systems that would allow electronic prescribing. Only in the last year has Point Click Care, the largest provider of electronic medical records for long-term care facilities in Arizona, added the functionality of electronic prescribing to their system. At this time the cost for installation of the system is approximately \$50,000, which is cost prohibitive for most facility owners. An option of obtaining a stand-alone electronic prescribing system does exist. While this reduces the costs associated with e-prescribing, the system would not be integrated into the medical record; therefore, the provider would necessarily record two sets of data entry. This option doubles the work for the provider and adds the burden of checking another system every time a refill or new prescription is needed.

- As part of BWY's efforts to understand and overcome barriers to electronic prescribing in long-term care, the plan has held multiple education events with its largest providers and with the Arizona Health Care Association. BWY has discussed the current workflow process for physicians with Independent Pharmacy Cooperative (IPC) and with nurse practitioners through Optum and Pop Health to see if using an electronic prescribing system would be feasible. Finally, BWY purchased its own stand-alone electronic prescribing system through MD Toolbox and gave access to 15 nurse practitioners who see BWY members in the community. This initiative has resulted in a 5 percent increase in electronic prescribing for BWY members within three months of initiation.
- BWY stated that many challenges in the adoption of electronic prescribing in long-term care remain. Each facility type, from assisted living to skilled nursing facility, has different rules for prescribing and medical recordkeeping of prescriptions. This use of multiple systems makes it difficult for a provider who operates in multiple venues to use electronic prescribing. Some slow gains are being made nationally, which will ultimately improve electronic prescribing in this sector. In 2016 several providers of long-term care medical record systems added electronic prescribing to their systems. As this market grows, the price should come down, making the adoption of e-prescribing more available for all facilities and providers. In talks with national provider groups such as IPC, Optum, Ensign, and Lifecare BWY learned that all are in process of creating individual electronic prescribing systems to integrate with their internal medical records. BWY will continue to look for short-term solutions and to educate providers until more cost-effective options are available.

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

- Reviewed 2015 survey results as part of the Arizona Alliance of Health Plans (AzAHP) E-Rx Workgroup formed with other AHCCCS Contractors and developed goals for 2016. One survey asked providers to identify contributing factors to e-prescribing rates to identify best practices or barriers, while another asked Arizona EHR vendors to determine system capabilities for e-prescribing controlled substances.
- Began coordinating with Health Net quality department to integrate education materials and initiatives for electronic prescribing PIP and co-branded current education flyers with both health plan logos and information.
- Purchased a stand-alone electronic prescribing module that can be given to contracted prescribers to use when writing new prescriptions for BWY members.
- Performed analysis to identify the top 20 prescribers that fax prescriptions to pharmacies and do not use electronic prescribing, with the goal of enrolling all 20 prescribers to use the stand-alone system to send new prescriptions electronically.

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

MCP-LTC submitted the following qualitative analysis:

- A survey of providers was conducted by all health plans in the Arizona Association of Health Plans. The findings were as follows:

- Almost all providers surveyed by MCP-LTC have an electronic health record (EHR).
- Barriers identified by MCP-LTC:
  - Prescriptions written in a hospital setting rather than in a clinic, did not allow for providers to use e-prescribing software.
  - Lack of understanding exists about the ability to use e-prescribing for all prescriptions, including controlled substances.
  - Belief exists that prescriptions are submitted electronically when, in reality, the prescription is submitted into an EHR, then converted to a fax or paper script.
  - Additional cost is assessed to the practice to add to the practice’s EHR system the ability to e-prescribe.
  - EHR system limitations exist—multiple providers reported that their EHR systems did not allow e-prescribing of narcotics.
  - Providers reported that pharmacies rejected any controlled substances e-prescribed, indicating it was “illegal” to e-prescribe as an original signature is required on the script.
  - A practice was told that to be able to e-prescribe they would need to add a fingerprinting security system to their current EHR, which could be costly and time-consuming for the practice.
  - Usually, a two-day delay exists for pharmacies to process and dispense prescriptions for members if those prescriptions are submitted electronically, which may cause an issue if the medication is needed urgently or emergently.
  - Providers that have e-prescribed controlled medications reported the process to be difficult, including the requirement of having a different password and a key tag to facilitate a revolving identification.
- Additional costs exist to add the ability to e-prescribe controlled substances to MCP-LTC’s EHR.
- Barriers identified by other Contractors:
  - EHR system glitches sometimes caused electronic prescription transmission errors.
  - Provider preference for writing prescriptions and physicians’ preference to hand prescriptions to members exist.
  - System limitations exist related to e-prescribing.
  - Difficulty was expressed related to pharmacies accepting prescriptions electronically, specifically in rural areas.
  - 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.

