

Arizona Health Care Cost Containment System



**Contract Year Ending 2016**  
**External Quality Review Annual Report**  
*for*  
**Behavioral Health Services**

*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.

In Arizona, behavioral health has historically been a carved-out benefit separately managed by Regional Behavioral Health Authorities (RBHAs). Related to this structure, for an individual with a serious mental illness to obtain care, up to four different healthcare systems might be necessary: the AHCCCS acute health plan, for physical health services; the RBHA, for behavioral health services; Medicare, for persons with a serious mental illness (SMI) who are dually eligible for both Medicaid and Medicare; and Medicare Part D, for medications. Navigating the complex healthcare system was one of the greatest barriers to obtaining medically necessary health care. For Arizonans with SMI, obtaining needed healthcare was challenging and further complicated by concerns around poor medication management and stigma, sometimes causing 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 poor among that population.<sup>1-2</sup>

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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.

<sup>1-2</sup> Arizona Health Care Cost Containment System. Behavioral Health Integration. Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/behavioralhealth.html>. Accessed on: Jan 29, 2018.

To help address these issues, AHCCCS collaborated with behavioral health partners to create a more streamlined system that reduced barriers to care for members and increased accountability of the RBHA for managing the “whole health” of persons with SMI.<sup>1-3</sup>

To be eligible for SMI services in Arizona, persons must have a specific SMI diagnosis and a functional impairment related to the diagnosis. SMI diagnoses include the following disorders: psychotic, bipolar, obsessive-compulsive, depressive, mood, anxiety, post-traumatic stress, dissociative, and personality.<sup>1-4</sup>

On April 1, 2014, approximately 17,000 members with SMI in Maricopa County were transitioned to a single plan, Mercy Maricopa Integrated Care, to manage both their behavioral and physical healthcare needs. On October 1, 2015, this model was launched statewide through contracts with Health Choice Integrated Care (HCIC) in Northern Arizona and Cenpatico Integrated Care (CIC) in Southern Arizona. Members residing in the following counties began receiving physical and behavioral health services from CIC beginning October 1, 2015: Cochise, Greenlee, La Paz, Pima, Pinal, Yuma, Santa Cruz, Graham, and ZIP Codes 85542 and 85192. Members residing in the following counties began receiving physical and behavioral health services from Health Choice Integrated Care beginning October 1, 2015: Apache, Coconino, Mohave, Navajo, Yavapai, and Gila (excepting ZIP Codes 85542 and 85192).

In addition, as part of the 2015 legislative session, Governor Ducey proposed and the Arizona Legislature approved an administrative simplification effort that brought together the AHCCCS program with its longstanding partner, the Division of Behavioral Health Services (DBHS), within the Arizona Department of Health Services (ADHS). Historically, ADHS/DBHS served as AHCCCS’ contracted managed care organization (MCO) for the provision of behavioral health services to AHCCCS members. In turn, ADHS/DBHS contracted with RBHAs, which provided behavioral health benefits for members. Through Governor Ducey’s Administrative Simplification Initiative, DBHS merged with AHCCCS and the RBHAs became AHCCCS-contracted MCOs for administration of behavioral health benefits.

Due to the Administrative Simplification Initiative and the change to integrated care with the RBHAs, AHCCCS did not complete operational reviews (ORs) for any of the RBHAs, but did conduct PIP and performance measure activities for Mercy Maricopa Integrated Care.

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.

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<sup>1-3</sup> Ibid.

<sup>1-4</sup> Arizona Health Care Cost Containment System. SMI Determination Process. October 20, 2016. Available at: <https://www.azahcccs.gov/AmericanIndians/Downloads/Handouts/CrisisResponseSMIDeterminationProcess102016.pdf>. Accessed on: Jan 29, 2018.

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 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 of, 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 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 initiatives that are specific to the behavioral health 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 new AHCCCS methodology for the organizational review (OR). (AHCCCS began a new OR in CYE 2016 [review period October 1, 2015, through September 30, 2016] to assess each Contractor’s compliance with AHCCCS’ contract standards.) CIC underwent a focused OR in January 2017. While the OR did not occur within the time frame that this annual report includes (CYE 2016), it did fall within the required three-year cycle. Therefore, AHCCCS has not submitted documentation for this reporting period.
- Section 7 (Performance Measure Performance)—A presentation of rates for AHCCCS-selected performance measures for the General Mental Health and Substance Abuse (GMH/SA) aggregate and one RBHA Contractor (i.e., Mercy Maricopa Integrated Care [MMIC]) servicing the Serious Mental Illness (SMI) population in Maricopa county as well as HSAG’s associated findings and recommendations for CYE 2015.
- Section 8 (Performance Improvement Project Performance)—A presentation of MMIC CYE 2014 PIP baseline rates for the GMH/SA population and CYE 2015 PIP baseline rates for the integrated population.

## Overview of the CYE 2016 External Review

AHCCCS conducted two of the three mandatory activities for this reporting period—performance improvement projects and performance measurement.

During the review period, AHCCCS contracted with the RBHA Contractors listed below to provide services to members enrolled in the AHCCCS Behavioral Health Medicaid managed care program.

The RBHA Contractors serving the GMH/SA and SMI populations and associated abbreviations used throughout this report are listed below:

- Mercy Maricopa Integrated Care (MMIC)
- Cenpatico Integrated Care (CIC)
- Health Choice Integrated Care (HCIC)



## 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

The CIC-focused OR was conducted January 2017. While this did not fall within the time frame of CYE 2016, it did fall within the required three-year cycle required; therefore, no documentation has been submitted to HSAG for this reporting period.

### Performance Measures

AHCCCS collected data and reported rates for a set of seven performance measure rates for the GMH/SA aggregate population and for 12 performance measures for the RBHA Contractor serving the SMI population (i.e., MMIC). The following tables display the performance measure rates with established minimum performance standards (MPSs). No MPS had yet been established for all reported performance measure rate. Rates for performance measures without an established MPS are found in the “Performance Measure Performance” section of this report.

