

Arizona Health Care Cost Containment System



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

**Acute Care and Comprehensive  
Medical and Dental Program**

*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 annual EQR technical report. This report presents AHCCCS' findings from conducting each activity as well as HSAG's analysis and assessment of the reported results for each Contractor's performance and, as applicable, recommendations to improve Contractors' performance.

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

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

- Section 2—An overview of the history of the AHCCCS program.
- Section 3—A description of the contract year ending (CYE) 2015 and CYE 2016 EQR activities.

- Section 4—An overview of AHCCCS’ statewide quality initiatives across its Medicaid managed care program and those that are specific to the Acute Care program for CYE 2016.
- Section 5—An overview of the Contractors’ best and emerging practices for CYE 2016.
- Section 6 (Organizational Assessment and Structure Performance)—An overview of the AHCCCS methodology for the organizational review (OR) and a presentation of Contractor-specific OR results as well as HSAG’s associated findings and recommendations. For this annual report, AHCCCS provided data and information for three Contractors for CYE 2016.
- Section 7 (Performance Measure Performance)—A presentation of rates for AHCCCS-selected performance measures for each Acute Care and Comprehensive Medical and Dental Program (CMDP) Contractor as well as HSAG’s associated findings and recommendations for CYE 2015.
- Section 8 (Performance Improvement Project Performance)—A presentation of Contractor-specific PIP qualitative analyses and interventions for the Acute Care Contractors and CMDP for CYE 2015.

## Overview of the CYE 2016 External Review

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

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

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

## 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 three Contractors—MCP, PHP, and CMDP—during CYE 2016. Based on the review period for this annual report, the remainder of the Contractors had not yet undergone their scheduled ORs. However, between CYE 2016 and CYE 2017, AHCCCS monitored the progress of all Contractors in implementing their CAPs for the recommendations from the 2016 OR.

The CYE 2016 OR was organized into 11 standard areas. For the Acute Care Contractors, each standard area consisted of several elements designed to measure the Contractor's performance and compliance. The following 11 standard areas and coinciding numbers of elements are used throughout the report:

- 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; Early and Periodic Screening, Diagnostic and Treatment (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

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 acute 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 includes details for each Contractor’s performance related to the standards measured in the OR. Based on the data, and considering that each of the 11 standards contained numerous elements, HSAG conducted an analysis of the scores for each standard area.

The following table summarizes outcomes of the reviews conducted by AHCCCS related to the three Contractors’ scores in the 11 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.

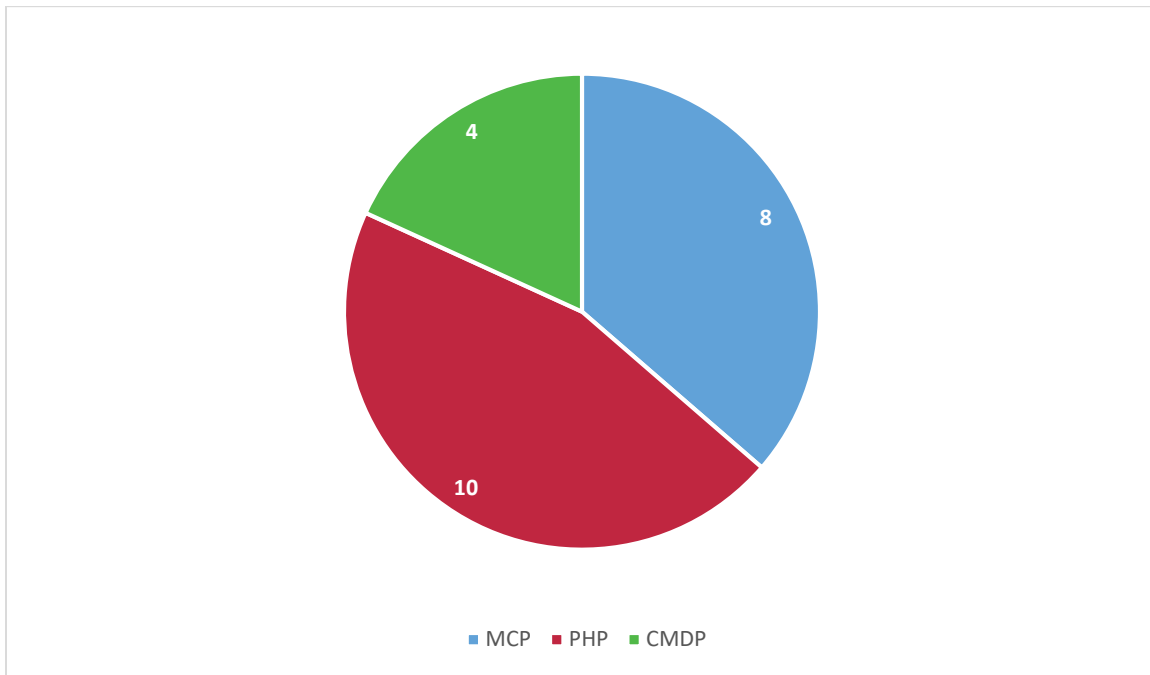
**Table 1-1—Score and CAP Summary per Standard Area**

Standard Area	Total Scores 95% and Above	Total Scores Below 95%	Required Corrective Actions
Corporate Compliance	1	2	5
Claims and Information Systems	1	2	9
Delivery Systems	2	1	5
General Administration	2	1	1
Grievance Systems	3	0	4
Adult, EPSDT, and Maternal Child Health	2	1	5
Medical Management	2	1	9
Member Information	3	0	2
Quality Management	2	1	12
Reinsurance	2	1	1
Third-Party Liability	2	1	2
<b>Combined Totals</b>	<b>22</b>	<b>11</b>	<b>55</b>

Standards with greatest opportunity for improvement, based on the number of CAPs required, were QM, CIS, and MM. Standards requiring the fewest CAPs were GA and RI. Even though for QM two of three Contractors scored above 95 percent, AHCCCS required 12 CAPs. The strongest performances were in GS and MI. For each of the CC and CIS standards, two Contractors scored below 95 percent.

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 PHP, 10 of 11 standard areas demonstrated scores of 95 percent and above. PHP had the highest number of standard areas at or above 95 percent, compared to the other two Contractors. Only for CIS did PHP not achieve a score of 95 percent or above. MCP demonstrated the second highest number of standard areas scored at 95 percent and above, with 8 of 11 standards. CMDP had four of 11 standard areas scored at or above 95 percent, the lowest number of standard areas at 95 percent and above compared to the other two contractors.

**Conclusions**

For the CYE 2016 AHCCCS OR, two of the three Contractors demonstrated overall positive results. All Contractors scored at or above 95 percent in the GS and MI standards; and two of three Contractors scored at or above 95 percent in the DS, GA, MCH, QM, MM, RI, and TPL standard areas. The two standard areas for which most Contractors scored below 95 percent were the CC and CIS standards.

## Recommendations

Based on AHCCCS' review of the Acute Care and CMDP 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, that they are in 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 procedures.
- Contractors should apply lessons learned from improving performance for one category of standards to other categories. Specifically, Contractors can learn from earlier completed CAPs as identified in previous ORs to determine best practices specific to their 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: QM, CIS, and MM. AHCCCS should specifically consider the CIS standard as this is the standard for which two of three Contractors scored under 95 percent and the standard with the second highest number of related CAPs.

## Performance Measures

### Comparative Results for Acute Care Contractors—CYE 2015

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 10 measure rates for the Acute Care Contractors and nine measure rates for CMDP. The tables following 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 established MPSs are found in the “Performance Measure Performance” section of this report.

### Findings

Table 1-2 presents the following information for each measure indicator for the aggregate of the eight Acute Care 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.

**Table 1-2—Acute Care Contractors—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> <sup>2</sup>					
<i>Adolescent Well-Care Visits</i>	40.7%	39.9%	-2.1%	<b>P&lt;.001</b>	41.0%
<b><i>Annual Dental Visits</i></b> <sup>2,3</sup>					
<i>2–20 Years</i>	63.5%	63.7%	0.3%	P=.094	60.0%
<b><i>Children and Adolescents’ Access to Primary Care Practitioners</i></b>					
<i>12–24 Months</i> <sup>2</sup>	97.1%	95.1%	-2.1%	<b>P&lt;.001</b>	93.0%
<i>25 Months–6 Years</i> <sup>2</sup>	88.5%	87.7%	-0.9%	<b>P&lt;.001</b>	84.0%
<i>7–11 Years</i>	92.4%	91.5%	-1.0%	<b>P&lt;.001</b>	83.0%
<i>12–19 Years</i>	90.1%	89.3%	-0.9%	<b>P&lt;.001</b>	82.0%
<b><i>Well-Child Visits in the First 15 Months of Life</i></b>					
<i>Six or More Well-Child Visits</i>	71.5%	62.1%	-13.1%	<b>P&lt;.001</b>	65.0%
<b><i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i></b> <sup>2</sup>					
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	64.9%	64.6%	-0.6%	P=.067	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 a Medicaid expansion for the Acute Care Contractors in CYE 2015, exercise caution when comparing CYE 2015 performance measure rates to historical performance measure rates (e.g., CYE 2014).

<sup>3</sup> Due to measure specification changes, exercise caution when comparing CYE 2015 performance measure rates for this measure to prior years’ rates.

As seen in Table 1-2, a statistically significant decrease was demonstrated by the Acute Care Contractors for six of the eight performance measure rates (*Adolescent Well-Care Visits; Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years; and Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*). No measures demonstrated statistically significant improvement in performance from CYE 2014 to CYE 2015. Five of the eight measure rates (*Annual Dental Visits—2–20 Years; and Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years*) met or exceeded the MPSs for CYE 2015. The four *Children and Adolescents’ Access to Primary Care Practitioners* measure rates exceeded the MPSs despite statistically significant declines in performance from CYE 2014 to CYE 2015.

**Conclusions**

The Acute Care Contractors showed low performance for the *Adolescent Well-Care Visits* and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* measure rates, with both rates having statistically significant declines in performance and falling below the MPSs. Acute Care Contractors displayed high performance for the *Annual Dental Visits—2–20 Years* measure rate, which exceeded the MPS and increased from CYE 2014 to CYE 2015, though the increase was not statistically significant.

**Recommendations**

With three measure rates (*Adolescent Well-Care Visits*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) falling below the established MPSs for CYE 2015, the Acute Care Contractors have opportunities for improvement.

HSAG recommends that the Acute Care Contractors focus efforts on increasing well-care visits for children and adolescents. Results of these focused efforts should be used to identify strategies that can be applied to drive improvement for other performance measures.

**Comprehensive Medical and Dental Program (CMDP)**

**Findings**

Table 1-3 presents performance measure rates for CMDP. The table displays the following information for each measure: 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.

**Table 1-3—CMDP—Performance Measurement Results**

Performance Measure	CYE 2014 Performance	CYE 2015 Performance	Relative Percentage Change	Significance Level (p value) <sup>1</sup>	Minimum Performance Standard
<b><i>Adolescent Well-Care Visits</i><sup>2</sup></b>					
<i>Adolescent Well-Care Visits</i>	68.2%	64.3%	-5.8%	<b>P=.005</b>	41.0%
<b><i>Annual Dental Visits</i><sup>2,3</sup></b>					
<i>2–20 Years</i>	78.8%	68.3%	-13.3%	<b>P&lt;.001</b>	65.0%
<b><i>Children and Adolescents’ Access to Primary Care Practitioners</i></b>					
<i>12–24 Months</i> <sup>2</sup>	98.7%	99.0%	0.3%	P=.621	93.0%
<i>25 Months–6 Years</i> <sup>2</sup>	93.8%	93.0%	-0.8%	P=.244	84.0%
<i>7–11 Years</i>	96.9%	94.3%	-2.7%	<b>P=.013</b>	83.0%
<i>12–19 Years</i>	96.4%	96.1%	-0.3%	P=.713	82.0%
<b><i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i><sup>2</sup></b>					

Performance Measure	CYE 2014 Performance	CYE 2015 Performance	Relative Percentage Change	Significance Level (p value) <sup>1</sup>	Minimum Performance Standard
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	71.8%	69.8%	-2.8%	P=.163	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 a Medicaid expansion for the Acute Care Contractors in CYE 2015, exercise caution when comparing CYE 2015 performance measure rates to historical performance measure rates (e.g., CYE 2014).

<sup>3</sup> Due to measure specification changes, exercise caution when comparing CYE 2015 performance measure rates for this measure to prior years' rates.

As seen in Table 1-3, a statistically significant decrease was demonstrated by CMDP for three measure rates (*Adolescent Well-Care Visits; Annual Dental Visits—2–20 Years; and Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*). No measures demonstrated statistically significant improvement in performance from CYE 2014 to CYE 2015. Further, all seven measure rates exceeded the established MPSs for CYE 2015.

### Conclusions

CMDP demonstrated strength in the *Children and Adolescents' Access to Primary Care Practitioners* performance measure rates, with all four measure rates exceeding its corresponding MPS by more than 5 percentage points. CMDP demonstrated an opportunity for improvement for the *Annual Dental Visits—2–20 Years* measure rate, which still exceeded the MPS despite a statistically significant decline in performance of over 13 percent.

### Recommendations

Following the CYE 2015 performance measurement period, with the rates for three measures (*Adolescent Well-Care Visits; Annual Dental Visits—2–20 Years; and Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*) demonstrating statistically significant declines in performance, CMDP has opportunity for improvement. HSAG recommends that CMDP focus efforts on increasing well-care visits and dental visits. Results of these focused efforts should be used to identify strategies that can be translated and applied to drive improvement for other performance measures. HSAG also recommends that AHCCCS re-evaluate the MPSs for the CMDP populations, as the MPSs are similar to those used for the Acute Care Contractors, despite the differences in the CMDP population.

### 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). 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 indicated 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.

### Summary of Interventions

This was the intervention reporting period for the *E-Prescribing* PIP; therefore, AHCCCS requested that HSAG include only qualitative analyses and interventions in this annual report. Remeasurement 1 period rates will be included in the CYE 2017 annual report. Following is a summary of the reported interventions employed by various Contractors in CYE 2015.

- Explored funding sources to assist selected providers with technical upgrades/other fees to have e-prescribing functionality.
- Initiated an e-prescribing subcommittee.
- Participated in the Arizona Alliance of Health Plans (AzAHP) e-prescribing workgroup.
- Collaborated with Pharmacy Services to distribute an AzAHP e-prescribing workgroup educational flyer to contracted providers. 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.
- Developed member educational materials to communicate the benefits of e-prescribing.
- Incorporated e-prescribing into a pay-for-performance (P4P) payment model.
- Educated prescribers on advantages of e-prescribing and offered assistance connecting with e-prescribing vendors.
- Incorporated e-prescribing presentations and information into provider forums.

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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.