As noted in The National Center for Biotechnology Information article "Electronic Prescribing: Improving the Efficiency and Accuracy of Prescribing in the Ambulatory Care Setting" published April 1, 2014,<sup>8-3</sup> "Results of this research study suggest that e-prescribing reduces prescribing errors, increases efficiency, and helps to save on healthcare costs. Medication errors have been reduced to as little as a seventh of their previous level, and cost savings due to improved patient outcomes and decreased patient visits are estimated to be between \$140 billion and \$240 billion over 10 years for practices that implement e-prescribing. However, there have been significant barriers to implementation including cost, lack of provider support, patient privacy, system errors, and legal issues." This research also identified the following barriers to implementation of e-prescribing:

- Cost of implementing an e-prescribing system—per the research, more than 80 percent of primary care providers report a lack of financial support necessary for implementation, training, and IT support for installation and maintenance of an e-prescribing system.
- E-prescribing system errors—system errors include:
  - System alerts which lack specificity and/or are produced excessively. This may lead to "alert fatigue," in which prescribers tend to stop reading the alerts and just quickly scroll through them. This may cause significant system alerts to be ignored.
  - Hardware problems.
  - Workflow issues.
  - Software problems.
  - Other problems such as cost, time consumption, and connection issues.
- Privacy and legal issues
  - Potential exists for patient information to be leaked from a web-based EHR system as proper firewalls and intrusion prevention systems are not in place.
  - E-prescribing controlled substances has the potential to cause legal issues. Although the Drug Enforcement Agency (DEA) made a final ruling on e-prescribing of controlled substances in 2010, there are many standards contained in the ruling including:
    - Identity proofing.
    - Two-factor authentication.
    - Digital certificates.
    - Monthly logs.
    - Third-party software audits.
    - Requirement to keep two years of records.

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<sup>8-3</sup> Porterfield A, Engelbert K, Coustasse A. Electronic prescribing: improving the efficiency and accuracy of prescribing in the ambulatory care setting. *Perspectives in Health Information Management*, 2014 Apr 1;11:1g.

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

- Developed, along with other members of the Arizona Association of Health Plans, a fact sheet for providers on the topic of EPCS.
- Conducted on-site visits and distribution of the EPCS fact sheet; the visits were conducted by an MCP-LTC medical director and provider relations staff.
- Targeted review/outreach to larger practices to show variances across providers.
- Incentivized e-prescribing with patient-centered medical homes (PCMHs) and Arizona Care Network (ACN). Improvements in e-prescribing will be one of MCP-LTC's performance measures 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 via the MCP-LTC website and/or Facebook posts.
- Developed and posted a provider toolkit to educate providers on the benefits and value of e-prescribing.
- Worked with CVS to send a fax blast to pharmacies reminding them of the importance of accurately reporting controlled substances prescription monitoring program (CSPMP) data.

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

UHCCP-LTC submitted the following qualitative analysis:

- An e-prescribing workgroup was formed with other Arizona Contractors. The workgroup first discussed barriers to adoption of e-prescribing. The group surveyed providers on their perceived barriers to e-prescribing. As several providers stated that their systems would not support EPCS, a survey of EMR vendors was initiated. From these activities were identified the need for further education on e-prescribing (including EPCS), the need to evaluate the ability for current EMR systems to support ECPS, and the identification and ranking of providers e-prescribing.

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

- Produced a report that ranked providers with the greatest volume of prescriptions and the lowest e-prescribing rates for intervention.
- Incorporated e-prescribing presentations and information into provider forums.
- Performed outreach to prescribers with low e-prescribing rates.