### GMH/SA Aggregate Findings

Table 1-1 presents the following information for each measure indicator for the GMH/SA aggregate: 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 1-1—GMH/SA Aggregate—Performance Measure Results**

Performance Measure	CYE 2014 Performance	CYE 2015 Performance	Relative Percentage Change	Significance Level (p value) <sup>1</sup>	Minimum Performance Standard
<b><i>Follow-Up After Hospitalization for Mental Illness<sup>2</sup></i></b>					
<i>7-Day Follow-Up</i>	36.8%	46.7%	26.6%	<b>P&lt;.001</b>	50.0%
<i>30-Day Follow-Up</i>	51.9%	63.7%	22.7%	<b>P&lt;.001</b>	70.0%

<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 changes in how mental health practitioners were identified in CYE 2015, exercise caution when comparing CYE 2015 rates to historical rates.



For CYE 2015, performance for the GMH/SA aggregate demonstrated statistically significant improvements for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* performance measure rates. Caution should be exercised when evaluating changes in rates for this measure due to changes in how mental health practitioners were identified between CYE 2014 and CYE 2015.

**Conclusions**

Despite statistically significant increases for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* from CYE 2014 to CYE 2015, both performance measure rates fell below the MPSs, by 3.3 percentage points and 6.3 percentage points, respectively.

**Recommendations**

Both performance measure rates fell below the MPS, suggesting that efforts should be focused on increasing follow-up visits for members after hospitalization for mental illness.

**SMI Population—MMIC Findings**

MMIC was the only RBHA Contractor providing integrated physical and mental health services to the SMI population in CYE 2015. Table 1-2 presents the following information for each measure indicator for MMIC: the CYE 2015 performance and the AHCCCS MPS. CYE 2015 was the first full reporting year for MMIC; therefore, no MPS had yet been established for most reported performance measure rates.

**Table 1-2—SMI Population—MMIC—Performance Measurement Results**

Performance Measure	CYE 2015 Performance	Minimum Performance Standard
<b><i>Adults’ Access to Preventive/Ambulatory Health Services</i></b>		
<i>Total</i>	94.0%	75.0%
<b><i>Cervical Cancer Screening</i></b>		
<i>Cervical Cancer Screening</i>	22.0%	64.0%

For CYE 2015, MMIC exceeded the MPS for (*Adults’ Access to Preventive/Ambulatory Health Services—Total*). Conversely, the performance measure rate for *Cervical Cancer Screening* fell below the MPS.

**Conclusions**

MMIC demonstrated a strength for the *Adults’ Access to Preventive/Ambulatory Health Services—Total* measure, exceeding the MPS by 19 percentage points. Conversely, MMIC demonstrated an opportunity for improvement for the *Cervical Cancer Screening* measure, which fell below the MPS by 42 percentage points.

## Recommendations

The performance for *Cervical Cancer Screening* fell below the MPS; therefore, MMIC should focus efforts on improving cervical cancer screening rates for women in the SMI 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 included 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). Upon initiation of the *E-Prescribing* PIP, all behavioral health services were provided under DBHS, an AHCCCS Contractor. However, behavioral health services for the GMH/SA and SMI populations within Maricopa County transitioned to MMIC effective April 1, 2014. GMH/SA and SMI members outside Maricopa County transitioned to either CIC or HCIC effective October 1, 2015. Therefore, the RBHA Contractors' PIP measurement periods differ from all other lines of business. As CYE 2015 was an intervention year for the GMH/SA member population, this annual report includes CYE 2014 baseline measurement data for MMIC's GMH/SA member population. This annual report also includes CYE 2015 baseline measurement data for MMIC's integrated member population, qualitative analyses, and interventions.

Due to the transitions noted preceding as well as the desire to create alignment amongst the GMH/SA and SMI populations, AHCCCS has elected to have the DBHS aggregate rates for CYE 2014 serve as the MMIC GMH/SA baseline rates, with the Remeasurement 1 period being CYE 2017.

AHCCCS implemented the *E-Prescribing* PIP to improve preventable errors in communicating a medication between a prescriber and a pharmacy. Research found that clinicians make fewer errors using an electronic system than with handwritten prescriptions.<sup>1-5</sup> AHCCCS found that sending electronic prescriptions can reduce mistakes related to medication types, dosages, and member information and that electronic prescribing assists pharmacies in identifying potential problems related to medication management as well as potential reactions that members may encounter, especially for those taking multiple medications.

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

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<sup>1-5</sup> Kaushal R, Kern LM, Barrón Y, et al. Electronic prescribing improves medication safety in community-based office practices. *Journal of General Internal Medicine*, 2010 Jun;25(6):530-6.

## Findings

This was the baseline reporting period for the *E-Prescribing* PIP; therefore, comparisons could not be made between rates for each indicator. HSAG recommends that the RBHA Contractors continually monitor the PIP rates to determine whether interventions are successful prior to the first remeasurement of the PIP for MMIC.

## Overall Findings, Recommendations, 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 RBHA Contractor performance support these goals. AHCCCS has a comprehensive system to monitor and improve the timeliness of, access to, and quality of care that RBHA Contractors provide to Medicaid members. All RBHA Contractors are working toward improving the delivery of services and quality of care provided to their members. Rates for AHCCCS-selected performance measures such as *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* demonstrated improvement from previous years, and targeted improvement opportunities were highlighted for other measures for the GMH/SA and SMI populations (i.e., MMIC). AHCCCS selected a PIP, *E-Prescribing*, for all lines of business which, to increase patient safety, measures the number of providers that write electronic prescriptions and the number of prescriptions submitted electronically. Initial results are not available for this report, with the exception of MMIC; however, the RBHA Contractors have employed significant interventions to improve the results of this PIP.