- Administered a provider survey to identify and analyze obstacles that providers experience related to implementing or using 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 OR. All Contractors scored at or above the 95 percent compliance threshold for all standards, excepting one Contractor who scored below the 95 percent compliance threshold for only one standard. Overall, the Acute Care Contractors' performance measure rates related to quality, including *Adolescent Well-Care Visits* and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*, demonstrated statistically significant declines in performance from CYE 2014 to CYE 2015. As a result, these performance measure rates are either now falling below the MPSs or continuing to fall below the MPSs. For CMDP, the performance measure rates demonstrate overall positive performance, with all performance measure rates performing above the related MPSs. AHCCCS has selected a new PIP, *E-Prescribing*, for all lines of business which, to increase patient safety, measures the number of providers who 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 three Contractors (MCP, PHP, and CMDP) during CYE 2016, reviewing 11 standards for each Contractor. Additionally, in CYE 2016 AHCCCS monitored the progress of the remaining Contractors in implementing their CAPs for the recommendations from the 2015 OR.

Overall results for all three Contractors for CYE 2016 were positive. All Contractors scored fully compliant for the MI and the GS standards. For the MI standard, MCP and PHP obtained 100 percent and CMDP obtained 95 percent. For the GS standard, CMDP received a 100 percent score, MCP received 99 percent, and PHP scored 95 percent. Two of the three Contractors, MCP and PHP, had five standards scored at full compliance with 100 percent. One Contractor, PHP, had seven standards in full compliance, with 100 percent scores. One Contractor, PHP, had only one standard below the 95 percent compliance threshold.

The standards that required the most corrective actions were Quality Management (12 CAPs), Claims and Information Systems (nine CAPs), and Medical Management (nine CAPs). The standards with the least number of corrective actions were General Administration (one CAP), Reinsurance (one CAP), Member Information (two CAPs), and Third-Party Liability (two CAPs).



## Performance Measures

Overall, performance for the Acute Care and CMDP Contractors varied across the areas of quality and access. The Acute Care Contractors' measure rates for the quality area indicated opportunities for improvement, with three measure rates (*Adolescent Well-Care Visits*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) falling below the MPSs. The Acute Care Contractors demonstrated positive performance in the access area, exceeding the CYE 2015 MPSs for the *Annual Dental Visits—2–20 Years* and the *Children and Adolescents' Access to Primary Care Practitioners* measure rate indicators.

Compared to the CYE 2015 MPSs, CMDP's performance in the quality and access areas indicated strength as all seven reportable measure rates (*Adolescent Well-Care Visits*; *Annual Dental Visits—2–20 Years*; *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) exceeded the established MPSs.

There were no performance measure rates related to timeliness; therefore, this area was not discussed.

## 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, Acute Care and CMDP Contractors made improvements in the timeliness of, access to, and quality of care they provide to Medicaid members. While several opportunities for improvement are highlighted throughout the report, those opportunities for improvement and the associated recommendations should not detract from the targeted progress made by each Acute Care and /CMDP 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.

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 toward increasing integration in the healthcare system and has already

resulted in beneficial outcomes and forward-thinking policy decisions which factor in care for both the mental and physical health of individuals.

## 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.

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 towards a financially sustainable healthcare delivery system, which rewards high quality care provided at an affordable cost.
- Increase use of value-based access fee schedule differentiation. For example, AHCCCS pursued adjustments in the fee-for-service payment schedule to incentivize certain value measures for providers. AHCCCS recently created a program for first responders to provide treatment and referrals instead of requiring transportation to an emergency room to receive payment.

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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.

- 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. For example, 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 healthcare 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 systemwide 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 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 Acute Care and CMDP Contractors:

- Validate Contractor 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. (The Operational Review was administered to only three of the Acute Contractors.)

AHCCCS contracted with HSAG to aggregate and analyze the data AHCCCS obtained from conducting the three mandatory activities for its Acute Care and CMDP 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 systems capabilities).
- Analyze and report results, including providing conclusions and recommendations based on optional activities that AHCCCS conducted.

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

## 4. AHCCCS Quality Initiatives

### AHCCCS Quality Initiatives

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

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

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

### 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 waiver 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 service 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. In 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 every one 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 healthcare has been challenging and further complicated by concerns around poor medication management and stigma, sometimes causing many individuals to forgo physical healthcare. Many persons with SMI also experience co-morbidities; therefore, management of chronic diseases like diabetes or hypertension has also been deficient.

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

AHCCCS proposes, to begin October 1, 2018, to offer fully integrated contracts to manage behavioral healthcare and physical healthcare 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 of 2 percent of household income or \$25, whichever is lesser.

- **Giving Citizens Tools to Manage Their Own Health:** Member premium contributions go into their AHCCCS CARE accounts, which work like flexible health savings accounts. These funds can be withdrawn by members and used for non-covered services, including dental, vision, chiropractic care, recognized weight loss programs, nutrition counseling, gym membership, and sunscreen.
- **Enforcing Member Contribution Requirements:** Members will be disenrolled for failure to pay their monthly premium requirements.
- **Engaging the Business and Philanthropic Community:** Employers and charitable organizations may contribute funds into the AHCCCS CARE account to support a healthy workforce and to support members achieving health goals.
- **Promoting Healthy Behaviors:** The AHCCCS CARE program includes incentives to promote healthy behaviors. Members may defer their premium payments for six months if they meet healthy targets that include: meeting 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 those 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 for 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 a policy and worked collaboratively with 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 and use of all drugs (prescription, opioids, alcohol, etc.) and neonatal abstinence syndrome (NAS). Mercy Care Plan (MCP) 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 Plan 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.
- ADHS Bureau of the United States Department of Agriculture (USDA) Nutrition Programs: AHCCCS works with ADHS Bureau of USDA Nutrition Programs on many initiatives ranging from Contractor education to Women, Infants, and Children promotion and obesity issues. The nutrition coordinators present the most up-to-date information at the AHCCCS Contractor quarterly meetings.
- Arizona Department of Health Services (ADHS) Immunization Program and Vaccine for Children (VFC) program: Ongoing collaboration with ADHS helps ensure efficient and effective administration and oversight of the federal Vaccines for Children (VFC) program. The VFC program representatives provide education to Contractors, regular notification to AHCCCS regarding vaccine-related trends and issues, and updates regarding the Arizona State Immunization Information System (ASIIS), an immunization registry that can capture immunization data on individuals within the state. ASIIS’s new staff, manager, and administrative assistant have been hired. Staff members also provide monthly data sharing regarding AHCCCS members receiving immunizations and ongoing collaboration regarding Stage 1 and Stage 2 Meaningful Use (MU) public health requirements. News from Arizona Department of Health Services Immunization office reported that the 2014–2015 was the first school year in a decade in which non-medical exemption rates did not increase. Also, both the kindergarten and childcare facilities saw a slight decrease in use of non-medical exemptions. One possible reason for the shift is the implementation of the Action Plan to Address Vaccine Exemption. AHCCCS also worked with the ADHS Immunization Program regarding implementation of new CHIP vaccine purchase requirements.
- Arizona Early Intervention Program: The Arizona Early Intervention Program (AzeIP), Arizona’s IDEA Part C program, is administered by the Department of Economic Security. Maternal and child health (MCH) staff in the Clinical Quality Management unit at AHCCCS work with AzeIP to facilitate early intervention services for children younger than 3 years of age who are enrolled with AHCCCS Contractors. These services are closely monitored to ensure timely access and availability of services to members. AHCCCS and AzeIP continue to collaborate and meet regularly to ensure that members receive care in a timely manner. AHCCCS added language to the contract to enforce that all Contractors must reimburse all AHCCCS AzeIP registered providers whether or not those

providers contracted with the AHCCCS Contractor. Individual Family Service Plan (IFSP) services must be reviewed for medical necessity prior to reimbursement. In addition, the AzeIP program has updated its vendor agreement to require that the provider accept the AHCCCS fee-for-service rate for services rendered to AHCCCS members. The two agencies will meet to discuss some impacts resulting from these changes. It is anticipated that this collaboration will increase the utilization of developmental services across the two programs.

- 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) involving 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 to 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 care coordination. Launched in early 2017, Southern Colorado, Arizona, Utah, and now Santa Cruz and San Diego HIEs are capable of sharing hospital admission, discharge, or transfer information with a Medicaid member's home HIE if that member seeks care outside his or her Arizona or "home" HIE.
- ADHS Bureau of Tobacco and Chronic Disease: In collaboration with ADHS, AHCCCS 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 team can make a recommendation for home care and timely follow-up with the member's primary care physicians.

- **Arizona Head Start Association:** The Arizona Head Start and Early Head Start programs provide education, development, health, nutrition, and family support services to qualifying families. The Arizona Head Start grantees—including the City of Phoenix, Maricopa County, Chicanos Por La Causa, and Southwest Human Development—continue to host community meetings quarterly. The meetings are attended by families participating in the Head Start program along with AHCCCS staff members and the AHCCCS Contractor MCH/EPSTD coordinators.
- **Arizona Medical Association (ArMA) and the Arizona Chapter of the American Academy of Pediatrics (AAP):** AHCCCS collaborates with ArMA and the Arizona Chapter of the AAP in numerous ways, from development and review of assessment tools to data sharing and support of system enhancements for providers, including the Electronic Health Records (EHR) Incentive Program. During this year AHCCCS continued discussions related to increasing use of developmental screening tools, the primary care enhanced payment structure, and care and services delivered to members with a diagnosis of autism. In addition, AHCCCS worked with the organizations related to changes in billing codes for photo-ocular vision screening codes.
- **Arizona Perinatal Trust (APT):** The APT oversees voluntary certification of hospitals for the appropriate level of perinatal care according to established guidelines and conducts site visits for initial certification and recertification. AHCCCS covers approximately 50 percent of the births in Arizona; therefore, the site reviews provide AHCCCS with a better assessment of the hospitals that provide care to pregnant women and newborns, from normal labor and delivery to neonatal intensive care. Details of the site visit review are kept confidential; however, site visit reviews do allow opportunities for collaboration among healthcare professionals to learn about innovative practices that hospitals have implemented as well as sharing of best practices, policies, and guidelines. AHCCCS continues to support APT and participate in site visits regularly.
- **Arizona Newborn Screening Advisory Committee:** The Newborn Screening Advisory Committee was established to provide recommendations and advice to ADHS regarding tests that should be included in the newborn screening panel. The committee recommended including the 29 disorders, including hearing loss, of the core panel of the Uniform Screening Panel from the U.S. Department of Health and Human Services (HHS) Secretary's Advisory Committee on Heritable Disorders in Newborns and Children. Any recommendation of a test to be added to the panel must be accompanied by a cost-benefit analysis. The committee is chaired by the ADHS Director and meets at least annually. The Director appoints the members of the committee, to include seven physicians representing the medical specialties of endocrinology, pediatrics, neonatology, family practice, otology, and obstetrics (OB); a neonatal nurse practitioner; an audiologist; a representative of an agency that provides services under Part C of the Individuals with Disabilities Education Act; at least one parent of a child with a hearing loss or a congenital disorder; a representative from the

insurance industry familiar with healthcare reimbursement issues; the AHCCCS Director or director's designee; and a representative of the hospital or healthcare industry.

- Behavioral Health Arizona Children's Executive Committee (ACEC): In 2002, the child-serving agencies of Arizona signed a memorandum of understanding (MOU) calling for the formation of the ACEC. The signers of the MOU included ADHS, Arizona Department of Economic Security, AHCCCS, the Arizona Department of Juvenile Corrections, the Arizona Department of Education, and the Administration of the Courts. ACEC brings together multiple State and government agencies, community advocacy organizations, and family members of children and youth with behavioral health needs to collectively ensure that behavioral health services are being provided to children and families according to the Arizona Vision and 12 Principles. ACEC strives to create and implement a successful system of behavioral healthcare in Arizona by serving as a state-level link for local, county, tribal, and regional teams. ACEC includes four subcommittees comprised of committee participants, family members, and other representatives from State agencies, behavioral health authorities, and family-run organizations—including those that address family involvement, clinical and substance abuse, training, and information sharing.
- Strong Families: Interagency Leadership Team (IALT): IALT was established related to the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant, which ensures that high-risk families have access to home visitation services in Arizona. IALT is composed of various stakeholders in the community including DES, the Department of Education, ADHS, and AHCCCS. The purpose of the leadership team is to discuss strategy for building a statewide home-visiting system. Additionally, this team oversees implementation of the MIECHV grant and any decisions required regarding home visitation practices. AHCCCS members benefit from home-visiting programs when identification and referrals are made by AHCCCS Contractors. AHCCCS continues to be a strong referral source to the home-visiting programs, with the anticipated results of improved birth outcomes for mothers and babies.
- Innovations in Childhood Obesity: AHCCCS was selected by the Center for Health Care Strategies (CHCS) to participate in this initiative; therefore, AHCCCS formed a collaborative workgroup to drive these improvements throughout the State. AHCCCS selected a federally qualified health center (FQHC) with which to work in partnership to collect data and implement interventions relevant to this initiative; AHCCCS Contractors joined that workgroup related to these directives. During Quarter 3, AHCCCS and the selected FQHC finalized methods for collecting data which are being generated by the FQHC to share with both AHCCCS and participating Contractors.
- 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.
- 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.

## 5. Contractor Best and Emerging Practices

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

### Care1st Health Plan Arizona, Inc. (Care1st)

- **Coordination of Care with Special Needs Population/Integrated Care Management Services Model:** Care1st understands the importance of ensuring that members with special needs have access to care that accommodates their unique healthcare requirements and partners with agencies, patient-centered medical homes, and other contracted AHCCCS network providers—including direct access to qualified specialists that accommodate their unique healthcare needs. Members with special needs may be assigned a case manager to assist with the coordination of care and education as well as communication with the provider network related to specialized needs. The Integrated Care Management Program targets strategies for improving coordination of care between the Care1st and tribal and RBHA service delivery system. Qualifying members must have an identified mental health and/or substance abuse issue and have problems with treatment adherence or over- or under-utilization of medical and behavioral services, with the goal to reduce high utilization. Care1st has ongoing identification of high-risk and/or high-cost members from both Maricopa and Pima counties and in need of integrated care management. Care1st develops short-term and long-term intervention strategies to improve care coordination and individual outcomes. Outcomes data, analysis, and progress toward goals are reported twice a year to the CASQIC committee and are included in the annual AHCCCS medical management plan.
- **E-prescribing Evaluation:** Care1st completed education about controlled substances and the use of the controlled substances prescription monitoring program (CSPMP) through: five fax blasts to the provider network throughout the contract year, patient-centered medical home (PCMH) joint operating meetings, monthly and quarterly reporting, and provider forum presentations.