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

DES/DDD submitted the following qualitative analysis.

The provider survey conducted by AzAHP notes the following barriers identified by the provider respondents:

- Cost of implementing an e-prescribing system.
- Provider's EMR system did not support e-prescribing controlled substances.
- Providers preferred to "hand" a prescription to the member.
- E-prescribing systems errors on provider and pharmacy side.
- Privacy and legal issues were cited as concerns.

DES/DDD's review of the literature, including a mixed method study regarding e-prescribing and patient safety; a community pharmacy workflow study; a patient interview study; and anecdotal cases involving members, providers, and/or caregivers noted the following:

- Pharmacies experience inaccurate and/or delayed e-prescriptions from provider offices. Overwhelming numbers of unclear and delayed e-prescriptions necessitated time-consuming processes to rectify the errors.
- Though the ability to receive e-prescriptions was in place, there appeared to be a disconnect between existing pharmacy workflow and the type of workflow needed to support e-prescribing.<sup>8-4</sup>
- Patients/members perceived a loss of control in the medication use process.
- Patients/members perceived a reduced opportunity to communicate with prescribers and pharmacists regarding their medications.
- Patients/members may need to be better engaged and/or educated, particularly at the point of prescribing.<sup>8-5</sup>

Anecdotally, many residential settings which serve the members of DES/DDD tend to receive faxed prescriptions which may be generated electronically from the provider's office but do not meet the criteria of a true e-prescription. The literature does support that long-term care providers have historically used, and continue today, to use faxed prescriptions. These faxes also serve as copies for member records.

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<sup>8-4</sup> Odukoya OK, Chui, MA. Relationship between e-prescriptions and community pharmacy workflow. *J Am Pharm Assoc.* 2012; 52: e168-74. Doi: 10.1331/JAPhA.2012.12066.

<sup>8-5</sup> Frail CK, Kline M, Snyder ME. Patient perceptions of e-prescribing and its impact on their relationships with providers: A qualitative analysis. *J AM Pharm Assoc.* 2014; 54:630-633.

- DES/DDD concludes that their contracted providers for residential services, including those providing home-based services, could benefit from education on e-prescribing processes and the potential benefits to them and the members that they serve.

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

- Educated members about e-prescribing in the member newsletter in Spanish and English. Some DES/DDD contracted health plans have begun member education.
- Provided education (regarding the benefits of e-prescribing) to residential and home-based services providers at the quarterly provider meetings around the State.
- Worked with contracted health plans to target high-volume providers for education surrounding e-prescribing. Incorporated e-prescribing education and information at provider forums and engagement meetings as well as in provider newsletters and other communications. All three contracted health plans committed to this education, and DES/DDD continues to monitor compliance.
- Incorporated e-prescribing into PCMH and quality improvement partnership agreements.
- Reported rankings of provider e-prescribing rates.
- Incorporated e-prescribing as a measure under Arizona Care Network targets for 2015 with rewards and incentives based on actual practice performance.
- Began quarterly data sharing for e-prescribing rates to practices.
- Developed member educational materials to communicate the benefits of e-prescribing via the website and/or Facebook posts.
- Developed and posted a provider toolkit to educate providers on the benefits and value of e-prescribing.
- Worked with CVS to send a fax blast to pharmacies reminding of the importance of accurately reporting CSPMP data.
- Sent fax blasts to providers reinforcing the legality of e-prescribing controlled substances, listing the benefits of e-prescribing, and outlining steps to get started on EPCS; the same blast fax was used multiple times to reinforce provider/staff education through consistent messaging.
- Developed an e-prescribe education and outreach program strategy through the workgroup to improve the adoption and use of e-prescribing among the AHCCCS Acute, Long Term Care, and Behavioral Health provider networks and to assist providers in advancing through the Meaningful Use stages.
- Mined data with the assistance of AHCCCS to determine changes (compared to data mining completed in 2015) and identified opportunities for further improvement (high-volume prescribers with low rates of e-prescribing, including EPCS).
- Developed physician education flyer for use by all AHCCCS health plans through the workgroup.