

Arizona Health Care Cost Containment System



**Contract Year Ending 2017
External Quality Review Annual Report**
for

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

June 2018



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1. Executive Summary

The Code of Federal Regulations (CFR) at 42 CFR §438.364¹⁻¹ requires that states use an external quality review organization (EQRO) to prepare an annual technical report that describes how data from activities conducted for Medicaid managed care organizations (MCOs), in accordance with the CFR, were aggregated and analyzed. The annual technical report also draws conclusions about the quality of, timeliness of, and access to healthcare services that managed care organizations provide.

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

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

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

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

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

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

¹⁻¹ 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.

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 14 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 as well as HSAG's recommendations for improving the quality of services.

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

- Section 2—An overview of the history of the AHCCCS program.

- Section 3—A description of the contract year ending (CYE) 2016 and CYE 2017 EQR activities.
- Section 4—An overview of AHCCCS’ statewide quality initiatives across its Medicaid managed care program and those initiatives that are specific to the Arizona Long Term Care (ALTC) program for CYE 2017.
- Section 5—An overview of the Contractors’ best and emerging practices for CYE 2017.
- Section 6 (Organizational Assessment and Structure Performance)—An overview of the new AHCCCS methodology for the organizational review (OR) and a presentation of Contractor-specific CYE 2016 OR CAP updates as well as HSAG’s associated findings and recommendations. (AHCCCS began a new OR in contract year ending [CYE] 2016 [review period October 1, 2015, through September 30, 2016] to assess each Contractor’s compliance with AHCCCS’ contract standards.) For this annual report, AHCCCS provided CAP updates for all ALTC Contractors reviewed in CYE 2016.
- Section 7 (Performance Measure Performance)—A presentation of rates for AHCCCS-selected performance measures for each ALTC Contractor and HSAG’s associated findings and recommendations for CYE 2016.
- Section 8 (Performance Improvement Project Performance)—A presentation of Contractor-specific PIP results for CYE 2016 for the ALTC Contractors as well as HSAG’s associated findings and recommendations.

Overview of the CYE 2017 External Review

During the review period, AHCCCS contracted with the Contractors listed below to provide services to members enrolled in the AHCCCS ALTC Medicaid managed care program. Associated abbreviations are included.

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

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

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

Organizational Assessment and Structure Standards

AHCCCS conducted a comprehensive OR for each Contractor during CYE 2016. In CYE 2017, AHCCCS monitored the progress of all Contractors in implementing their CAPs for the recommendations from the CYE 2016 OR.

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

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

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

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

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

Contractors are required to complete a CAP for any standard for which the total score is less than 95 percent. In addition, when AHCCCS evaluated performance for a standard as less than fully compliant

or made a recommendation worded as “The Contractor must” or “The Contractor should,” the Contractor was required to develop a CAP, submit it to AHCCCS for review and approval, and implement the corrective actions once approved.

Findings

In Section 6 (Organizational Assessment and Structure Performance) of this report, HSAG included details for each Contractor’s CAPs related to the standards measured in the CYE 2016 OR.

Table 1-1 summarizes outcomes of the reviews conducted by AHCCCS related to the four Contractors’ scores in the 12 standard areas. The table details number, if any, of corrective actions for each standard area reviewed for each Contractor as well as the total number of corrective actions for all four Contractors.

Table 1-1—CAP Summary per Standard Area by Contractor

Standard Area	BWY	MCP-LTC	UHCCP-LTC	DES/DDD	Total Required Corrective Actions
Case Management	1	2	3	5	11
Corporate Compliance	1	1	1	1	4
Claims and Information Systems	5	1	2	5	13
Delivery Systems	0	1	2	2	5
General Administration	0	0	0	0	0
Grievance Systems	0	1	0	0	1
Adult, EPSDT, and Maternal Child Health	0	0	0	0	0
Medical Management	0	2	5	4	11
Member Information	1	0	0	0	1
Quality Management	4	2	1	4	11
Reinsurance	0	0	0	3	3
Third-Party Liability	0	0	0	3	3
Total	12	10	14	27	63

Table 1-1 preceding details that, overall, AHCCCS required 63 CAPs from the four Contractors combined (of which DES/DDD was required to complete 27). Standards with greatest opportunity for improvement, based on the number of CAPs required, were CM, CIS, MM, and QM. However, of the 11 CAPs that AHCCCS required from all ALTCS Contractors for the CM standard, DES/DDD was required to complete five. Additionally, of the 11 CAPs that AHCCCS required of all ALTCS Contractors combined for the MM standard, UHCCP-LTC was required to complete five. Based on the number of CAPs, the strongest performances were in the following standards: GA, GS, MCH, and MI.

Conclusions

For the CYE 2016 AHCCCS OR, AHCCCS accepted and closed CAPs for two ALTCS Contractors (BWY and UHCCP-LTC). Two ALTCS Contractors (MCP-LTC and DES/DDD) collectively had seven CAPs that remained open for the CC, CIS, and DS standards as of the date of the six-month CAP update submission requested in a letter from AHCCCS to each of the Contractors. (The six-month CAP update resubmissions that MCP-LTC and DES/DDD were required to provide were not available at the time of this report and are therefore not included.)