### Health Choice Arizona (HCA)

- **Written Educational Outreach to Members:** OB care navigators provide care coordination and on-site education, using AHCCCS approved written materials, to mothers who have recently delivered prior to their discharge from the delivering facility. Health Choice Arizona also includes provider education located on the Health Choice website and created an OB toolkit that includes a *Measure Improvement Resources* document set for distribution at on-site provider visits.
- **ER and Inpatient Utilization:** HCA's Medical Management Team monitors emergency department (ED) and inpatient utilization data through reporting tools developed in coordination with CareRadius<sup>®</sup>, the medical management system. The case management team receives daily ER and

inpatient reports from various contracted facilities and then conducts outreach calls to assist members/beneficiaries with coordination of care activities, provides education to members/beneficiaries and providers, evaluates PCP availability, and identifies barriers that may be impeding access to care and services. HCA uses the HIE and Blindspot data to guide interventions, especially with those members who have no history of utilization within HCA. Primary interventions include transition of care services as well as high-risk member identification and inclusion in active case management. The transition of care program includes care navigator staff who reach out to members after they are discharged from the hospital. The care navigators help to identify members who need additional assistance transitioning their care. Care navigators actively intervene to help transition as well as identify members who need additional case management support and refer them internally as appropriate to a high-risk program. The care navigators assist members to ensure follow-up appointments with PCPs and to help schedule appointments. Members who meet criteria are assigned to case managers for additional support. The case managers work one on one with the members to help coordinate care, educate about health conditions, and assist in navigating resources available to improve member health.

## Health Net Access (Health Net)

- **ED Overutilization:** Health Net uses a 3-pronged approach to ED overutilization. The case managers and behavioral health team identify high-need/high-cost (HNHC) members for review with the RBHA. This has increased member engagement with the behavioral health providers and has made communications with the RBHA more robust. The second approach around ED overutilization is the member outreach letter. Health Net launched this program and has identified 600 members with three or more visits to the ED in the last six months. The health plan is reviewing case management and RBHA engagement. The last prong in this approach is to work with the PCMH to increase the use of community resources and decrease misuse of the ED.
- **Immunization Rates:** Provider relations staff members and the medical director have participated in the Joint Oversight Committee (JOC) to increase immunization rates and infant, child, and adolescent checkups. Health Net uses value-based contracts to increase outcomes.
- **Opioid Abuse:** Medical management has worked with the RBHA in high need, high cost (HNHC) rounds, and a work group concerned with opioid use and abuse has been formed to develop tools for managing high-utilization subpopulations.

## Maricopa Health Plan (MHP)

- **Admissions to Skilled Nursing Facilities (SNFs):** Admission to a SNF is approved after review of the acute care stay. When clinical notes demonstrate the need to transition to this level of care and the care need falls within the Milliman Care Guidelines (MCG), the concurrent review staff member assigns an authorization number to the facility. Each approved admission is assigned a next review date for continued stay review based on MCG and the member's medical condition.



- **Concurrent Review:** Concurrent review nursing staff follow a structured, criterion-based process for review including identification of quality of care issues; reasonableness of length of stay, including any possible delay of care days; regulatory notifications such as AHCCCS 45-day notification to members in a skilled nursing facility (SNF); CMS notification of co-pay days or use of lifetime reserve days; allocations of resources to best meet the member's needs; needs of the member for safe discharge to a lower or alternate level of care; plan for continuing care following discharge from the hospital or institution, including need for referral to case management; collection of mandatory reportable data; analysis of utilization patterns such as readmissions and quality issues; and transitions of care, to include medication reconciliation and follow-up PCP appointment. Concurrent review meetings with the medical director and/or the utilization management manager occur weekly. All acute hospitalizations and chronic cases are reviewed as appropriate. These meetings also serve as an educational platform in which information is shared and consistency in the review process is developed and maintained. The concurrent review staff collaborates daily with the utilization management manager on the more difficult discharge planning cases; when necessary, cases are reviewed with the medical director for further determination. The concurrent review staff monitors the length of stay in the SNF following MCG criteria. The concurrent review nurse sends a 45-day letter notifying the SNF that, for the member residing at that facility, the health plan responsibility will end soon. With this letter and conversations between the concurrent review staff and the discharge planner in the SNF, the facility is advised to initiate an ALTCS application if not completed prior to this time. The concurrent review staff member monitors AHCCCS online as well as interacts with the facility case manager to determine when the ALTCS application is approved.
- **Transition of Care Program:** The transition of care program focuses on identifying the member's healthcare needs proactively to reduce the chance of readmission. Additionally, through the discharge planning process and authorization of next level of care services, the concurrent review nurses can constantly assess the health plan's network and provide feedback to network development staff regarding any gaps in service areas and opportunities for new contracts. Discharge planning is carried out on all planned and unplanned admissions. All health plan members are called within 24 to 72 hours post discharge, with the exception of Medicare beneficiaries, who are called within 24 hours post discharge. During the discharge call the member is assessed for follow-up appointments with the PCP and/or specialist within seven days of discharge, prescription medications, durable medical equipment (DME), home health, or therapies to ensure that their healthcare needs are being met. Members found to have additional needs such as meals, support groups, and the like are referred to appropriate community resources; or, if their needs are more extensive, members are referred to the health plan's case management department for further intervention. When the health plan is not the primary payer, the health plan collaborates with hospital discharge planners or case management staff members to ensure that the member and/or the member's caregivers are receiving appropriate discharge planning support.
- **University of Arizona Health Plan (UAHP) Case Management Model:** The UAHP Case Management model is a collaborative process that integrates the member's individual physical and behavioral health needs with the member's values and coordinates with the PCP to deliver member-centric care. The program is in alignment with UAHP values of "Honoring Those We Touch" and has adopted the Commission for Case Manager Certification definition of "case management," which is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes. This model has been developed based on the

needs of members and an overarching desire to have closer collaboration with each area's RBHA and local PCPs. The regional integrated case management model is centered on each RBHA region and serves the members and providers located within that region. The case management team for each region consists of the following staff members: RN case manager supervisors, RN case managers, transition coaches, LPN medical management specialists, case management associates, behavioral health case managers, and utilization management RNs. The multidisciplinary team is structured to offer comprehensive services to the member while providing seamless collaboration with the RBHA and the member's assigned provider. The case management model offers a holistic approach to the member's health, addressing the member's physical and behavioral care as well as his or her human service needs.

- **Care Coordination:** MHP uses multiple methods to identify members in need of care coordination. Clinical data analytics (ED visits, admissions, readmissions, costs, top-50 utilization, etc.), claims data, pharmacy adherence reports, as well as data from AHCCCS and Health Current (formerly known as Arizona Health-e Connection) assist the health plan with pinpointing members who appear to have the greatest needs for case management. Additionally, providers and members or their family members can self-refer to case management. MHP has fully adopted AHCCCS recommendations for the HNHC program. MHP has established collaborative relationships with the RBHAs, focused on developing care coordination for identified HNHC members to reduce overall costs while improving health outcomes. MHP meets monthly with each individual RBHA to case conference the identified members for the purpose of developing an integrated care coordination approach; including mutually agreed upon goals, interventions, monitoring, and evaluating of outcomes. Case management care plans are member-centric, with attention given to the identification and resolution of barriers. Weekly interdisciplinary rounds allow for discussion of members in case management and identification of new members with case management and/or condition management needs.
- **Comprehensive Medication Reconciliation Program:** MHP has broadened the scope of its collaborative case management program to include a comprehensive medication reconciliation program. This integrated medication reconciliation program, driven by the MHP Pharmacy Department, includes post-discharge reconciliation of behavioral health and medical drugs and treatments and is aimed at decreasing adverse medication events and improving medication adherence by at-risk members. Through this collaborative approach, members with both medical and behavioral health needs benefit from having a medication safety program in addition to their existing medical case managers and social workers, thus improving the members' paths toward positive outcomes.
- **Care Coordination with Patient-Centered Medical Home (PCMH) Practices:** In partnership with MCP's high-volume PCMH practices, MHP faxes a daily admission/discharge/ED utilization report to the PCMH practices; admission/discharge information and discharge summaries are sent to the providers if such is available. On-site PCMH care coordinators outreach to members to ensure appropriate follow-up. Sending this information to the assigned primary care provider assists the member in receiving appropriate follow-up care after discharge.

## Mercy Care Plan (MCP)

- **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 Substance-Exposed Newborn (SEN) Guidelines, while members' publications included information that related to the exposure/use of all drugs (prescription, opioids, alcohol, etc.) and neonatal abstinence syndrome (NAS). MCP worked out processes to refer infants with NAS to Southwest Human Development. 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.
- **Readmission Reduction Within 30 Days:** MCP analyzes and reviews data submitted by, at a minimum, the chief medical officer, the head of medical management, and the medical management administrator. Data analysis and trending reports are used to improve communication with providers, monitor use of generic medications, provide feedback to providers in order to change practice patterns, identify patterns that influence credentialing and recredentialing activities, identify potential quality of care concerns and how data reflects quality of care, identify opportunities for improvement in areas such as hospital discharge planning, and consider case management activities. MCP presents data to the Medical Management Committee for analysis of outcomes and recommendations as appropriate and acts upon variances that are untoward by changing interventions and re-evaluating new interventions for effectiveness and outcomes.
- **Avoidable Admissions:** MCP 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, condition, or contractual obligation. The initial review is completed within one business day of MCP's notification of admission. The concurrent review nurse begins discharge planning upon admission. Members who meet care management criteria are referred to case management, and readmission rates and avoidable admissions are monitored. MCP 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 has monthly joint operation meetings with all the acute care facilities to review the facilities' outcomes (e.g., observation days, avoidable admissions, length of stays, or any relevant data found by reviewing the facility outcomes).

## Phoenix Health Plan, LLC (PHP)

- **Neonatal Intensive Care Unit (NICU) Utilization Review:** PHP has intensified utilization review for the NICU to decrease average length of stay to 15 days or fewer: PHP maintains one HCRN NICU specialist as well as a back-up HCRN to conduct all NICU reviews and uses an outside contracted neonatologist to assist with NICU utilization. Trends are tracked using NAS guidelines with the Level 3 NICUs. PHP continued collaboration with the maternal child health /high-risk assigned OB

case manager and conducted bi-monthly NICU team meetings to review bed day results, analyze trends, and plan needed interventions.

- **Welcome Home Discharge Program:** PHP enhanced the Welcome Home Discharge Program that includes member follow-up after hospitalization. Eighty percent of all discharged at-risk SNF members are contacted, and appointments are scheduled with an appropriate provider within seven days. PHP revised concurrent review policies to ensure accurate and timely entry of discharge date. PHP collaborates with members to educate them on the importance of filling all prescriptions in a timely manner; and the transitional case managers coordinate with contracted home health agencies to provide necessary DME, physical and occupational therapy, and other community resources. PHP developed reports and indicators to identify which members did/or did not attend their appointments, then conducted follow-up calls.

## UnitedHealthcare Community Plan-Acute (UHCCP-Acute)

- **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-Acute 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-Acute accountable care consultants are assigned by practice and engage in active collaboration with practice clinical leaders to significantly improve the delivery of high-quality care and service to members. The goal is to improve use of evidence-based care and reduce inappropriate ED use and admissions by providing practices with real-time actionable data on access to care, ED utilization, admissions, discharges, and care opportunities; and to facilitate timely PCP follow-up.
- **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.

## University Family Care (UFC)

- **Admissions to Skilled Nursing Facilities (SNFs):** Admission to a SNF is approved after a review of the acute care stay. When clinical notes demonstrate the need to transition to this level of care and is within the Milliman Care Guidelines (MCG), the concurrent review staff member assigns an authorization number to the facility. Each approved admission is assigned a next review date for continued stay review based on MCG and the member's medical condition.
- **Concurrent Review:** Concurrent review nursing staff follow a structured, criterion-based process for review including identification of quality of care issues; reasonableness of the length of stay, including any possible delay of care days; regulatory notifications such as AHCCCS 45-day notification to members in SNF; CMS notification of co-pay days or use of lifetime reserve days; allocations of resources to best meet the member's needs; needs of the member for safe discharge to a lower or alternate level of care; plan for continuing care following discharge from the hospital or institution, including the need for a referral to case management; collection of mandatory reportable data; analysis of utilization patterns such as readmissions and quality issues; and transitions of care, to include medication reconciliation and follow-up PCP appointment. Concurrent review meetings with the medical director and/or the utilization management manager occur weekly. All acute hospitalizations and chronic cases are reviewed as appropriate. These meetings also serve as a teaching opportunity in which information is shared and consistency in the review process is developed and maintained. The concurrent review staff collaborates daily with the utilization management manager on the more difficult discharge planning cases; when necessary, cases are reviewed with the medical director for further determination. The concurrent review staff monitors the length of stay in the SNF following MCG criteria. The concurrent review nurse sends a 45-day letter notifying the SNF that, for the member residing at that facility, the health plan responsibility will end soon. With this letter and conversations between the concurrent review staff and the discharge planner in the SNF, the facility is advised to initiate an ALTCS application if not completed prior to this time. The concurrent review staff member monitors the AHCCCS online as well as interacts with the facility case manager to determine when the ALTCS application is approved.
- **Transition of Care Program:** The transition of care program focuses on identifying the member's healthcare needs proactively to reduce the chance of readmission. Additionally, through the discharge planning process and authorization of next level of care services, the concurrent review nurses can constantly assess the health plan's network and provide feedback to network development

staff regarding any gaps in service areas and opportunities for new contracts. Discharge planning is carried out on all planned and unplanned admissions. All health plan members are called within 24 to 72 hours post discharge, with the exception of Medicare beneficiaries, who are called within 24 hours post discharge. During the discharge call, the member is assessed for follow-up appointments with the PCP and/or specialist within seven days of discharge, prescription medications, DME, home health, or therapies to ensure that their healthcare needs are being met. Members found to have additional needs such as meals, support groups, and the like are referred to appropriate community resources; or, if their needs are more extensive, members are referred to the health plan's case management department for further intervention. When the health plan is not the primary payer, the health plan collaborates with hospital discharge planners or case management staff members to ensure that the member and/or the member's caregivers are receiving appropriate discharge planning support.