## Performance Measures

Overall, compared to the CYE 2015 MPS, MMIC’s performance for the SMI population and the RBHA Contractors for the GMH/SA population varied across all three areas of **quality**, **access**, and **timeliness**. Across all three areas, the performance measure rates for the GMH/SA aggregate population for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* demonstrated statistically significant improvement from CYE 2014 to CYE 2015, although the MPS was not met for either measure. Additionally, positive performance was observed in the **access** area, with MMIC’s *Adults’ Access to Preventive/Ambulatory Health Services* measure rate exceeding the MPS. The *Cervical Cancer Screening* performance measure rate indicated an opportunity for improvement in the **quality** area, falling 42 percentage points below the MPS.

As this was the first year of reporting for MMIC, AHCCCS was unable to perform any trending of performance over time; however, in future years AHCCCS will also analyze the direction of any change in rates from the previous measurement period and whether the change was statistically significant.

HSAG recommends the following:

- MMIC and the RBHA Contractors serving the GMH/SA population should focus efforts on monitoring and improving the quality of, timeliness of, and access to care and services for members enrolled in the Behavioral Health Medicaid managed care program for all measure rates reported. Results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.
- AHCCCS should develop MPSs for the performance measures that do not have an MPS to provide actionable feedback to the RBHA Contractors and trend data more effectively over time.
- More appropriate MPSs should be assigned to the SMI population performance measures, given that this special population may not benefit from exceeding the MPSs currently assigned.

### **Performance Improvement Projects**

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

This was the baseline reporting period for the *E-Prescribing* PIP; therefore, no comparable findings were noted. MMIC did, however, implement solid interventions. In addition, because this was the baseline measurement period, strong conclusions have not been identified regarding the strengths and opportunities for MMIC's performance improvement.

HSAG recommends the following:

- MMIC should continue to monitor and evaluate the effectiveness of interventions for this PIP.

In addition, HSAG recommends that AHCCCS consider the following:

- Require the Contractors to have more than one PIP. AHCCCS now requires the *E-Prescribing* PIP; however, AHCCCS could require the RBHA Contractors to expand to one other PIP that improves outcomes of one of the lower-scoring performance measures.
- Establish a standing agenda item at the Contractor Quarterly Meetings for Contractors to share PIP results, including successes and lessons learned. Improvement strategies and interventions that were successful and resulted in sustained improvement should be considered for system-wide implementation.

### **Conclusions**

In general, and as documented in detail in other sections of this report, MMIC and the RBHA Contractors serving the GMH/SA population demonstrated positive performance and opportunities for improvement in the timeliness of, access to, and quality of care they provide to Medicaid members. While highlighted throughout the report, opportunities for improvement and associated recommendations should not detract from the targeted progress made by each 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 affordable costs.
- Increase use of value-based access fee schedule differentiation. AHCCCS pursued adjustments in the fee-for-service payment schedule to incentivize certain value measures for providers. Additionally, AHCCCS recently created a program for first responders to provide treatment and referrals instead of requiring transportation to an emergency room to receive payment.

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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. 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 percent of the dual eligible member population aligned which is the highest percentage ever.
- Establish policies and programs to support integrated providers. For example, the structure of AHCCCS is transforming towards integrated care delivery systems with better alignment of incentives that seeks to efficiently improve health outcomes.
- Leverage health information technology (HIT) investments to create more data flow in healthcare delivery system. AHCCCS devoted significant resources to integrate health information across





providers and now it has a fully functioning Health Information Exchange to facilitate the coordination of information for all the delivery systems.

- Develop a strategy to strengthen the availability of behavioral health resources within the integrated delivery system. AHCCCS is planning on offering fully integrated services to all its members by 2019.
- Develop comprehensive strategy to curb opioid abuse and dependency.
- Improve access for individuals transitioning out of the justice system.

#### **4. AHCCCS must maintain core organizational capacity, infrastructure, and workforce planning that effectively serve its operations.**

- Pursue continued deployment of electronic solutions to reduce health care administrative burden. In addition, define strategies to make data available and reliable for decision-making processes.
- Continue to manage workforce environment, promoting activities that support employee engagement and retention; and address potential gaps in the organization's knowledge base due to retirements and other staff departures.
- Strengthen system-wide security and compliance with privacy regulations related to all information and data by evaluating, analyzing, and addressing potential security risks.
- Improve and maintain information technology (IT) infrastructure, including server based applications, ensuring business continuity.
- Continue work and effort around implementation of the Arizona management system.

### **AHCCCS Quality Strategy**

The U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS) Medicaid managed care regulations at 42 CFR §438.200 and §438.340 implement Section 1932(c)(1) of the Medicaid managed care act, which defines certain Medicaid state agency responsibilities. The regulations require Medicaid state agencies operating Medicaid managed care programs to develop and implement a written quality strategy for assessing and improving the quality of healthcare services offered to their members. The written strategy must describe the standards that a state and its contracted MCOs and PIHPs must meet. The Medicaid state agency quality strategy must include all of the following:

- The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs as well as examples of evidence-based clinical practice guidelines required by the State.
- The State's goals and objectives for continuous quality improvement, which must be measurable and take into consideration the health status of each population that the State serves.
- A description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP; the performance improvement projects to be implemented, including any interventions that the State proposes to improve access, quality, or timeliness of care.



- Arrangements for annual, external independent reviews of the quality outcome and timeliness of and access to, the covered services.
- A description of the State’s transition of care policy.
- The State’s plan to identify, evaluate, and reduce health disparities based on age, race, ethnicity, sex, primary language, and disability status, to the extent practicable.
- Appropriate use of intermediate sanctions for MCOs.
- A description of how the State will assess the performance and quality outcomes achieved by each primary care case management (PCCM) entity.
- The mechanisms implemented by the State to comply with requirements relating to the identification of persons who need long-term services and supports or persons with special healthcare needs.
- Information relating to non-duplication of EQR activities.
- The State’s definition of “significant change” related to instances in which significant changes are made to the quality strategy or occur in the State Medicaid program.