- University of Arizona Health Plan (UAHP) Case Management Model: The UAHP Case Management model is a collaborative process that integrates the member's individual physical and behavioral health needs with the member's values and coordinates with the PCP to deliver member-centric care. The program is in alignment with UAHP values of "Honoring Those We Touch" and has adopted the Commission for Case Manager Certification definition of "case management," which is characterized by advocacy, communication, and resource management, promoting quality and cost-effective interventions and outcomes. This model has been developed based on the needs of members and an overarching desire to have closer collaboration with each area's RBHA and local PCPs. The regional integrated case management model is centered on each RBHA region and serves the members and providers located within that region. The case management team for each region consists of the following staff members: RN case manager supervisors, RN case managers, transition coaches, LPN medical management specialists, case management associates, behavioral health case managers, and utilization management RNs. The multidisciplinary team is structured to offer comprehensive services to the member while providing seamless collaboration with the RBHA and member's assigned provider. The case management model offers a holistic approach to the member's health, addressing the member's physical and behavioral care as well as his or her human service needs.
- Care Coordination: MHP uses multiple methods to identify members in need of care coordination. Clinical data analytics (ED visits, admissions, readmissions, costs, top-50 utilization, etc.), claims data, pharmacy adherence reports, as well as data from AHCCCS and Health Current assist the health plan with pinpointing members who appear to have the greatest needs for case management. Additionally, providers and members or their family members can self-refer to case management. MHP has fully adopted AHCCCS recommendations for the HNHC program. MHP has established collaborative relationships with the RBHAs, focused on developing care coordination for identified HNHC members to reduce overall costs while improving health outcomes. MHP meets monthly with each individual RBHA to case conference the identified members for the purpose of developing an integrated care coordination approach; including mutually agreed upon goals, interventions, monitoring, and evaluating of outcomes. Case management care plans are member-centric, with attention given to the identification and resolution of barriers. Weekly interdisciplinary rounds allow for discussion of members in case management and identification of new members with case management and/or condition management needs.

- **Comprehensive Medication Reconciliation Program:** MHP has broadened the scope of its collaborative case management program to include a comprehensive medication reconciliation program. This integrated medication reconciliation program, driven by the MHP Pharmacy Department, includes post-discharge reconciliation of behavioral health and medical drugs and treatments and is aimed at decreasing adverse medication events and improving medication adherence by at-risk members. Through this collaborative approach, members with both medical and behavioral health needs benefit from a medication safety program in addition to having their existing medical case managers and social workers, thus improving the members' paths toward positive outcomes.
- **Care Coordination With Patient-Centered Medical Home (PCMH) Practices:** In partnership with MCP's high-volume PCMH practices, MHP faxes a daily admission/discharge/ED utilization report to the PCMH practices; admission/discharge information and discharge summaries are sent to the providers if such is available. On-site PCMH care coordinators outreach to members to ensure appropriate follow-up. Sending this information to the assigned primary care provider assists the member in receiving appropriate follow-up care after discharge.

## Comprehensive Medical and Dental Plan (CMDP)

- **Referrals to Community Resources for Obesity:** CMDP improved the consistency of follow-through for referrals to community resources for obesity when such were identified during the EPSDT. CMDP identifies members prescribed psychotropic medications with high rates of weight gain, offering to them community resources and educational materials. In addition, CMDP ensures that prescribing PCPs are aware that CMDP covers nutritional consults with a physician's assistant.

## AHCCCS and All Contractors

- **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 Substance-Exposed Newborn (SEN) Guidelines, while members' publications included information that related to the exposure/use of all drugs (prescription, opioids, alcohol, etc.) and NAS. MCP and 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.

## 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 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 each of three Contractors (Mercy Care Plan, Comprehensive Medical and Dental Plan, and Phoenix Health Plan). In addition, AHCCCS monitored the progress of Contractors implementing CAPs for the recommendations from the 2015 OR.

The results of the OR for the three 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 11 standards in various categories for each Contractor included in the OR. 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 accomplishment.
- Review the Contractor's progress in implementing recommendations that AHCCCS made during prior ORs.
- Determine if the Contractor complied with its own policies and evaluate the effectiveness of those policies and procedures.
- Perform oversight of the Contractor as required by CMS in accordance with AHCCCS' 1115 waiver.
- Provide information to HSAG as AHCCCS' EQRO to use in preparing this report as described in 42 CFR §438.364.

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

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

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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.

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

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

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

## **Standards**

The CYE 2016 OR was organized into 11 standard areas. For the Acute Care Contractors, each standard area consisted of several elements designed to measure the Contractor's performance and compliance. Following are the 11 standards and number of elements involved in each standard used throughout the report:

- 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 acute 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 opportunity to respond to AHCCCS concerning 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 the OR considering 11 standards for each Contractor. Contractor-specific results are presented following.

#### ***Mercy Care Plan (MCP)***

AHCCCS conducted an on-site review of MCP 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 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 11 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 MCP**

Standard Area	Total Number of Elements	Standard Area Score	Required Corrective Actions
<b>Corporate Compliance</b>	5	93%	1
<b>Claims and Information Systems</b>	12	93%	3
<b>Delivery Systems</b>	9	98%	1
<b>General Administration</b>	3	100%	0
<b>Grievance Systems</b>	17	99%	1
<b>Adult, EPSDT and Maternal Child Health</b>	15	100%	0
<b>Medical Management</b>	25	91%	3
<b>Member Information</b>	9	100%	0
<b>Quality Management</b>	27	97%	2
<b>Reinsurance</b>	4	100%	0
<b>Third-Party Liability</b>	7	100%	0

Table 6-1 illustrates the following compliance results for the 11 standards reviewed for the MCP OR:

- **Corporate Compliance:** For the five elements within this standard, the Contractor received a score of 93 percent (466 out of 500).
- **Claims and Information Systems:** For the 12 elements within this standard, the Contractor received a score of 93 percent (1,123 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 99 percent (1,680 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 25 elements within this standard, the Contractor received a score of 91 percent (2,288 out of 2,500).

- 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 27 elements within this standard, the Contractor received a score of 97 percent (2,628 out of 2,700).
- 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 11 standards. MCP was fully compliant (100 percent scores) with five of the 11 standards reviewed (GA, MCH, MI, RI, and TPL). The Contractor also demonstrated strong performance in the DS, GS, and QM standards, with compliance scores between 97 and 99 percent.

AHCCCS identified solid processes for MCP within the GA standard as it pertained to policies and procedures for the maintenance of records and internal training and policy development. In addition, the Contractor demonstrated that it established a comprehensive maternity care program, with goals directed toward achieving optimal birth outcomes that meet AHCCCS minimum requirements.

For the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, the Contractor also demonstrated through policies and procedures and implementation of processes that it appropriately coordinated care for members, conducted adequate follow-up to verify that members received timely and appropriate treatment, and monitored member and provider compliance with the EPSDT guidelines as required by AHCCCS.

MCP also performed well in the MI standard, demonstrating that all member materials and notices complied with AHCCCS requirements. For the RI standard, AHCCCS established that MCP had adequate policies and procedures for monitoring reinsurance cases to ensure consistency with AHCCCS requirements and for reporting reinsurance issues as discovered.

Although MCP did not receive 100 percent compliance for the DS, GS, and QM standards, the Contractor demonstrated strong compliance with most required elements. For instance, the Contractor received a score of 99 percent for the grievance system standard for which AHCCCS identified that the Contractor had policies and procedures in place to support a robust grievance and appeals process in accordance with federal rule and AHCCCS contractual requirements.

## Opportunities for Improvement and Recommendations

The results of the OR established opportunities for improvement as MCP was less than fully compliant in three standards reviewed, with percentages that varied between 91 and 93 percent, below the compliance threshold of 95 percent established by AHCCCS.

For the CC standard, the Contractor was found non-compliant with the element that required the Contractor to educate the staff and the provider network on fraud, waste, and abuse. MCP was required to add language and content regarding reporting of fraud, waste, and abuse directly to AHCCCS—OIG. Information on how to report fraud, waste, or abuse of the program online, by phone or letter, and by fax is available on the AHCCCS website. The Contractor received a score of 93 percent in this standard and was required to submit a CAP.

MCP proposed a CAP and provided evidence of proposed changes to the MCP16 Corporate Compliance Plan and MCP Policy 3000.00 Compliance Program to include the AHCCCS requirements. The CAP was approved by AHCCCS.

AHCCCS also identified opportunities for improvement in the CIS standard. MCP obtained a score of 93 percent, below the compliance threshold. It failed to demonstrate compliance with the element that requires the Contractor to pay the applicable interest on all claims, including overturned claim disputes, and it also failed to demonstrate that it accurately applies quick-pay discounts as required by AHCCCS.

MCP was also found deficient in the requirement related to the remittance advice to providers as those must contain the minimum required information as established by AHCCCS. AHCCCS determined that the remits should have included the reasons for all denials and adjustments as well as detailed explanation or 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. In addition, the dental subcontractor's remits must include the reasons for the denial, detailed description for all denials and adjustments, and instructions and time frames for the submission of claim disputes and corrected claims. AHCCCS also required MCP to ensure that it pays applicable interest on all claims, including overturned claim disputes, and that it accurately applies quick-pay discounts. The Contractor was required to submit a CAP on September 12, 2016, to address the findings; however, the first CAP submission was not accepted by AHCCCS, and a resubmission was required. On October 25, 2016, MCP resubmitted a CAP that was accepted by AHCCCS as it addressed all findings identified during the OR.

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

For the GS standard, AHCCCS required MCP to comply with the policy of providing oral notification of an expedited appeal resolution decision and to provide AHCCCS with proof of compliance.

For the MM standard, the Contractor was found deficient in areas related to proactive discharge planning for members admitted into acute care facilities, the coordination of services being provided to a member when the member is transitioning between Contractors, and the provision of medical home services to members. MCP submitted a CAP on September 12, 2016, with the proposed activities to correct the deficiencies; but it was not accepted by AHCCCS. The Contractor proposed a second CAP on October 25, 2016, that was approved by AHCCCS. In this CAP the Contractor indicated that it had created a new policy for post-discharge member outreach and that it had updated the Post Discharge

Member Outreach policy to include all members discharged from the hospital. In addition, and to address additional findings, MCP explained its monitoring process to ensure the effectiveness of the contracted medical homes through regular meetings, which are held with providers to identify best practices as well as to address problems, barriers, and performance.

For the QM standard, AHCCCS required MCP 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.

All of these standards that were identified by AHCCCS required corrective actions.

### Summary

MCP was fully compliant with most standards reviewed. Of the 11 standards, MCP was compliant with eight standards at or above the 95 percent threshold. For the GA, MCH, MI, RI, and TPL, the Contractor obtained a full compliance (100 percent) score. For the DS, GS, and QM standards, the Contractor received an “at or above 95 percent” score.

The MM standard received the lowest score (91 percent). AHCCCS identified several deficiencies in the standard and required CAPs to address various components of the findings. For instance, AHCCCS indicated that the Contractor should consider having a separate policy for discharge planning. The proactive discharge planning policy language must contain the required elements of the AHCCCS policy as follows:

- Arrangement of follow-up appointment with the PCP or specialist.
- Coordination of prescription medications, therapies, and DME as medically necessary.
- Post-discharge telephone call within seven days of discharge.
- Confirmation that discharge needs were met.
- Referral to appropriate health plan case management (CM), disease management (DM), or community resources.

In summary, MCP was in full compliance or within the 95 percent threshold of compliance for most standards reviewed. The Contractor had only three standards below the 95 percent threshold of compliance, and for those standards the Contractor submitted CAPs satisfactorily accepted by AHCCCS. The Contractor received the acceptance letter on October 25, 2017, and had six months from the date of the letter to provide AHCCCS with an update on any open CAPs. It is AHCCCS’ expectation that all CAP steps will be completed within six months. MCP’s CAP update was due April 25, 2017.

### **Phoenix Health Plan, LLC (PHP)**

AHCCCS conducted an on-site review of PHP from September 19, 2016, through September 22, 2016. A copy of the draft version of the report was provided to the Contractor on November 2, 2016. PHP 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 11 standards. Table 6-2 presents the total number of elements, the standard area score, and the required CAP for each standard area reviewed.

**Table 6-2—Standards and Compliance Scores for PHP**

Standard Area	Total Number of Elements	Standard Area Score	Required Corrective Actions
Corporate Compliance	5	100%	0
Claims and Information Systems	12	92%	4
Delivery Systems	9	100%	0
General Administration	3	100%	0
Grievance Systems	17	95%	3
Adult, EPSDT, and Maternal Child Health	15	100%	0
Medical Management	25	99%	1
Member Information	9	100%	0
Quality Management	27	96%	4
Reinsurance	4	100%	0
Third-Party Liability	7	100%	0

Table 6-2 illustrates the following compliance scores for the 11 standards reviewed for the PHP OR:

- Corporate Compliance (CC): For the five elements within this standard, the Contractor received a standard area score of 100 percent (500 out of 500).
- Claims and Information Systems (CIS): For the 12 elements within this standard, the Contractor received a score of 92 percent (1,105 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 95 percent (1,613 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 25 elements within this standard, the Contractor received a score of 99 percent (2,472 out of 2,500).
- **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 27 elements within this standard, the Contractor received a score of 96 percent (2,592 out of 2,700).
- **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 11 standards. PHP was fully compliant (100 percent) for seven of the 11 standards reviewed (CC, DS, GA, MCH, MI, RI and TPL). The Contractor also demonstrated strong performance in the MM, GS, and QM standards, with compliance scores between 95 and 99 percent.

PHP's strong performance across most standards was reflected in the scoring received during the comprehensive review.

### Opportunities for Improvement and Recommendations

The results of the OR demonstrated opportunities for improvement for PHP in various areas. For the CIS standard, wherein PHP received a score of 92 percent, AHCCCS identified several issues for which the Contractor needed to demonstrate improvement. For instance, AHCCCS indicated that the Contractor's subcontracted dental remits should include the reasons for denials and adjustment, detailed explanation about payments less than billed charges, denials and adjustments; and appropriate instructions and time frames for the submission of claim disputes.

For the same standard, AHCCCS established that PHP must ensure that it pays applicable interest on all claims—including overturned claim disputes—as well as ensure that it accurately and timely incorporates AHCCCS provider registration data in its claims processing system. In addition, PHP was required to have a process to ensure that all contracts/agreements were loaded accurately and timely and that non-contracted providers were paid pursuant to ARS §36-2903, 2904, and 2905.01.

Although PHP received a score of 95 percent on the GS standard, AHCCCS identified some issues related to the appeals decisions and the time frames associated with those decisions. PHP was found deficient in the element that requires the Contractor to ensure that the individuals who make decisions on appeals were not involved in any previous level of review or decision making. AHCCCS also indicated that the Contractor must issue all provider claim dispute Notices of Decision citing factual and legal basis.

PHP was found deficient in one element within the MM standard that requires PHP to ensure compliance with its retrospective review policies and procedures.

For the QM standard, PHP was required to demonstrate improvement in the areas of documentation for open and closing letters, research and analysis, documentation of substantiation determination and leveling, and implementation of member resolutions. This should be completed and clearly documented in the quality of care (QOC) files. The Contractor was also required to monitor and document the success of actions taken or implement new actions when necessary and must clearly document this for substantiated QOC cases.

In addition, AHCCCS indicated that the Contractor was required to determine system resolutions for substantiated QOC issues identified and monitor the actions and interventions taken to correct deficiencies. System resolutions must be clearly documented, as should the success of existing interventions or newly implemented interventions.

AHCCCS recommended that PHP develop policies to address advanced directive confidentiality in these settings and have a process to ensure interrater reliability when more than one person is collecting and entering data specific to measuring performance.

PHP was required to propose CAPs for each deficiency found during the OR. The Contractor submitted a CAP initially on January 20, 2017, with a second CAP submission on March 13, 2017. All the CAPs proposed by PHP were approved and accepted by AHCCCS. PHP was required by AHCCCS to provide a narrative of the progress for each CAP and to submit by April 10, 2017, documentation demonstrating where PHP was in terms of completing the accepted CAP steps.

## Summary

The scores received by PHP during the comprehensive OR reflect an outstanding performance for most standards reviewed by AHCCCS. PHP had some areas requiring improvement; however, PHP addressed all identified areas with comprehensive CAPs that were satisfactory to AHCCCS.

## *Comprehensive Medical and Dental Programs (CMDP)*

AHCCCS conducted an on-site review of CMDP from August 8, 2016, through August 10, 2016. A copy of the draft version of the report was provided to the Contractor on September 22, 2016. CMDP 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 11 standards. Table 6-3 presents the total number of elements, the standard area score, and the required CAP for each standard area reviewed.

**Table 6-3—Standards and Compliance Scores for CMDP**

Standard Area	Total Number of Elements	Standard Area Score	Required Corrective Actions
Corporate Compliance	5	62%	4
Claims and Information Systems	12	95%	2
Delivery Systems	8	77%	4
General Administration	3	89%	1
Grievance Systems	17	100%	0
Adult, EPSDT, and Maternal Child Health	15	91%	5
Medical Management	23	95%	5
Member Information	9	95%	2
Quality Management	21	86%	6
Reinsurance	4	94%	1
Third-Party Liability	7	71%	2

Table 6-3 illustrates the following compliance scores for the 11 standards reviewed for the PHP OR:

- Corporate Compliance (CC): For the five elements within this standard, the Contractor received a standard area score of 62 percent (309 out of 500).
- Claims and Information Systems (CIS): For the 12 elements within this standard, the Contractor received a score of 95 percent (1,144 out of 1,200).
- Delivery Systems (DS): For the eight elements within this standard, the Contractor received a score of 77 percent (614 out of 800).
- General Administration (GA): For the three elements within this standard, the Contractor received a score of 89 percent (267 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 91 percent (1,368 out of 1,500).
- Medical Management (MM): For the 23 elements within this standard, the Contractor received a score of 95 percent (2,180 out of 2,300).
- Member Information (MI): For the nine elements within this standard, the Contractor received a score of 95 percent (856 out of 900).
- Quality Management (QM): For the 21 elements within this standard, the Contractor received a score of 86 percent (1,814 out of 2,100).
- Reinsurance (RI): For the four elements within this standard, the Contractor received a score of 94 percent or the equivalent to 375 out of 400.

- **Third-Party Liability (TPL):** For the seven elements within this standard the Contractor received a score of 71 percent (500 out of 700).

### Strengths

For this OR AHCCCS reviewed a total of 11 standards. CMDP was fully compliant with a 100 percent score in one of the 11 standards reviewed (GS). The Contractor also demonstrated solid performance in the CIS, MM, and MI standards, with compliance scores at 95 percent.

### Opportunities for Improvement and Recommendations

The results of the OR demonstrated opportunities for improvement as CMDP was less than fully compliant in ten of the 11 standards reviewed. In the report generated from the CMDP's OR, AHCCCS included recommendations for CMDP that required the submission of CAPs. AHCCCS included the following findings and recommendations in the final OR report to CMDP.

AHCCCS required submission of CAPs for all standards except the GS standard; CMDP scored 100 percent in that area. CMDP submitted CAPs for all other standards; however, AHCCCS did not accept several of the CAPs and issued a Notice of Concern to CMDP on January 27, 2017. On March 3, 2017, AHCCCS accepted all CAPs and informed CMDP that AHCCCS must see demonstrated progress in each proposed step of the CAPs until AHCCCS agrees that the CAPs have been accomplished.

For the CC standard, CMDP received a score of 62 percent; AHCCCS identified several issues for which the Contractor needed to demonstrate improvement. For instance, AHCCCS indicated that the Contractor must submit documentation related to Compliance Committee meetings reflecting how the issues outlined in this standard and contained in the Corporate Compliance Plan are addressed; this is to include which officers and key staff members are in attendance. CMDP must incorporate the term "waste" in its training materials and supporting documentation, including the definition of "waste" in materials and documents that contain definitions. The Contractor must have in place provisions for internal monitoring and auditing. The Contractor must provide the external auditing schedule and executive summary of all audits to AHCCCS—OIG. The fraud policies must address frequency of required regular auditing of the claims payments and health information system for potential fraud of the system and submit evidence of the implementation of corrective or other administrative actions where appropriate. Finally, CMDP must provide demographic information of the individuals checked in List of Excluded Individuals and Entities/System for Award Management (LEIE/SAM) and evidence of positive and negative results.

For the CIS standard, although CMDP received a score of 95 percent, AHCCCS identified several issues for which the Contractor needed to demonstrate improvement. CMDP must ensure that its remits include the reason(s) for denials and adjustments as well as detailed explanation about payments less than billed charges, denials, and adjustments. CMDP must also ensure that it pays applicable interest on all claims, including overturned claim disputes.

For the DS standard, CMDP scored 77 percent and was required to demonstrate improvement in the provider call tracking/resolution time frames systems when assessing staffing needs. AHCCCS required

CMDP to ensure that its provider services representatives were adequately trained in provider inquiry handling and tracking, including requirements for resolution time frames. In addition, the Contractor must ensure that its policies and procedures address the process for taking systemic action and demonstrate that corrective action is implemented when appropriate. CMDP must ensure that it develops, distributes, and maintains a provider manual and makes its providers and subcontractors aware of its availability. The Contractor's provider manual must include all requirements listed in the *AHCCCS Contractor Operations Manual (ACOM) 416*. Each of these requirements must be outlined in policy or procedure.

For the GA standard, CMDP scored 89 percent and was required to demonstrate improvement by ensuring that all policies and procedures were reviewed annually.

For the MCH standard, CMDP scored 91 percent and must develop a process that enhances monitoring of provider compliance with completing perinatal and postpartum depression screenings and making appropriate counseling and referrals when positive screens occur. The Contractor must have a process in place to ensure identification of member postpartum depression, member referral to appropriate healthcare providers, and member connection to care. AHCCCS required that CMDP have processes in place to educate providers about AzeIP, including the need for providers to request authorization for medically necessary services, and to verify that members receive timely and appropriate treatment for medical and behavioral health referrals. Finally, the Contractor must ensure that it has a process to transition any child receiving nutritional therapy to or from another Contractor or another service program.

For the MM standard, although CMDP received a score of 95 percent, AHCCCS identified several areas for which the Contractor needed to demonstrate improvement. The Contractor must develop and implement an effective concurrent review process which includes initiation within one business day of hospital notification. AHCCCS required that CMDP implement processes to ensure that Enrollment Transition Information (ETI) forms are completed accurately. In addition, the Contractor must develop and implement a process for proactive discharge planning for hospitalized members and coordinate care for members with special healthcare needs, including documented follow-up to ensure that members receive the specific services for which referrals are made. Finally, CMDP must collaborate with the RBHAs to identify members with high needs and high costs and to improve coordination of care.

For the MI standard, although CMDP received a score of 95 percent, AHCCCS identified several issues for which the Contractor needed to demonstrate improvement. CMDP must ensure that its member services representatives receive ongoing staff training to appropriately identify, document, refer, and respond to member inquiries and grievances. In addition, CMDP must ensure that its member newsletters reference Medicare Part D issues in at least in one publication per year.

For the QM standard, CMDP received a score of 86 percent and AHCCCS identified several areas for which the Contractor needed to demonstrate improvement. AHCCCS required the Contractor to use an initial credentialing process to ensure that network sufficiency is sustained and to ensure that new providers meet minimum standards. CMDP must conduct organizational credentialing in order to demonstrate compliance with this standard and provide a description of how the Contractor will achieve this goal in the future. AHCCCS required that CMDP develop a systemic process to complete on-site

quality management monitoring and investigations, including a process for developing a corrective action when any health information system issue occurs, including notifying AHCCCS of the issue. The Contractor must have a process for determining best practices related to performance improvement projects (PIPs) and achieving significant improvement. CMDP must identify opportunities for improvement using the health information system and implement PIPs to improve outcomes or results. Finally, the Contractor must have a process to ensure interrater reliability specific to performance measures as well as a process for determining best practices related to performance measures, including achieving the minimum performance standard.

For the RI standard, CMDP received a score of 94 percent. AHCCCS identified that CMDP must demonstrate that it provides reinsurance education for personnel regarding the processes, procedures, and submission of transplant reinsurance cases to AHCCCS for reimbursement.

For the TPL standard, CMDP scored 71 percent and was required to demonstrate that it appropriately files and releases liens on total plan casualty cases that exceed \$250 each. In addition, the Contractor must demonstrate that it contacts Health Management Systems (HMS) prior to negotiating a settlement on a total plan case to ensure that no payments have been made by AHCCCS.

## Summary

For the GS standard, CMDP was fully compliant (100 percent score). CMDP was within the 95 percent threshold of compliance for the CIS, MM, and MI standards. The Contractor received scores below the 95 percent threshold in the CC, GA, MCH, QM, and RI standards. CMDP scored lower on the DS and TPL standards, with scores of 77 percent and 71 percent respectively. AHCCCS required the Contractor to submit CAPs to correct the deficiencies identified during the OR.

## Overall Comparative Results for Acute Care and CMDP Contractors

### Findings

AHCCCS conducted the comprehensive OR for three Contractors for CYE 2016. Table 6-4 details the percentage score for each Contractor for each of the 12 standards.

**Table 6-4—Acute Care and CMDP Contractors Standard Area Scores**

Standard	MCP	CMDP	PHP
Corporate Compliance	93%	62%	100%
Claims and Information Systems	93%	95%	92%
Delivery Systems	98%	77%	100%
General Administration	100%	89%	100%
Grievance Systems	99%	100%	95%
Adult, EPSDT, and Maternal Child Health	100%	91%	100%
Medical Management	91%	95%	99%
Member Information	100%	95%	100%
Quality Management	97%	86%	96%
Reinsurance	100%	94%	100%
Third-Party Liability	100%	71%	100%

### Corporate Compliance

For the CC standard, PHP received the highest score (100 percent) of the three Contractors. MCP received 93 percent and CMDP 62 percent, both below the 95 percent threshold for compliance. These two Contractors were found deficient in various elements within the standard and had to submit CAPs to address the findings.

### Claims and Information Systems

Of the three Contractors, CMDP received the highest score (95 percent) for the CIS standard. MCP and PHP underperformed in this standard, with scores below the 95 percent threshold. AHCCCS found deficiencies in the same element for this standard for the three Contractors related to the requirement that Contractors’ remittance advice to providers contain the minimum required information. Likewise, for the same standard for all three Contractors, AHCCCS found deficiencies related to the requirement that Contractors pay applicable interest on all claims, including overturned claim disputes.

## Delivery Systems

PHP and MCP received the highest score within the DS standard. CMDP was found deficient in several elements within this standard and received a score of 77 percent. MCP and CMDP each necessitated a CAP related to the element requiring a mechanism for tracking and trending provider inquiries to include timely acknowledgement, resolution, and systemic action as appropriate.

## General Administration

For the GA standard, performance of MCP and PHP was fully compliant, but for CMDP it was deficient (89 percent). AHCCCS required CMDP to ensure that all policies and procedures are reviewed annually.

## Grievance Systems

For the GS standard, AHCCCS found that the three Contractors had performed well, with two Contractors receiving a score above 99 percent and PHP receiving a score of 95 percent. PHP was required to propose a CAP to address the issues identified by AHCCCS.

## Adult, EPSDT and Maternal Child Health

For the MCH standard, AHCCCS found that two of the Contractors, MCP and PHP, were in full compliance with all required elements (100 percent scores). CMDP received a 91 percent score, below the 95 percent compliance threshold. AHCCCS indicated that the Contractor must develop a process that enhances monitoring of provider compliance with completing perinatal and postpartum depression screenings and make appropriate counseling and referrals if a positive screen is obtained as well as have a process in place to ensure identification of postpartum depression, referral of members to the appropriate healthcare providers, and connection of referred members to care. CMDP proposed CAPs to address the findings and correct the issues.

## Medical Management

For the MM standard, PHP and CMDP performed within the 95 percent compliance threshold; however, MCP scored 91 percent. AHCCCS found that two Contractors, MCP and CMDP, had deficiencies related to the ETI form; and only one Contractor, PHP, had deficiencies related to compliance with its retrospective review policies and procedures.

## Member Information

For the MI standard, two Contractors, MCP and PHP, performed remarkably well, and achieved full compliance (100 percent scores). CMDP received a 95 percent score, within the threshold of compliance. CMDP was required to propose CAPs to address the various issues identified by AHCCCS.



## Quality Management

Two of the Contractors, MCP and PHP, performed well for the QM standard, scoring above the 95 percent threshold for compliance; and one Contractor, CMDP, scored below the threshold with 86 percent. AHCCCS found several deficiencies within this standard for all Contractors, and all were required to propose CAPs to address the various issues. Two Contractors were found deficient in the same element which requires Contractors to maintain a health information system that collects, integrates, analyzes, and reports data necessary to implement a quality management/quality improvement (QM/QI) program. Likewise, two Contractors presented issues related to the element requiring Contractors to implement a process to measure and report to the State performance using standard measures required by the State as related to interrater reliability.

## Reinsurance

For the RI standard, two Contractors, MCP and PHP, were scored fully compliant (100 percent) and one Contractor, CMDP, received 94 percent. AHCCCS required the CMDP to demonstrate that it provided reinsurance education for personnel regarding the processes, procedures, and submission of transplant reinsurance cases to AHCCCS for reimbursement.

## Third-Party Liability

Two of the Contractors, MCP and PHP, performed well for the TPL standard and achieved full compliance (100 percent scores). CMDP received a 71 percent score, below the compliance threshold of 95 percent. AHCCCS required CMDP to demonstrate appropriate filing and releasing of liens on total plan casualty cases that exceed \$250 each.

## Strengths

Although no Contractors obtained 100 percent in all standards combined, some Contractors obtained high scores—within the 95 percent threshold of compliance in some standards. For instance, all three Contractors obtained full compliance for the MI and GS standards. While MCP and PHP obtained 100 percent, CMDP obtained 95 percent in the MI standard. For the GS standard, MCP received a 99 percent score, CMDP received 100 percent, and PHP was scored 95 percent.