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

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

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

AHCCCS operates from a well-established objective and systematic process in identifying priority areas for improvement and selecting new Contractor-required performance measures and PIPs. The process involves a review of internal and external data sources. AHCCCS also considers the prevalence of a particular condition, the population affected, and the resources required by both AHCCCS and the Contractors to conduct studies and drive improvement. AHCCCS also:

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



## ***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.

For CYE 2015, because of the administrative simplification and merger of ADHS/DBHS and AHCCCS, an operational review was not conducted for the behavioral health Contractors.

In CYE 2016, for the RBHA Contractors, ORs were scheduled to occur between July 2017 and October 2017. Cenpatico Integrated Care (CIC) underwent a focused OR in January 2017; however, this did not fall within the CYE 2016 (current reporting period) time frame. Therefore, no documentation has been submitted for this reporting period.

## ***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 requires that RBHA 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 RBHA 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 RBHA Contractors must conduct.



For the AHCCCS-mandated PIPs, AHCCCS and the RBHA Contractors measure performance for at least two years after the RBHA 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 RBHA Contractors to demonstrate improvement, and then sustain the improvement over at least one subsequent remeasurement cycle to ensure institutionalization of the interventions. AHCCCS requires RBHA 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 RBHA Contractors:

- Validate Contractor PIP—validation performed by AHCCCS.
- Validate Contractor performance measures. (The validation of performance measures was only conducted for Mercy Maricopa Integrated Care.)
- 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 not completed for the RBHAs.)

AHCCCS contracted with HSAG to aggregate and analyze the data AHCCCS obtained from conducting the two mandatory activities for its RBHA 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.

### 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.

Starting on October 1, 2018, AHCCCS proposes 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 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/EPSDT coordinators.
- **Task Force on Prevention of Prenatal Exposure to Alcohol and other Drugs (Task Force):** The Task Force is composed of representatives from various agencies who work to increase awareness and address concerns in the community regarding fetal alcohol spectrum disorders. AHCCCS staff members attend the monthly meetings and regularly participate in discussions related to solutions to reduce prenatal exposure to alcohol and other drugs. A strategic plan has been finalized by the Task Force, and members are meeting regularly to work on goals and objectives.
- **Arizona Medical Association (ArMA) and the Arizona Chapter of the American Academy of Pediatrics (AAP):** AHCCCS collaborates with ArMA and the Arizona Chapter of the AAP in 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 CHCS to participate in this initiative, and AHCCCS formed a collaborative workgroup to drive these improvements across the state. AHCCCS has selected an FQHC to work in partnership with to collect data and implement interventions relevant to this initiative; AHCCCS Contractors have joined the workgroup that is driving the intensive planning efforts related to these directives. During quarter three AHCCCS and the selected FQHC finalized methods for collecting data which is being generated by the FQHC to share with both AHCCCS and participating Contractors.
- Medicare and Medicaid Alignment for Duals: Arizona leads the nation with the highest percentage of dual-eligible members aligned in the same plan for Medicaid and Medicare outside the demonstration authority. Arizona has over 65,000 members enrolled in the same plan for Medicare and Medicaid. AHCCCS conducted a study to determine the impact that plan alignment has for dual-eligible members. The study compared national data for dual-eligible members enrolled in traditional Medicare fee-for-service to data for aligned dual-eligible members served by one of the AHCCCS health plans. The study found that the aligned AHCCCS dual-eligible members exhibited a 31 percent lower rate of hospitalization, a 43 percent lower rate of days spent in a hospital, a 9 percent lower rate of ED use, and a 21 percent lower readmissions rate.

- **Value-Based Purchasing (VBP) Initiatives:** AHCCCS is promoting a number of VBP initiatives for both providers and Contractors. Implementation of initiatives is now contractually mandated, with requirements increasing each year. Additionally, AHCCCS leverages VBP strategies with the Contractors on certain performance measures, strengthening the focus on initiatives that AHCCCS deems most meaningful to the populations served.
- **Early Reach-In:** Contractors are required to participate in criminal justice system “reach-in” care coordination efforts through collaboration with criminal justice partners (e.g., jails; sheriff’s office; Correctional Health Services; and Arizona Department of Corrections, including community supervision, and probation courts). AHCCCS is engaged in a data exchange process that allows AHCCCS to suspend eligibility upon incarceration rather than terminate coverage. Upon the member’s release, the member’s AHCCCS eligibility is un-suspended allowing for immediate care coordination activities. Using the 834 data to identify incarcerated members who have been incarcerated for 30 days or longer and who have anticipated release dates, the Contractor conducts reach-in care coordination for members with chronic and/or complex care needs, including assessment and identification of medication assisted treatment (MAT)-eligible members. The Contractors, with the criminal justice partners, facilitate the transition of members out of jails and prisons and into communities. Members are provided with education regarding care, services, resources, appointment information, and health plan case management contact information. Post-release initial physical and behavioral health appointments are scheduled within seven days of member release. Ongoing follow-up occurs with the member to assist with accessing and scheduling necessary services as identified in the member’s care plan, including access to all three U.S. Food and Drug Administration (FDA)-approved MAT options covered under the AHCCCS Behavioral Health Drug List and assignment to peer support services to help navigate and retain the member in MAT when appropriate.
- **Foster Care Initiative:** AHCCCS is committed to providing comprehensive, quality healthcare for children in foster, kinship, or adoptive care. Foster children are eligible for medical and dental care, inpatient, outpatient, behavioral health, and other services through the Comprehensive Medical and Dental Program (CMDP) and the 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 Contractor 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.