MCP had five standards and PHP had seven standards scored at full compliance (100 percent). One Contractor, PHP, had only one standard below the 95 percent compliance threshold. All three Contractors were required to submit CAPs for all deficiencies found by AHCCCS during the OR. The CAPs submitted by the Contractors were accepted by AHCCCS and were all in process of implementation during CYE 2016.

## Opportunities for Improvement and Recommendations

All Contractors made progress in meeting the standards; however, opportunities for improvement do exist. The three Contractors proposed CAPs during the time frame allowed by AHCCCS according to

the review period. AHCCCS accepted the activities proposed within each CAP and requested that, within six months of acceptance of each CAP, each Contractor provide CAP updates.

Based on AHCCCS' review of the Acute Care and CMDP Contractors' performance in CYE 2016 and associated opportunities for improvement identified resulting 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 processes and activities to identify strengths and vulnerable areas. When deficiencies are noted, the Contractors should develop mechanisms to address such areas and enhance the existing procedures.
- 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.
- Apply lessons learned from improving performance for one category of standards to other categories. Specifically, Contractors should look to CAPs completed from earlier ORs to determine best practices specific to their organizations so as to identify and correct deficient standards and monitor subsequent compliance.
- Implement control systems to address specific findings in the CIS standard; this seems a prevalent issue across Contractors, particularly related to the requirement that Contractors must pay applicable interest on all claims, including overturned claim disputes.

Based on the highest number of CAPs, AHCCCS should concentrate improvement efforts on the following standard areas: CIS, MM, and QM. AHCCCS should pay special attention to the QM standard as this is the standard within which most Contractors had the most CAPs. AHCCCS may consider including QM education during the quarterly meetings with the Contractors.

## Summary

AHCCCS' CYE 2016 Acute Care and CMDP OR demonstrated positive results overall. All Contractors scored fully compliant in at least one standard, with PHP scoring 100 percent in seven standards and MCP scoring 100 percent in five standards. Although the lowest score, 62 percent, was obtained by CMDP in the CC standard, the Contractor addressed the deficiencies satisfactorily through the CAP process.

The MI and GS standards were strengths across acute care and CMDP Contractors. All three Contractors were in full compliance with these standards. Conversely, the CIS standard resulted in the highest number of noncompliant scores.

## 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 calculation 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 measure rates for CYE 2015 for inclusion in this report for the following measures for the Acute Care Contractors and CMDP:

- *Adolescent Well-Care Visits*
- *Ambulatory Care (per 1,000 Member Months)—Emergency Department (ED) Visits—Total*
- *Annual Dental Visits—2–20 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years*
- *Plan All-Cause Readmissions—Total*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

For CMDP, AHCCCS calculated and approved the rates for inclusion for the following measures for CYE 2015:

- *Adolescent Well-Care Visits*
- *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*
- *Annual Dental Visits—2–20 Years*

- *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years*
- *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 Contractors' performance rates, HSAG organized, aggregated, and analyzed the performance data. From the analysis, HSAG was able to draw conclusions about Contractor-specific and statewide aggregate performance related to the quality of, access to, and timeliness of care and services provided to AHCCCS members for CYE 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 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 eight Acute Care Contractors and CMDP. The summary tool focused on HSAG's objectives for aggregating and analyzing the data, which were to:

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

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

For 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 performance rates and statewide aggregate rates for all Contractors for each 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 production of this report, AHCCCS had not 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' performance rates were calculated for AHCCCS-selected measures using administrative data collected from the automated managed care data system known as the Prepaid Medicaid Management Information System (PMMIS).

Performance measures used the Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>)<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 Contractor-specific and statewide aggregate performance results for each measure to determine if performance rates met or exceeded corresponding AHCCCS MPSs. Relative rate change and statistical analyses are presented to show the magnitude and direction of any change in rates from the previous measurement period and whether that change was 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 its 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 considering all Contractors for CYE 2015.

## Contractor-Specific Results—CYE 2015

AHCCCS provided HSAG data related to the CYE 2015 performance measure rates for eight Acute Care Contractors and for CMDP. The eight CYE 2015 Acute Care Contractors were Care1st, HCA, Health Net, MHP, MCP, PHP, UFC, and UHCCP-Acute. The CYE 2015 performance measures reported for the Acute Care Contractors and CMDP are listed in the "Conducting the Review" section preceding. No discussion of CAPs is included in the report this year for CYE 2015 data.

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

## Care1st Health Plan Arizona, Inc. (Care1st)

### Findings

Table 7-1 presents the performance measure rates for Care1st. 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 available.

**Table 7-1—Care1st—Performance Measurement Results**

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<sup>2</sup></b>					
Adolescent Well-Care Visits	45.2%	42.7%	-5.6%	<b>P&lt;.001</b>	41.0%
<b>Ambulatory Care (per 1,000 Member Months)<sup>2,4</sup></b>					
ED Visits—Total	53	55	—	—	—
<b>Annual Dental Visits<sup>2,3</sup></b>					
2–20 Years	67.2%	65.0%	-3.3%	<b>P&lt;.001</b>	60.0%
<b>Children and Adolescents' Access to Primary Care Practitioners</b>					
12–24 Months <sup>2</sup>	97.8%	94.1%	-3.8%	<b>P&lt;.001</b>	93.0%
25 Months–6 Years <sup>2</sup>	89.3%	87.8%	-1.7%	<b>P=.001</b>	84.0%
7–11 Years	93.2%	91.6%	-1.7%	<b>P=.002</b>	83.0%
12–19 Years	88.1%	88.6%	0.6%	P=.444	82.0%
<b>Plan All-Cause Readmissions<sup>2,4</sup></b>					
Total	14.2%	13.8%	-3.0%	P=.732	—
<b>Well-Child Visits in the First 15 Months of Life</b>					
Six or More Well-Child Visits	72.8%	66.3%	-8.9%	<b>P&lt;.001</b>	65.0%
<b>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life<sup>2</sup></b>					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.4%	70.4%	-2.7%	<b>P=.006</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 a Medicaid expansion for the Acute Care Contractors in CYE 2015, exercise caution when comparing CYE 2015 performance measure rates to historical performance measure rates (e.g., CYE 2014).

<sup>3</sup> Due to measure specification changes, exercise caution when comparing CYE 2015 performance measure rates for this measure to prior years' rates.

<sup>4</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 was not performed 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

Care1st exceeded the MPSs for all eight measure rates with an MPS for CYE 2015.

## Opportunities for Improvement

Although Care1st exceeded the MPSs for CYE 2015 for all eight performance measure rates with an MPS, a statistically significant decline was demonstrated in seven of these rates, indicating opportunities for improvement.

## Summary

Overall, performance for Care1st demonstrated strength in the areas of **quality** and **access** as all eight measure rates exceeded the established MPSs for CYE 2015. However, with seven of these performance measure rates showing statistically significant declines in performance, Care1st should monitor these measure rates. There were no performance measure rates related to **timeliness**; therefore, this area was not discussed.

## Health Choice Arizona (HCA)

### Findings

Table 7-2 presents performance measure rates for HCA. 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 available.

**Table 7-2—HCA—Performance Measurement Results**

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<sup>2</sup></b>					
Adolescent Well-Care Visits	37.1%	36.7%	-0.9%	P=.409	41.0%
<b>Ambulatory Care (per 1,000 Member Months)<sup>2,4</sup></b>					
ED Visits—Total	58	62	—	—	—
<b>Annual Dental Visits<sup>2,3</sup></b>					
2–20 Years	60.0%	62.1%	3.6%	<b>P&lt;.001</b>	60.0%
<b>Children and Adolescents' Access to Primary Care Practitioners</b>					
12–24 Months <sup>2</sup>	96.0%	94.4%	-1.6%	<b>P=.001</b>	93.0%
25 Months–6 Years <sup>2</sup>	85.8%	85.1%	-0.7%	P=.073	84.0%
7–11 Years	90.3%	89.2%	-1.2%	<b>P=.001</b>	83.0%
12–19 Years	86.9%	86.9%	-0.1%	P=.850	82.0%
<b>Plan All-Cause Readmissions<sup>2,4</sup></b>					
Total	11.9%	12.6%	5.5%	P=.352	—
<b>Well-Child Visits in the First 15 Months of Life</b>					
Six or More Well-Child Visits	69.0%	63.1%	-8.5%	<b>P&lt;.001</b>	65.0%
<b>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life<sup>2</sup></b>					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	59.4%	58.7%	-1.2%	P=.191	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 a Medicaid expansion for the Acute Care Contractors in CYE 2015, exercise caution when comparing CYE 2015 performance measure rates to historical performance measure rates (e.g., CYE 2014).

<sup>3</sup> Due to measure specification changes, exercise caution when comparing CYE 2015 performance measure rates for this measure to prior years' rates.

<sup>4</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 was not performed 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

HCA exceeded the MPS for five of the eight performance measure rates (*Annual Dental Visits—2–20 Years*; and *Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years*) with an MPS for CYE 2015. Of note, the performance measure rate for *Annual Dental Visits—2–20 Years* showed a statistically significant increase from CYE 2014 to CYE 2015.

## Opportunities for Improvement

Three of the eight performance measure rates that were compared to an MPS fell below the MPS for CYE 2015, indicating opportunities for improvement for *Adolescent Well-Care Visits*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*. All three of these measures declined from CYE 2014 to CYE 2015, with the *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* measure rate demonstrating a statistically significant decline. Additionally, despite meeting the MPSs, the *Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months and 7–11 Years* measure rates demonstrated statistically significant declines.

## Summary

Overall, performance for HCA varied across the areas of **quality** and **access**. For the **quality** area, the performance measure rates for *Adolescent Well-Care Visits*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* each fell below the related MPS, indicating opportunities for improvement. HCA demonstrated positive performance in the **access** area, exceeding the CYE 2015 MPS for the *Annual Dental Visits—2–20 Years* and *Children and Adolescents’ Access to Primary Care Practitioners* measure indicators. There were no performance measure rates related to **timeliness**; therefore, this area was not discussed.

## Health Net Access (Health Net)

### Findings

Table 7-3 presents performance measure rates for Health Net. 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 available. Health Net was still in the process of enrolling members during the CYE 2014 measurement period; therefore, exercise caution when evaluating CYE 2014 measure rates, as rates may represent data incompleteness instead of performance.

**Table 7-3—Health Net—Performance Measurement Results**

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<sup>2</sup></b>					
Adolescent Well-Care Visits	23.9%	24.7%	3.3%	P=.767	41.0%
<b>Ambulatory Care (per 1,000 Member Months)<sup>2,4</sup></b>					
ED Visits—Total	49	51	—	—	—
<b>Annual Dental Visits<sup>2,3</sup></b>					
2–20 Years	33.1%	41.2%	24.3%	<b>P&lt;.001</b>	60.0%
<b>Children and Adolescents’ Access to Primary Care Practitioners</b>					
12–24 Months <sup>2</sup>	84.9%	91.1%	7.3%	P=.213	93.0%
25 Months–6 Years <sup>2</sup>	79.9%	77.3%	-3.2%	P=.380	84.0%
7–11 Years	NA	80.1%	—	—	83.0%
12–19 Years	NA	68.3%	—	—	82.0%
<b>Plan All-Cause Readmissions<sup>2,4</sup></b>					
Total	NA	13.8%	—	—	—
<b>Well-Child Visits in the First 15 Months of Life</b>					
Six or More Well-Child Visits	NA	41.6%	—	—	65.0%
<b>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life<sup>2</sup></b>					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	53.8%	50.7%	-5.8%	P=.446	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 a Medicaid expansion for the Acute Care Contractors in CYE 2015, exercise caution when comparing CYE 2015 performance measure rates to historical performance measure rates (e.g., CYE 2014).

<sup>3</sup> Due to measure specification changes, exercise caution when comparing CYE 2015 performance measure rates for this measure to prior years’ rates.

<sup>4</sup> A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance.

NA indicates that the rate was not displayed because the denominator was less than 30.

— Indicates that comparison of performance between CYE 2014 and CYE 2015 was not performed 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

Although no performance measure rates met the established MPSs for CYE 2015 for Health Net, one measure rate, *Annual Dental Visits—2–20 Years*, demonstrated a statistically significant increase in performance between CYE 2014 and CYE 2015.

## Opportunities for Improvement

All eight performance measure rates that were compared to an MPS fell below the MPS for CYE 2015, indicating opportunities for improvement for Health Net. Of note, the rates for *Adolescent Well-Care Visits*; *Annual Dental Visits—2–20 Years*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* all fell below the related MPS by more than 15 percentage points.

## Summary

In the second year of reporting, no Health Net measure rates met the related MPSs, suggesting that Health Net has opportunities for improvement in the areas of **quality** and **access**. There were no performance measure rates related to **timeliness**; therefore, this area was not discussed.

## Maricopa Health Plan (MHP)

### Findings

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

**Table 7-4—MHP—Performance Measurement Results**

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<sup>2</sup></b>					
Adolescent Well-Care Visits	42.9%	40.9%	-4.6%	<b>P=.<!--009</b--></b>	41.0%
<b>Ambulatory Care (per 1,000 Member Months)<sup>2,4</sup></b>					
ED Visits—Total	62	61	—	—	—
<b>Annual Dental Visits<sup>2,3</sup></b>					
2–20 Years	61.2%	62.0%	1.4%	P=.066	60.0%
<b>Children and Adolescents' Access to Primary Care Practitioners</b>					
12–24 Months <sup>2</sup>	95.0%	92.9%	-2.3%	<b>P=.<!--021</b--></b>	93.0%
25 Months–6 Years <sup>2</sup>	87.8%	87.1%	-0.7%	P=.264	84.0%
7–11 Years	90.1%	89.1%	-1.1%	P=.107	83.0%
12–19 Years	88.0%	86.3%	-2.0%	<b>P=.<!--007</b--></b>	82.0%
<b>Plan All-Cause Readmissions<sup>2,4</sup></b>					
Total	15.3%	15.4%	0.8%	P=.922	—
<b>Well-Child Visits in the First 15 Months of Life</b>					
Six or More Well-Child Visits	70.6%	58.3%	-17.5%	<b>P&lt;.<!--001</b--></b>	65.0%
<b>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life<sup>2</sup></b>					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.3%	70.2%	-1.5%	P=.228	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 a Medicaid expansion for the Acute Care Contractors in CYE 2015, exercise caution when comparing CYE 2015 performance measure rates to historical performance measure rates (e.g., CYE 2014).

<sup>3</sup> Due to measure specification changes, exercise caution when comparing CYE 2015 performance measure rates for this measure to prior years' rates.

<sup>4</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 was not performed 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

MHP exceeded the MPSs for five of the eight performance measure rates (*Annual Dental Visits—2–20 Years; Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years, 7–11 Years, and 12–19 Years; and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) with established MPSs for CYE 2015.