### Cenpatico Integrated Care (CIC)

- **Supplemental Dental Services for Title XIX/XXI-Eligible Adults with SMI (21 Years of Age and Older):** Implemented a program whereby Title XIX/XXI adults with SMI who are 21 years of age and older are eligible for additional dental services if employed at least a quarter of the time, as indicated within provider/member demographics. Eligibility begins on the first of the month following a successful demographic submission verifying that the member is employed at least a quarter of the time. Eligibility terminates on the last day of the month following receipt of a demographic verifying that a member is no longer employed at least a quarter of the time. Adults with SMI may be eligible for dental benefits upon completion of a CIC-approved six-month pre-employment program. Eligibility under this criterion begins on the first of the month following verification of completion of the training program; continues for twelve months; and terminates on the last day of the twelve-month period, unless the member becomes employed at least a quarter of the time in the interim. Members are eligible for one twelve-month extension upon completion of a second, advanced, six-month pre-employment training program. The maximum dental benefit for this program is \$700 annually. Title XIX/XXI-eligible adults with SMI 21 years of age and older may select a contracted general dentist and receive preventive dental services without a referral, unless such services require prior authorization.
- **Prior Authorization Expedited Determinations:** CIC instructed staff on how to determine if a request meets expedited criteria and how to downgrade the request appropriately. CIC continues to strive to improve this measure by reviewing the Daily Authorization Report each day to ensure that staff members capture authorizations and work on them in advance rather than on due dates. Extensive education was provided to behavioral health providers regarding the appropriate use of expedited determinations, as the prevailing thought seemed to be that everything should be expedited. CIC provider mentors were educated about prior authorization requirements, and they now present such education to the provider community.

### Health Choice Integrated Care (HCIC)

- **Performance Improvement Process and Methodology:** HCIC has trained staff members in specific quality improvement methods including, among other topics, strategies to integrate quality management (QM) functions across the organization and best practices in QM. HCIC continues to train staff members in the Lean Six Sigma QM methodology. Within HCIC, Lean Six Sigma



mentors, known as Black Belts, are trained as experts in statistical methods, project management, and performance improvement team leadership. HCIC Black Belts coach change leaders (Green Belts) to lead high-priority, well-defined, time-limited, and measurable PIPs that have direct impact on outcomes, member satisfaction, and cost effectiveness of integrated care delivery.

- **Emergency Room Utilization:** The readmissions rate of the recovery wellness population (SMI-integrated) has decreased each quarter. HCIC started several initiatives to reduce readmissions, including post-discharge calls, outreach letters to members unable to be reached by phone, letters to members assigned to health homes, and evaluating those members for assignment to integrated care managers.
- **Discharge Planning:** HCIC implemented a program to reach out to members discharged from inpatient settings. HCIC created a “Health Care Buddy” position, an individual responsible for calling members to ensure that post-discharge needs are met and who confirms upcoming behavioral health medical practitioner (BHMP) and PCP appointments. During the last quarter, “Health Care Buddies” reached out to 96 percent of members discharged from acute care hospitals and 99 percent of members discharged from psychiatric hospitals.

## Mercy Maricopa Integrated Care (MMIC)

- **Prenatal Exposure to Alcohol and Other Drugs:** AHCCCS and the Contractors 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). MMIC worked out processes to refer infants with NAS to Southwest Human Development and had a perinatal care manager for pregnant members with a designation of SMI. All pregnancies in women with SMI were considered high-risk, and all such members 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.
- **Monitoring and Evaluation of Provider Network:** MMIC confirms that the physician or other healthcare professional within the group reviews diagnostic information and reports resulting from referrals and consultations, hospitalizations, and emergency/urgent care as indicated by the physician’s signature or initials. The medical record review verifies that the physician or other healthcare professional within the group provides care and coordinates care with behavioral healthcare professionals, if applicable. This component is reviewed using evaluation criteria specific to the diagnosis and treatment of anxiety, depression, and ADHD. MMIC Integrated Care Academy provides updates on the management of these conditions by trainings offered to the PCP community. Consultation for PCPs managing these behavioral health conditions is also available from MMIC’s behavioral health medical directors.

## AHCCCS and All Contractors

- **Prenatal Exposure to Alcohol and Other Drugs:** AHCCCS and the Contractors 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 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 all such members 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.

CYE 2012 concluded a three-year cycle of OR reviews; and within this cycle, AHCCCS conducted ORs for ADHS/DBHS during CYE 2010 and CYE 2012. The results of the CYE 2012 OR were reported in the CYE 2013 EQR report. AHCCCS' OR-related activities during CYE 2014 were limited to oversight of CAPs resulting from the CYE 2012 OR findings. Specifically, AHCCCS accepted 19 CAPs submitted by ADHS/DBHS during CYE 2014 and an additional 10 CAPs pending follow-up activities (e.g., receipt and approval of specific documentation). These CAPs address recommendations for all standards reported as less than fully compliant during the CYE 2012 OR.

During CYE 2015, AHCCCS conducted focused ORs for areas wherein the Contractor was determined to not be fully compliant during the previous OR. AHCCCS did not conduct a CYE 2015 focused OR of ADHS/DBHS. AHCCCS elected to waive the ADHS/DBHS OR for CYE 2015 for the following reasons:

- The intent of the CYE 2015 focused OR was to follow up on the findings of the 2014 full OR; however, ADHS/DBHS did not conduct a full OR in 2014.
- Arizona Law 2015, Chapter 19 Section 9, Senate Bill (SB) 1480 required that, after June 30, 2016, behavioral health services for AHCCCS members be administered through AHCCCS directly, not through ADHS/DBHS. In March 2015, at the beginning of the CYE 2015 OR cycle, SB 1480 was signed. As a result, AHCCCS did not conduct a focused OR of ADHS/DBHS.

In CYE 2016, for the behavioral health Contractors, ORs were scheduled to occur between July 2017 and October 2017. Cenpatico Integrated Care (CIC) underwent a Focused OR in January 2017; however, this did fall within the CYE 2016 (current reporting period) time frame. Therefore, no documentation has been submitted for this reporting period.

While AHCCCS did not conduct ORs for the RBHA Contractors in this reporting period, the following sections describe the process that AHCCCS uses to meet the requirements for ORs of its RBHA Contractors' performance in complying with federal and AHCCCS' contract requirements.

## 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

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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 3, 2018.

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, and Finance and Reinsurance; the Division of Budget and Finance (DBF); Office of Administrative Legal Services; and the Office of the Inspector General (OIG).

## 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 2017 OR. Within each standard are specific scoring detail criteria worth defined percentages of the total possible score.