## Opportunities for Improvement

Three of the eight performance measure rates that were compared to established MPSs fell below the MPSs and demonstrated statistically significant declines for CYE 2015, indicating opportunities for improvement for *Adolescent Well-Care Visits, Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months, and Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*.

## Summary

Overall, performance for MHP varied across the areas of **quality** and **access**. For the **quality** area, the performance measure rate for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* exceeded the established MPS for CYE 2015, whereas the performance measure rates for *Adolescent Well-Care Visits* and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* both had statistically significant declines and fell below the related MPSs. MHP demonstrated mostly positive performance in the **access** area, exceeding the CYE 2015 MPS for the *Annual Dental Visits—2–20 Years* measure and three of the four *Children and Adolescents’ Access to Primary Care Practitioners* measure indicators. The *Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months* measure rate was the only access measure that did not exceed the MPS, due to a statistically significant decline from CYE 2014 to CYE 2015. There were no performance measure rates related to **timeliness**; therefore, this area was not discussed.

## Mercy Care Plan (MCP)

### Findings

Table 7-5 presents performance measure rates for MCP. 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 available.

**Table 7-5—MCP—Performance Measurement Results**

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<sup>2</sup></b>					
Adolescent Well-Care Visits	41.8%	40.6%	-2.9%	<b>P&lt;.001</b>	41.0%
<b>Ambulatory Care (per 1,000 Member Months)<sup>2,4</sup></b>					
ED Visits—Total	56	60	—	—	—
<b>Annual Dental Visits<sup>2,3</sup></b>					
2–20 Years	65.7%	65.7%	0.0%	P=.956	60.0%
<b>Children and Adolescents' Access to Primary Care Practitioners</b>					
12–24 Months <sup>2</sup>	98.0%	96.2%	-1.9%	<b>P&lt;.001</b>	93.0%
25 Months–6 Years <sup>2</sup>	90.4%	89.6%	-0.9%	<b>P&lt;.001</b>	84.0%
7–11 Years	93.0%	93.1%	0.2%	P=.423	83.0%
12–19 Years	90.7%	90.3%	-0.4%	P=.100	82.0%
<b>Plan All-Cause Readmissions<sup>2,4</sup></b>					
Total	14.6%	12.8%	-11.9%	<b>P=.001</b>	—
<b>Well-Child Visits in the First 15 Months of Life</b>					
Six or More Well-Child Visits	74.5%	69.3%	-6.9%	<b>P&lt;.001</b>	65.0%
<b>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life<sup>2</sup></b>					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.1%	65.8%	-3.3%	<b>P&lt;.001</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 a Medicaid expansion for the Acute Care Contractors in CYE 2015, exercise caution when comparing CYE 2015 performance measure rates to historical performance measure rates (e.g., CYE 2014).

<sup>3</sup> Due to measure specification changes, exercise caution when comparing CYE 2015 performance measure rates for this measure to prior years' rates.

<sup>4</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 was not performed 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 exceeded the MPS for six of the eight performance measure rates (*Annual Dental Visits—2–20 Years; Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years; and Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*) with established MPSs for CYE 2015. Additionally, as a lower rate indicates better performance for this measure, the performance measure rate for *Plan All-Cause Readmissions* demonstrated statistically significant improvement from CYE 2014 to CYE 2015.

## Opportunities for Improvement

Two of the eight performance measure rates that were compared to established MPSs fell below the MPSs for CYE 2015, indicating opportunities for improvement for *Adolescent Well-Care Visits* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*. Of note, both of these measures demonstrated statistically significant declines from CYE 2014 to 2015, which resulted in the rates being below the MPSs for CYE 2015.

## Summary

Overall, performance for MCP varied across the areas of **quality** and **access**. For the **quality** area, the performance measure rate for *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* exceeded the established MPS for CYE 2015; whereas, performance measure rates for *Adolescent Well-Care Visits* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* fell below the MPS. MCP demonstrated positive performance in the **access** area, exceeding the CYE 2015 MPSs for the *Annual Dental Visits—2–20 Years* measure and *Children and Adolescents’ Access to Primary Care Practitioners* measure indicators. Additionally, three performance measure rates for measures that exceeded the MPS demonstrated statistically significant declines from CYE 2014 to CYE 2015 (*Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months and 25 Months–6 Years; and Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*). MCP should monitor performance on these measures to ensure that performance does not decline below the MPSs. There were no performance measure rates related to **timeliness**; therefore, this area was not discussed.

## Phoenix Health Plan, LLC (PHP)

### Findings

Table 7-6 presents performance measure rates for PHP. 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 available.

**Table 7-6—PHP—Performance Measurement Results**

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<sup>2</sup></b>					
Adolescent Well-Care Visits	56.6%	50.6%	-10.7%	<b>P&lt;.001</b>	41.0%
<b>Ambulatory Care (per 1,000 Member Months)<sup>2,4</sup></b>					
ED Visits—Total	56	54	—	—	—
<b>Annual Dental Visits<sup>2,3</sup></b>					
2–20 Years	70.1%	71.8%	2.4%	<b>P&lt;.001</b>	60.0%
<b>Children and Adolescents' Access to Primary Care Practitioners</b>					
12–24 Months <sup>2</sup>	97.9%	97.4%	-0.5%	P=.286	93.0%
25 Months–6 Years <sup>2</sup>	92.3%	92.3%	0.0%	P=.918	84.0%
7–11 Years	94.9%	95.0%	0.1%	P=.751	83.0%
12–19 Years	93.3%	92.8%	-0.5%	P=.199	82.0%
<b>Plan All-Cause Readmissions<sup>2,4</sup></b>					
Total	13.9%	12.6%	-9.6%	P=.341	—
<b>Well-Child Visits in the First 15 Months of Life</b>					
Six or More Well-Child Visits	76.5%	69.0%	-9.8%	<b>P&lt;.001</b>	65.0%
<b>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life<sup>2</sup></b>					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.6%	73.6%	-5.2%	<b>P&lt;.001</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 a Medicaid expansion for the Acute Care Contractors in CYE 2015, exercise caution when comparing CYE 2015 performance measure rates to historical performance measure rates (e.g., CYE 2014).

<sup>3</sup> Due to measure specification changes, exercise caution when comparing CYE 2015 performance measure rates for this measure to prior years' rates.

<sup>4</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 was not performed 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

PHP exceeded the MPS for all eight performance measure rates with an MPS for CYE 2015. The performance measure rate for *Annual Dental Visits—2–20 Years* demonstrated a statistically significant increase in performance from CYE 2014 to CYE 2015 and exceeded the MPS by approximately 12 percentage points.

## Opportunities for Improvement

Although PHP exceeded the MPS for CYE 2015 for eight performance measure rates, statistically significant declines were demonstrated in three of these performance measure rates (*Adolescent Well-Care Visits*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*), indicating opportunities for improvement.

## Summary

Overall, performance for PHP demonstrated strength in the areas of **quality** and **access** as all eight measure rates exceeded the established MPSs for CYE 2015. However, with three of these performance measure rates showing statistically significant declines in performance, PHP should continue to monitor these measure rates. There were no performance measure rates related to **timeliness**; therefore, this area was not discussed.

## University Family Care (UFC)

### Findings

Table 7-7 presents performance measure rates for UFC. 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 available.

**Table 7-7—UFC—Performance Measurement Results**

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<sup>2</sup></b>					
Adolescent Well-Care Visits	41.2%	40.2%	-2.2%	P=.089	41.0%
<b>Ambulatory Care (per 1,000 Member Months)<sup>2,4</sup></b>					
ED Visits—Total	58	57	—	—	—
<b>Annual Dental Visits<sup>2,3</sup></b>					
2–20 Years	55.7%	60.7%	8.9%	<b>P&lt;.001</b>	60.0%
<b>Children and Adolescents’ Access to Primary Care Practitioners</b>					
12–24 Months <sup>2</sup>	95.0%	95.1%	0.1%	P=.876	93.0%
25 Months–6 Years <sup>2</sup>	86.8%	86.9%	0.0%	P=.937	84.0%
7–11 Years	91.8%	89.9%	-2.1%	<b>P&lt;.001</b>	83.0%
12–19 Years	91.1%	89.4%	-1.8%	<b>P&lt;.001</b>	82.0%
<b>Plan All-Cause Readmissions<sup>2,4</sup></b>					
Total	12.0%	11.2%	-6.9%	P=.385	—
<b>Well-Child Visits in the First 15 Months of Life</b>					
Six or More Well-Child Visits	67.3%	55.4%	-17.7%	<b>P&lt;.001</b>	65.0%
<b>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life<sup>2</sup></b>					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64.1%	65.0%	1.4%	P=.199	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 a Medicaid expansion for the Acute Care Contractors in CYE 2015, exercise caution when comparing CYE 2015 performance measure rates to historical performance measure rates (e.g., CYE 2014).

<sup>3</sup> Due to measure specification changes, exercise caution when comparing CYE 2015 performance measure rates for this measure to prior years’ rates.

<sup>4</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 was not performed 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

UFC exceeded the MPS for five of the eight performance measure rates (*Annual Dental Visits—2–20 Years*; and *Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years*) with established MPSs for CYE 2015. Additionally, the performance measure rate for *Annual Dental Visits—2–20 Years* demonstrated a statistically significant increase in performance from CYE 2014 to CYE 2015.

## Opportunities for Improvement

Three of the eight performance measure rates that were compared to established MPSs fell below the MPSs for CYE 2015, indicating opportunities for improvement for *Adolescent Well-Care Visits*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*. Of note, the rate for *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* demonstrated a statistically significant decline in performance from CYE 2014 to CYE 2015 and fell below the MPS by 9.6 percentage points.

## Summary

Overall, performance for UFC varied across the areas of **quality** and **access**. For the **quality** area, the performance measure rates for *Adolescent Well-Care Visits*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* fell below the MPS, indicating opportunities for improvement. UFC demonstrated positive performance in the **access** area, exceeding the CYE 2015 MPS for the *Children and Adolescents’ Access to Primary Care Practitioners* and *Annual Dental Visits—2–20 Years* measure indicators. There were no performance measure rates related to **timeliness**; therefore, this area was not discussed.

## UnitedHealthcare Community Plan-Acute (UHCCP-Acute)

### Findings

Table 7-8 presents performance measure rates for UHCCP-Acute. 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 available.

**Table 7-8—UHCCP-Acute—Performance Measurement Results**

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<sup>2</sup></b>					
Adolescent Well-Care Visits	35.7%	39.4%	10.5%	<b>P&lt;.001</b>	41.0%
<b>Ambulatory Care (per 1,000 Member Months)<sup>2,4</sup></b>					
ED Visits—Total	56	59	—	—	—
<b>Annual Dental Visits<sup>2,3</sup></b>					
2–20 Years	63.6%	63.9%	0.4%	P=.243	60.0%
<b>Children and Adolescents' Access to Primary Care Practitioners</b>					
12–24 Months <sup>2</sup>	97.5%	95.5%	-2.0%	<b>P&lt;.001</b>	93.0%
25 Months–6 Years <sup>2</sup>	87.5%	87.8%	0.4%	P=.195	84.0%
7–11 Years	92.6%	91.4%	-1.3%	<b>P&lt;.001</b>	83.0%
12–19 Years	90.6%	89.4%	-1.3%	<b>P&lt;.001</b>	82.0%
<b>Plan All-Cause Readmissions<sup>2,4</sup></b>					
Total	13.1%	10.4%	-20.5%	<b>P&lt;.001</b>	—
<b>Well-Child Visits in the First 15 Months of Life</b>					
Six or More Well-Child Visits	67.7%	56.9%	-16.0%	<b>P&lt;.001</b>	65.0%
<b>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life<sup>2</sup></b>					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	58.0%	63.1%	8.8%	<b>P&lt;.001</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 a Medicaid expansion for the Acute Care Contractors in CYE 2015, exercise caution when comparing CYE 2015 performance measure rates to historical performance measure rates (e.g., CYE 2014).

<sup>3</sup> Due to measure specification changes, exercise caution when comparing CYE 2015 performance measure rates for this measure to prior years' rates.

<sup>4</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 was not performed 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-Acute exceeded the MPS for five of the eight performance measure rates (*Annual Dental Visits—2–20 Years*; and *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years*) with established MPSs for CYE 2015. Additionally, as a lower rate indicates better performance for this measure, the performance measure rate for *Plan All-Cause Readmissions* demonstrated statistically significant improvement.

## Opportunities for Improvement

Three of the eight performance measure rates that were compared to established MPSs fell below the MPSs for CYE 2015, indicating opportunities for improvement for *Adolescent Well-Care Visits*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*. Additionally, four performance measure rates demonstrated statistically significant decreases from CYE 2014 to CYE 2015 (*Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, 7–11 Years, and 12–19 Years*; and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*).

## Summary

Overall, performance for UHCCP-Acute varied across the areas of **quality** and **access**. For the **quality** area, the performance measure rates for *Adolescent Well-Care Visits*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* fell below the MPS, indicating opportunities for improvement. Although falling short of their respective MPSs, the performance measure rates for *Adolescent Well-Care Visits* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* demonstrated statistically significant increases in performance from CYE 2014 to CYE 2015. Positive performance within the **quality** area was also seen for the *Plan All-Cause Readmissions* measure, with the measure rate demonstrating statistically significant improvement from CYE 2014 to CYE 2015. UHCCP-Acute demonstrated positive performance in the **access** area, exceeding the CYE 2015 MPSs for all five measures within this domain (*Annual Dental Visits—2–20 Years* measure and all four *Children and Adolescents' Access to Primary Care Practitioners* measure indicators). Three of the four *Children and Adolescents' Access to Primary Care Practitioners* demonstrated statistically significant declines in performance, indicating that UHCCP-Acute should monitor this measure to ensure that performance does not decline below the MPS. There were no performance measure rates related to **timeliness**; therefore, this area was not discussed.

## Comparative Results for Acute Care Contractors—CYE 2015

### Findings

Table 7-9 presents the aggregate performance measure rates for the eight Acute Care 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 available.