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

Contractors are required to complete a Corrective Action Plan (CAP) for any standard where 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.

## 7. Performance Measure Performance

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

As permitted by 42 CFR §438.358(a), AHCCCS elected to conduct the functions associated with the mandatory activity of validating performance measures. In accordance with and satisfying the requirements of 42 CFR §438.364(a)(1–5), AHCCCS contracted with HSAG as an EQRO to use the information that AHCCCS obtained from the performance measure calculations and data validation activities to prepare this CYE 2016 annual report.

### Conducting the Review

AHCCCS calculates and reports rates for a variety of Contractor-specific performance measures to address different quality initiatives. AHCCCS calculated and approved the rates for inclusion in this report for the following performance measures for the GMH/SA population for CYE 2015:

- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up and 30-Day Follow-Up*
- *Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)—Total Inpatient, Maternity, Surgery, and Medicine*
- *Plan All-Cause Readmissions—Total*

For the SMI population (i.e., MMIC), AHCCCS calculated and approved the rates for inclusion for the following measures for CYE 2015:

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

- *Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)—Total Inpatient, Maternity, Surgery, and Medicine*
- *Plan All-Cause Readmissions—Total*

Using AHCCCS’ results of the RBHA Contractors’ performance rates, HSAG organized, aggregated, and analyzed CYE 2015 results for the GMH/SA aggregate and MMIC SMI population. From its analysis, HSAG was able to draw conclusions about performance related to the quality of, access to, and timeliness of care and services that the Contractor 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 the Contractor.
- Collected Contractor data for use in calculating the performance measure rates.

HSAG designed a summary tool to organize and present the information and data that AHCCCS provided regarding the GMH/SA aggregate and MMIC SMI population performance on each AHCCCS-selected measure. The summary tool focused on HSAG’s objectives for aggregating and analyzing the data, which were to:

- Determine performance on each of the AHCCCS-selected measures.
- Compare 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.
- Aggregate and assess the AHCCCS-required CAPs to provide an overall evaluation of performance.

### ***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 encounter data associated with each State-selected performance measure
- Calculated each performance measure
- Reported performance results
- Compared performance rates with standards defined by AHCCCS’ contract

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

The 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 GMH/SA's and MMIC's results for each performance measure to determine if performance rates met or exceeded corresponding AHCCCS MPSs. As this was the first year of reporting for these measures for MMIC, AHCCCS was unable to perform any trending of Contractor performance over time; however, in future years AHCCCS will also analyze the direction of any change in rates from the previous measurement period and consider whether the change was statistically significant.

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

The following sections describe HSAG's findings, conclusions, and recommendations for GMH/SA and MMIC serving the SMI population for CYE 2015.

## GMH/SA Population Results

AHCCCS collected data and reported rates for a set of seven performance measure rates for the GMH/SA aggregate population for CYE 2015. The CYE 2015 performance measures reported for the GMH/SA population are listed in the "Conducting the Review" section preceding. As mentioned previously, no discussion of CAPs is included in the report this year for CYE 2015 data.

### GMH/SA Findings

Table 7-1 presents the GMH/SA aggregate performance measure rates. 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.

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



**Table 7-1—GMH/SA Aggregate—Performance Measure Results**

Performance Measure	CYE 2014 Performance	CYE 2015 Performance	Relative Percentage Change	Significance Level (p value) <sup>1</sup>	Minimum Performance Standard
<b><i>Follow-Up After Hospitalization for Mental Illness<sup>2</sup></i></b>					
<i>7-Day Follow-Up</i>	36.8%	46.7%	26.6%	<b>P&lt;.001</b>	50.0%
<i>30-Day Follow-Up</i>	51.9%	63.7%	22.7%	<b>P&lt;.001</b>	70.0%
<b><i>Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)</i></b>					
<i>Total Inpatient</i>	—	9.0	—	—	—
<i>Maternity</i>	—	0.0	—	—	—
<i>Surgery</i>	—	0.0	—	—	—
<i>Medicine</i>	—	8.9	—	—	—
<b><i>Plan All-Cause Readmissions<sup>3</sup></i></b>					
<i>Total</i>	22.4%	17.0%	-24.1%	<b>P&lt;.001</b>	—

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

<sup>2</sup> Due to changes in how mental health practitioners were identified in CYE 2015, exercise caution when comparing CYE 2015 rates to historical rates.

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

— Indicates either that 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

The GMH/SA aggregate performance for the *Plan All-Cause Readmissions* measure indicates a strength; as a lower rate indicates better performance for this measure, this rate demonstrated statistically significant improvement from CYE 2014 to CYE 2015.

### Opportunities for Improvement

Though both *Follow-Up After Hospitalization for Mental Illness* rates demonstrated statistically significant improvement from CYE 2014 to CYE 2015, both performance measure rates fell below the MPS for CYE 2015, indicating opportunities for improvement for the GMH/SA population in follow-up after hospitalization.

## Summary

No performance measure rates with an established MPS exceeded the MPS for CYE 2015; therefore, the RBHA Contractors serving the GMH/SA population have opportunities for improving access to follow-up care for beneficiaries who were hospitalized for mental illness. The remaining measures are utilization measures and performance should be monitored.

## SMI Population Results

AHCCCS provided data to HSAG on CYE 2015 performance measure rates for MMIC for the SMI population. CYE 2015 was the first full year that MMIC reported rates for these measures; therefore, historical rates are not available. The performance measures reported by MMIC are listed in the “Conducting the Review” section preceding. As mentioned previously, no discussion of CAPs related to CYE 2015 data is included in the report this year.

## MMIC Findings

Table 7-2 presents the performance measure performance rates for SMI members enrolled in MMIC. The table displays the CYE 2015 performance measure rate and the AHCCCS MPS, when available.

**Table 7-2—MMIC—SMI Population—Performance Measure Results**

Performance Measure	CYE 2015 Performance	Minimum Performance Standard
<b><i>Adults’ Access to Preventive/Ambulatory Health Services</i></b>		
<i>Total</i>	94.0%	75.0%
<b><i>Ambulatory Care (per 1,000 Member Months)<sup>1</sup></i></b>		
<i>ED Visits—Total</i>	160	—
<b><i>Asthma in Younger Adults Admission Rate (per 100,000 Member Months)<sup>1</sup></i></b>		
<i>Asthma in Younger Adults Admission Rate</i>	21.4	—
<b><i>Cervical Cancer Screening</i></b>		
<i>Cervical Cancer Screening</i>	22.0%	64.0%
<b><i>COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)<sup>1</sup></i></b>		
<i>COPD or Asthma in Older Adults Admission Rate</i>	114.4	—
<b><i>Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)<sup>1</sup></i></b>		
<i>Diabetes Short-Term Complications Admission Rate</i>	47.5	—
<b><i>Heart Failure Admission Rate (per 100,000 Member Months)<sup>1</sup></i></b>		
<i>Heart Failure Admission Rate</i>	32.7	—
<b><i>Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)</i></b>		
<i>Total Inpatient</i>	455.9	—
<i>Maternity</i>	5.9	—

Performance Measure	CYE 2015 Performance	Minimum Performance Standard
<i>Surgery</i>	34.4	—
<i>Medicine</i>	416	—
<b><i>Plan All-Cause Readmissions<sup>1</sup></i></b>		
<i>Total</i>	26.1%	—

<sup>1</sup> A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance.

— Indicates that an MPS has not yet been established by AHCCCS.

### CAPs

No discussion of CAPs is included in the report.

### Strengths

For CYE 2015, MMIC’s performance for the *Adults’ Access to Preventive/Ambulatory Health Services* measure rate demonstrated a strength for the Contractor as this rate exceeded the corresponding established MPS by 19 percentage points.

### Opportunities for Improvement

The performance measure rate for *Cervical Cancer Screening* fell below the MPS by 42 percentage points, indicating an opportunity for improvement for the SMI population in screenings for women.

### Summary

One of the two performance measure rates with an established MPS (*Adults’ Access to Preventive/Ambulatory Health Services*) exceeded the MPS for CYE 2015. With the rate of one performance measure (*Cervical Cancer Screening*) failing to meet the MPS, MMIC has opportunities for improvement in screenings for women.

Ten performance measure rates reported by MMIC did not have corresponding MPSs; therefore, none of these rates were compared to an MPS. Even though an MPS has not been established for some measures, MMIC should monitor the performance of these measures.

## 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 RBHA to report the status and results of each PIP not less than once per year.

### Conducting the Review

AHCCCS requires RBHAs 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 analyses for baseline and successive measurements and reports the performance results of mandated PIPs for each Contractor and across RBHAs.

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 included CYE 2014 (data from October 1, 2013, through September 30, 2014), to be followed by two remeasurement periods, CYE 2016 (October 1, 2015, through September 30, 2016), and CYE 2017 (October 1, 2016, through September 30, 2017). Upon initiation of the *E-Prescribing* PIP, all behavioral health services were provided under the Department of Behavioral Health Services (DBHS), an AHCCCS Contractor. However, behavioral health services for the General Mental Health/Substance Abuse (GMH/SA) and Serious Mental Illness (SMI) populations within Maricopa County transitioned to Mercy Maricopa Integrated Care (MMIC) effective April 1, 2014. GMH/SA and SMI members outside of Maricopa County transitioned to either Cenpatico Integrated Care (CIC) or Health Choice Integrated Care (HCIC) effective October 1, 2015. Therefore, the RBHAs' PIP measurement periods differ from all other lines of business. Thus, this annual report will include CYE 2014 baseline measurement data for MMIC's

GMH/SA member population, CYE 2015 baseline measurement data for MMIC's integrated member population, qualitative analyses, and interventions for MMIC only.

Due to the noted transitions above and desire to create alignment among the GMH/SA and SMI populations, AHCCCS has elected to have the DBHS aggregate rates for CYE 2014 serve as the MMIC GMH/SA baseline rate, with the Remeasurement 1 period being CYE 2017.

AHCCCS implemented the *E-Prescribing* PIP because research suggested that an opportunity existed to improve preventable errors in using the standard, handwritten paper method to communicate a medication between 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 over time.

### ***Objectives for Conducting the Review***

In its objectives for evaluating Contractor PIPs, AHCCCS:

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

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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.

- 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 RBHAs' 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.
- 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 RBHAs and statewide comparatively across RBHAs.
- Aggregate and assess the AHCCCS-required Contractor CAPs to provide an overall evaluation of performance for each Contractor and statewide comparatively across RBHAs.

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

AHCCCS developed a methodology to measure performance in a standardized way across RBHAs 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 RBHAs collect additional data. In these cases, AHCCCS requires the RBHAs 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. RBHAs 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 RBHAs to evaluate the effectiveness of their interventions and report to AHCCCS the results of their evaluations and any new or revised interventions. RBHAs 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 RBHAs 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 RBHAs 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 RBHAs' 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.

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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.

For the CYE 2016 annual report, the following sections have been updated to include CYE 2015 baseline measurement data, qualitative analysis, and interventions for MMIC only.

## Results

As noted previously, the RBHA Contractors’ PIP measurement periods differ from all other lines of business, and AHCCCS elected to have the DBHS aggregate rates for CYE 2014 serve as the MMIC GMH/SA baseline rate. AHCCCS provided HSAG with its CYE 2014 and CYE 2015 RBHA Contractor PIP data for MMIC’s GMH/SA and integrated populations. The PIP conducted during CYE 2014 and CYE 2015 was *E-Prescribing*, which, to improve patient safety, focused on increasing the number of providers ordering prescriptions electronically and increasing the percentage of prescriptions submitted electronically.

Baseline data were used to assist MMIC 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 MMIC, provider, and member education efforts during this intervention period will result in more AHCCCS members being prescribed prescriptions electronically.