**Table 7-9—Acute Care Contractors—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>Adolescent Well-Care Visits<sup>2</sup></b>					
Adolescent Well-Care Visits	40.7%	39.9%	-2.1%	<b>P&lt;.001</b>	41.0%
<b>Ambulatory Care (per 1,000 Member Months)<sup>2,4</sup></b>					
ED Visits—Total	56.2	59	—	—	—
<b>Annual Dental Visits<sup>2,3</sup></b>					
2–20 Years	63.5%	63.7%	0.3%	P=.094	60.0%
<b>Children and Adolescents' Access to Primary Care Practitioners</b>					
12–24 Months <sup>2</sup>	97.1%	95.1%	-2.1%	<b>P&lt;.001</b>	93.0%
25 Months–6 Years <sup>2</sup>	88.5%	87.7%	-0.9%	<b>P&lt;.001</b>	84.0%
7–11 Years	92.4%	91.5%	-1.0%	<b>P&lt;.001</b>	83.0%
12–19 Years	90.1%	89.3%	-0.9%	<b>P&lt;.001</b>	82.0%
<b>Plan All-Cause Readmissions<sup>2,4</sup></b>					
Total	13.6%	12.1%	-10.7%	<b>P&lt;.001</b>	—
<b>Well-Child Visits in the First 15 Months of Life</b>					
Six or More Well-Child Visits	71.5%	62.1%	-13.1%	<b>P&lt;.001</b>	65.0%
<b>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life<sup>2</sup></b>					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64.9%	64.6%	-0.6%	P=.067	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 a Medicaid expansion for the Acute Care Contractors in CYE 2015, exercise caution when comparing CYE 2015 performance measure rates to historical performance measure rates (e.g., CYE 2014).

<sup>3</sup> Due to measure specification changes, exercise caution when comparing CYE 2015 performance measure rates for this measure to prior years' rates.

<sup>4</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 was not performed 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

Of the eight performance measure rates with established MPSs, five aggregate measure rates (*Annual Dental Visits—2–20 Years*; and *Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years*) exceeded the MPS in CYE 2015. Additionally, as a lower rate indicates better performance for this measure, the performance measure rate for *Plan All-Cause Readmissions* demonstrated statistically significant improvement from CYE 2014 to CYE 2015.

## Opportunities for Improvement

Three of the eight performance measure rates that were compared to established MPSs fell below the MPSs for CYE 2015, indicating opportunities for improvement for *Adolescent Well-Care Visits*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*. In addition to falling below the MPSs, the rates for *Adolescent Well-Care Visits* and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* demonstrated statistically significant declines in performance from CYE 2014 to CYE 2015.

## Summary

Overall, performance for the Acute Care Contractors varied across the areas of **quality** and **access**. For the **quality** area, the performance measure rates for *Adolescent Well-Care Visits*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* fell below the MPSs, indicating opportunities for improvement. The *Plan All-Cause Readmission* performance measure rate demonstrated positive performance within the **quality** area, as the rate demonstrated statistically significant improvement from CYE 2014 to CYE 2015. The Acute Care Contractors demonstrated positive performance in the **access** area, exceeding the CYE 2015 MPS for the *Annual Dental Visits—2–20 Years* and the *Children and Adolescents’ Access to Primary Care Practitioners* measure rate indicators; though the rates for all four *Children and Adolescents’ Access to Primary Care Practitioners* measure indicators demonstrated statistically significant declines in performance. There were no performance measure rates related to **timeliness**; therefore, this area was not discussed.

## Comprehensive Medical and Dental Program (CMDP)

### Findings

Table 7-10 presents performance measure rates for CMDP. 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 available.

**Table 7-10—CMDP—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>Adolescent Well-Care Visits<sup>2</sup></b>					
Adolescent Well-Care Visits	68.2%	64.3%	-5.8%	<b>P=.005</b>	41.0%
<b>Ambulatory Care (per 1,000 Member Months)<sup>2,4</sup></b>					
ED Visits—Total	42	46	—	—	—
<b>Annual Dental Visits<sup>2,3</sup></b>					
2–20 Years	78.8%	68.3%	-13.3%	<b>P&lt;.001</b>	65.0%
<b>Children and Adolescents' Access to Primary Care Practitioners</b>					
12–24 Months <sup>2</sup>	98.7%	99.0%	0.3%	P=.621	93.0%
25 Months–6 Years <sup>2</sup>	93.8%	93.0%	-0.8%	P=.244	84.0%
7–11 Years	96.9%	94.3%	-2.7%	<b>P=.013</b>	83.0%
12–19 Years	96.4%	96.1%	-0.3%	P=.713	82.0%
<b>Plan All-Cause Readmissions<sup>2,4</sup></b>					
Total	NA	NA	—	—	—
<b>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life<sup>2</sup></b>					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.8%	69.8%	-2.8%	P=.163	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  $\leq 0.05$ . Significance levels (*p*-values) in bold font indicate statistically significant values.

<sup>2</sup> Due to a Medicaid expansion for the Acute Care Contractors in CYE 2015, exercise caution when comparing CYE 2015 performance measure rates to historical performance measure rates (e.g., CYE 2014).

<sup>3</sup> Due to measure specification changes, exercise caution when comparing CYE 2015 performance measure rates for this measure to prior years' rates.

<sup>4</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 was not performed 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

CMDP exceeded the MPS for all seven performance measure rates with an MPS for CYE 2015. Of note, the performance measure rate for *Adolescent Well-Care Visits* exceeded the MPS by approximately 23 percentage points.

## Opportunities for Improvement

Although CMDP exceeded the MPS for CYE 2015 for seven performance measure rates, a statistically significant decline was demonstrated for three of these performance measure rates (*Adolescent Well-Care Visits*, *Annual Dental Visits—2–20 Years*, and *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*), indicating opportunities for improvement.

## Summary

Overall, performance for CMDP demonstrated strength in the areas of **quality** and **access** as all seven measure rates exceeded the established MPS for CYE 2015. However, with three of these performance measure rates showing a significant decline in performance, CMDP should continue to monitor these measures. There were no performance measure rates related to **timeliness**; therefore, this area was not discussed.

## 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: Remeasurement 1 period (October 1, 2015, through September 30, 2016), and Remeasurement 2 period (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 to increase the percentage of prescriptions submitted electronically in order to improve patient safety. AHCCCS' goal is to demonstrate a statistically significant increase in the number of providers submitting prescriptions electronically and the number of prescriptions submitted electronically, followed by 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 systemwide interventions to achieve improvement in quality.
- Evaluates the effectiveness of each Contractor's interventions.
- Ensures that each Contractor planned and initiated activities to increase or sustain its improvement.
- Ensures that each Contractor reported to the State data/information it collected for each project in a reasonable period to allow timely information on the status of PIPs.
- Calculates and validates the PIP results from the Contractor data/information.
- Reviews the impact and effectiveness of each Contractor's performance improvement program.
- Requires each Contractor to have an ongoing process to evaluate the impact and effectiveness of its performance improvement program.

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

- Determine Contractor performance on the AHCCCS-selected PIP.

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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. 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 analysis and interventions for seven Acute Care Contractors and CMDP. The Acute Care Contractors for which data were provided were Care1st, HCA, MCP, PHP, UFC, UHCCP-Acute, Health Net, and CMDP. The interventions reported during CYE 2015 for the Acute Care Contractors and for CMDP were for the *E-Prescribing* PIP, which, to improve patient safety, focused on increasing the number of providers ordering prescriptions electronically and increasing the percentage of prescriptions submitted electronically rather than via paper or other method.

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.

### **Care1st Health Plan Arizona, Inc. (Care1st)**

Care1st submitted the following qualitative analysis:

- Feedback from providers indicated continued misunderstanding about the fact that prescriptions for controlled substances can be prescribed electronically; this is an ongoing barrier to improvement, and one that Care1st is addressing through provider education. Active participation in collaborative efforts between Care1st, AHCCCS, Arizona Alliance of Health Plans (AzAHP) and Health Current (formerly known as Health-e Connection) (collectively referred to as “workgroup”) continues, as described in the below interventions implemented after analysis of baseline data was completed.

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

- Explore funding sources to assist selected providers with technical upgrades/other fees, to gain e-prescribing functionality.
- Complete implementation of e-prescribing incentives into contracts with value-based purchasing (VBP) groups (e.g., Primary Care Medical Homes [PCMHs]).
- Send fax blasts to providers reinforcing the legality of e-prescribing controlled substances, listing the benefits of e-prescribing, and outlining steps to begin electronic prescriptions for controlled substances (EPCS); the same blast fax was used multiple times to reinforce provider/staff education through consistent messaging.
- Target high-volume prescribers for education with a focus on EPCS through AzAHP E-Rx workgroup (workgroup) collaboration since providers contract with multiple health plans.

- Conduct provider forum presentations in Maricopa and Pima counties including information on e-prescribing along with the same message from fax blasts to reinforce provider/staff education.
- Mailed to all Acute and Division of Developmental Disabilities member households the Care1st *Summer 2016 Member Newsletter*, with an article, “The Safest Way to Get Your Medication,” which informed members about the benefits of e-prescribing.
- Develop e-prescribing an 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.
- Mine data with assistance of AHCCCS to determine changes (compared to data mining completed in 2015) and identify opportunities for further improvement (high-volume prescribers with low rates of e-prescribing, including EPCS).
- Develop a physician education flyer for use by all AHCCCS Contractors through the workgroup.

### **Health Choice Arizona (HCA)**

HCA submitted the following qualitative analysis:

- CY 2015 data showed a negative variance from baseline, which the HCA network team attributed to initial provider resistance to e-prescribing. HCA identified trends in rural areas for providers who use paper charts with no stated intention of converting to electronic medical records. Year 1 demonstrated a July dip in results and was noted for future trending. This drop is attributed to a reduction in clinic visits due to summer vacation (members and providers), with an upswing in August/September when school starts.
- An interrater reliability (IRR) audit was conducted to test the accuracy of three sources of data to determine the best data source for reporting. Three separate run reports were conducted, and data were reviewed against AHCCCS e-prescribing data to determine which report most aligned with AHCCCS. In 2016, HCA identified that the most valuable report came from pharmacy claims data generated on the date of service and not date of entry.
- HCA participates in the workgroup and incorporated their educational material in educating their providers as needed.

HCA reported the following interventions to increase both the rate of providers prescribing prescriptions electronically and the rate of prescriptions sent electronically:

- The e-prescribe strategy was reassigned to the quality director and new medical director for HCA.
- An analysis of ACOM 321/e-prescribing PIP was conducted and educational material was created.
- IRR was completed on three internal reports.
- Initiated an e-prescribing subcommittee.
- Educated network representatives.

- Network representatives initiated educational outreach as well as an environmental scan of e-prescribing capabilities of providers in the network.
- Initiated rapid Plan-Do-Study-Act (PDSA) cycles every two weeks for laser focus on the initiative for the upcoming year.
- Health Current educational flyer was uploaded to HCA's provider website.

### ***Health Net Access (Health Net)***

Health Net submitted the following qualitative analysis:

- Researched the possible cause of the issue and identified that a Drug Enforcement Administration (DEA) rule allowed for writing prescriptions for controlled substances electronically. This rule was published March 2010, but did not become effective until June 2010. This rule did not mandate that practitioners prescribe using only electronic methods, nor did it require pharmacies to accept prescriptions for controlled substances electronically; both were left as voluntary actions. Prescribing practitioners were still allowed to write and sign for schedules II, III, IV, and V controlled substances. Prescribers may not be aware that the original DEA rule was revised to allow for controlled substances and may be functioning under the assumption that the rule remains restricted to medications not considered controlled substances.
- An opportunity exists to reinforce education provided to prescribing clinicians that includes information on the ability to prescribe controlled substances electronically. Revision of the education included in the original Provider Quality of Care Guide has been completed and includes information on controlled substances. Additionally, flyers that have been developed by the workgroup through the Health Current have been distributed widely to providers.

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

- Revise the member educational article for inclusion in the summer version of the member newsletter. The article will provide education to the members about the benefits of using e-prescribing options when visiting healthcare providers.
- Collaborated with pharmacy services to distribute a workgroup educational flyer to contracted providers.
- Distributed information on Health Current webinars and/or forums to contracted providers.
- Continued participation in the workgroup addressing e-prescribing interventions.

### ***Maricopa Health Plan (MHP)***

A PIP submission was not required as part of MHP's closeout activities. All members transitioned from MHP effective February 1, 2017.



## **Mercy Care Plan (MCP)**

MCP submitted the following qualitative analysis:

- A survey of providers was conducted by all Contractors in the Arizona Association of Health Plans. The findings by MCP are as follows:
  - Almost all providers surveyed by MCP have an electronic health record (EHR) system.
  - Barriers identified by MCP:
    - 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, and 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.
- 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.

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

- Developed member educational materials to communicate the benefits of e-prescribing.
- Provided updated information on each practice's e-prescribing rate to the practice representatives and had them discuss the results with each practice periodically, making it specific to individual doctors and concentrating on outlier low users.
- 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 substance prescription monitoring program (CSPMP) data.

### ***Phoenix Health Plan, LLC (PHP)***

PHP submitted the following qualitative analysis:

- PHP conducted a qualitative provider survey at a PHP provider forum. Provider office staff in attendance documented what they perceived to be barriers to the adoption of e-prescribing in their offices. PHP compiled and analyzed the survey results, then used those results to develop interventions that began in early 2015 and will continue at least through the end of the measurement period in 2017. For example, PHP identified the cost of an EHR as a barrier; and the intervention was to connect offices with a non-profit organization that could educate the providers on no-cost e-prescribing software and inform the providers of incentives that could offset the cost of more sophisticated systems.

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

- Attended e-prescribing conferences to increase expertise.
- Incorporated e-prescribing into a P4P payment model.
- Implemented and built the metric for a new system for the foundation for the P4P analytics.

### ***UnitedHealthcare Community Plan-Acute (UHCCP-Acute)***

UHCCP-Acute 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 EHR vendors was initiated. From these activities were identified needs for: further education on e-prescribing (including EPCS), evaluation of ability for current EHR systems to support ECPS, and identification and ranking of providers' e-prescribing.

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

- Educated prescribers on advantages of e-prescribing and offered assistance in connecting with e-prescribing vendors.
- Incorporated e-prescribing presentations and information into provider forums.

### ***University Family Care (UFC)***

UFC submitted the following qualitative analysis:

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

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

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

### ***Comprehensive Medical and Dental Program (CMDP)***

CMDP submitted the following qualitative analysis:

- CMDP members typically are prescribed less-complicated medications such as antibiotics and asthma/allergy medications, allowing for easier implementation of e-prescribing.

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

- Include articles in the spring and fall provider newsletter addressing benefits in e-prescribing.
- CMDP's provider services unit sent out an email blast to 216 providers regarding e-prescribing, including a provider profile update containing information related to e-prescribing.
- Administered a provider survey to identify and analyze obstacles that providers experience with implementing or using e-prescribing.
- Targeted high-utilizing paper prescribers.
- Developed e-prescribing brochures highlighting the benefits to providers.
- Incorporated e-prescribing protocols as a formal item to be addressed as part of provider education during office on-site visits conducted by the Provider Services Unit.
- Developed and inserted e-prescription check stuffers into envelopes with paper checks and remittance statements for providers.
- Generated monthly e-prescriber reports to identify the top 10 percent of providers who prescribe medications to CMDP members either not e-prescribing or e-prescribing inconsistently.
- Supported and continues to support efforts of the workgroup to encourage e-prescribing.