This section includes MMIC’s PIP baseline results as submitted to AHCCCS, along with specific activities, qualitative analyses, and interventions during the baseline period of CYE 2014 for GMH/SA members (from October 1, 2013, through September 30, 2014) and CYE 2015 for integrated members (from October 1, 2014, through September 30, 2015). HSAG has made minimal edits to the analysis and interventions for grammar and punctuation.

### *Mercy Maricopa Integrated (MMIC)*

#### Findings

Table 8-1 presents the baseline period results for the *E-Prescribing* PIP for MMIC’s GMH/SA member population.

Table 8-1—MMIC GMH/SA E-Prescribing

PIP Measure	Baseline Period Oct. 1, 2013, to Sept. 30, 2014	Remeasurement Period 1 Oct. 1, 2016, to Sept. 30, 2017	Remeasurmen t Period 2 Oct. 1, 2017, to Sept. 30, 2018	Relative Percentage Change From Baseline	Statistical Significance
Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically.	48.44%	NA	NA	NA	NA

PIP Measure	Baseline Period Oct. 1, 2013, to Sept. 30, 2014	Remeasurement Period 1 Oct. 1, 2016, to Sept. 30, 2017	Remeasur ment Period 2 Oct. 1, 2017, to Sept. 30, 2018	Relative Percentage Change From Baseline	Statistical Significance
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider sent electronically.	31.96%	NA	NA	NA	NA

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-1 shows that 48.44 percent of MMIC’s providers prescribed at least one prescription electronically and that 31.96 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically.

Table 8-2 presents the baseline results for the *E-Prescribing* PIP for MMIC’s integrated members.

Table 8-2—MMIC Integrated *E-Prescribing*

PIP Measure	Baseline Period Oct. 1, 2014, to Sept. 30, 2015	Remeasurement Period 1 Oct. 1, 2017, to Sept. 30, 2018	Remeasurement Period 2 Oct. 1, 2018, to Sept. 30, 2019	Relative Percentage Change From Baseline	Statistical Significance
Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically.	51.54%	NA	NA	NA	NA
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider sent electronically.	42.34%	NA	NA	NA	NA

CYE 2015 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-2 shows that 51.54 percent of MMIC’s providers prescribed at least one prescription electronically and that 42.34 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically.

MMIC submitted the following qualitative analysis:

- Nationally, e-prescribing was on the rise from 2006 to 2013.<sup>8-3</sup> The global market for e-prescribing was expected to increase at an annual compound rate of 23.5 percent from 2013 to 2019.<sup>8-4</sup> This trend existed before the statewide PIP began.

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

- Provide prescribers feedback regarding their rates and educate them about the importance of prescribing electronically. SMI clinic prescribers were given their rates in 2015 and early 2016. For individual prescribing events, MMIC encountered limitations with connecting prescribers to the clinic to which they were prescribing. MMIC's report is being revised and will list only prescribers and their rates. Other provider education has included:
  - Primary Care Provider Outreach Manual placed on the MMIC website.
  - Behavioral Health Provider Outreach Manual placed on MMIC's website.
  - Pharmacy newsletters.
  - Individual provider technical assistance by email and phone, upon request from providers.
- Conduct a survey of prescribers, including their self-reported use of electronic prescribing and their years of birth.
- Survey the top 10 electronic health record (EHR) vendors used by MMIC's network to determine the extent to which e-prescribing of controlled substances is supported by the EHR software. The survey revealed that four of the 10 EHR vendors did not support e-prescribing of controlled substances in Arizona. Advocate with the vendors to allow electronic prescribing of controlled substances.
- Include e-prescribing implementation as a required onboarding step for new integrated clinics.
- Require SMI clinics to create and implement formal written procedures to improve their e-prescribing rates.

## Strengths

MMIC provided feedback to prescribers regarding their e-prescribing rates and educated them about the importance of e-prescribing; updated their website with e-prescribing educational materials and pharmacy newsletters; and provided technical assistance by email and phone, upon request from providers. Additional interventions were deployed that should show a sufficient return by the next measurement cycle.

## Opportunities for Improvement and Recommendations

MMIC has an opportunity for improvement for both the rate of providers prescribing prescriptions electronically and the rate of prescriptions sent electronically indicators.

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<sup>8-3</sup> Gabriel MH, Swain M. E-Prescribing Trends in the United States. *ONC Data Brief, no.18*. Washington, DC: Office of the National Coordinator for Health Information Technology, July 2014.

<sup>8-4</sup> Monegain, Bernie (2015, June 18). "E-prescribing takes off like a rocket." *Healthcare IT News*. Available at: <http://www.healthcareitnews.com/news/e-prescribing-takes-rocket>. Accessed on: Feb 13, 2018.

HSAG recommends the following:

- MMIC should consider continuing to monitor the outcomes associated with the reported interventions.
- AHCCCS should consider continuing the collaboration among RBHAs to improve these indicators.

HSAG recommends that AHCCCS consider the following:

- Require the Contractors to have more than one PIP. AHCCCS now requires the *E-Prescribing* PIP; however, AHCCCS could require the RBHA Contractors to expand to one other PIP that improves outcomes of one of the lower-scoring performance measures.
- Establish a standing agenda item at the Contractor Quarterly Meetings for RBHA Contractors to share PIP results, including successes and lessons learned. Improvement strategies and interventions that were successful and resulted in sustained improvement should be considered for system-wide implementation.

### Summary

MMIC's GMH/SA baseline rate for the *E-Prescribing* PIP Indicator 1 (the percentage of AHCCCS-contracted providers who prescribed at least one electronic prescription) was 48.44 percent and for Indicator 2 (the percentage of prescriptions prescribed by an AHCCCS-contracted provider sent electronically) was 31.96 percent. MMIC's integrated baseline rate for the *E-Prescribing* PIP Indicator 1 was 51.54 percent and for Indicator 2 was 42.34 percent. MMIC is encouraged to monitor the progress of the PIP interventions employed to increase providers prescribing electronically and prescriptions sent electronically, and adjust interventions as needed to ensure that the rates increase by a statistically significant amount during the first remeasurement period.