Recommendations

Based on AHCCCS' review of the ALTCS and DES/DDD Contractors' performance in CYE 2016 and the subsequent CAP submissions, HSAG recommends the following:

- Contractors should conduct internal reviews of operational systems to identify barriers that impact their compliance with AHCCCS standards, State rules, and federal regulations. Specifically, Contractors should cross-reference existing policies, procedures, and information distributed to providers, subcontractors, and members with AHCCCS requirements and ensure, at a minimum, alignment with both the intent and content of AHCCCS standards, State rules, and federal regulations.
- Contractors should regularly monitor and ensure that updates are made to contracts with providers and that policy manual updates from AHCCCS are also included in Contractors' policies, procedures, and manuals (if impacted by the updates) in a timely manner. Contractors should ensure that communication to all areas directly and indirectly impacted by these updates (including Contractor staff, providers, subcontractors, and members) is provided and documented. In addition, Contractors should assess current monitoring processes and activities to identify strengths and opportunities for improvement within operational processes. When deficiencies are noted, the Contractors should develop mechanisms to address such areas and enhance existing procedures. In addition, Contractors should implement periodic assessments of those elements reviewed by AHCCCS for which Contractors were found deficient.
- Contractors should apply lessons learned from improving performance for one category of standards to other categories. For example, Contractors should look at CAPs completed from previous ORs to determine best practices specific to their organizations to identify and correct policies, procedures and practices to address deficient standards and monitor subsequent compliance. Further, Contractors should use opportunities to address and discuss issues identified during ORs. For example, include in OR interview discussions topics such as metrics and associated example

methodologies currently reported in the medical home’s report cards and discuss if and how the metrics align with the State’s goals for effectively managing medical home services to members.

- AHCCCS should consider distributing technical assistance documents to all Contractors and holding in-person meetings with Contractors who scored lowest in the ALTCS OR standards, including guidance on how to complete a CAP.
- AHCCCS should consider using the quarterly meetings with Contractors as forums in which to share lessons learned from both the State and Contractor perspectives. AHCCCS should present identified best practices on the predominant issues for ALTCS Contractors issues and facilitate a group discussion on Contractors’ policies and procedures. In addition, AHCCCS should consider conducting a root cause analysis with the Contractors to determine why Contractors continue to have difficulty complying with specific standards.

Performance Measures

AHCCCS collected data and reported Contractor performance for a set of performance measures selected by AHCCCS for the CYE 2016 measurement period. For CYE 2016, AHCCCS selected 13 performance measure rates for the ALTCS Contractors. The following tables display the performance measure rates with established minimum performance standards (MPSs). An MPS had not yet been established for all reported performance measure rates. Rates for performance measures without an established MPS are found in the “Performance Measure Performance” section of this report.

Findings

Table 1-2 presents the following information for each performance measure indicator for all the ALTCS Contractors: CYE 2015 performance, CYE 2016 performance; the relative percentage change between the CYE 2015 and CYE 2016 rates; the statistical significance of the relative percentage change; and the CYE 2016 MPS, when applicable.

Table 1-2—ALTCS Contractors—Performance Measurement Results

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (p value) ¹	Minimum Performance Standard
Adults’ Access to Preventive/Ambulatory Health Services					
Adults’ Access to Preventive/Ambulatory Health Services	90.5%	91.5%	1.0%	P=.001	75.0%
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up	—	28.2%	—	—	50.0%
30-Day Follow-Up	—	50.8%	—	—	70.0%

¹ Significance levels (p values) noted in the table were calculated by AHCCCS and HSAG and demonstrate whether the differences in performance between CYE 2015 and CYE 2016 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. — Indicates the Contractors were not required to report the measure or comparison of performance between CYE 2015 and CYE 2016 was not possible.

The performance measure rate for *Adults' Access to Preventive/Ambulatory Health Services* demonstrated statistically significant improvement from CYE 2015 to CYE 2016 and exceeded the MPS for the ALTCS Contractors. Conversely, the performance measure rates for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* fell below the MPSs.

Conclusions

For ALTCS, the performance measure rate for *Adults' Access to Preventive/Ambulatory Health Services* exceeded the MPS by 16.5 percentage points, demonstrating a strength. Conversely, the performance measure rates for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* fell below the MPS by 21.8 percentage points and 19.2 percentage points, respectively, demonstrating opportunities for improvement.

Recommendations

Performance for two of three measure rates fell below established MPSs, which demonstrates that ALTCS Contractors have opportunities for improvement. Therefore, HSAG recommends focusing efforts on increasing follow-up care after hospitalization. Results of these focused efforts should be used to identify strategies that can be applied to drive improvement for other performance measures.

DES/DDD Performance Measures

AHCCCS collected data and reported Contractor performance for a set of performance measures selected by AHCCCS for the CYE 2016 measurement period. For CYE 2016, AHCCCS selected 21 performance measure rates for DES/DDD. The tables below display those performance measure rates with an established MPS. An MPS has not yet been established for all reported performance measures. Rates for performance measures without an established MPS are found in the “Performance Measure Performance” section of this report.

Findings

Table 1-3 presents the performance measure rates for DES/DDD. The table displays the following information: CYE 2015 performance; CYE 2016 performance; the relative percentage change between the CYE 2015 and CYE 2016 rates; the statistical significance of the relative percentage change; and the AHCCCS MPS, when applicable.

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

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (<i>p</i> value) ¹	Minimum Performance Standard
Adolescent Well-Care Visits					
<i>Adolescent Well-Care Visits</i>	39.8%	43.5%	9.3%	P<.001	41.0%
Adults' Access to Preventive/Ambulatory Health Services					
<i>Adults' Access to Preventive/Ambulatory Health Services</i>	85.2%	86.0%	0.9%	P=.068	75.0%
Annual Dental Visits					
<i>2–20 Years</i>	55.7%	51.9%	-6.9%	P<.001	60.0%
Breast Cancer Screening					
<i>Breast Cancer Screening</i>	45.1%	46.2%	2.5%	P=.644	50.0%
Cervical Cancer Screening					
<i>Cervical Cancer Screening</i>	18.0%	17.4%	-3.1%	P=.493	64.0%
Children and Adolescents' Access to Primary Care Practitioners					
<i>12–24 Months</i>	98.3%	100.0%	1.7%	P=.100	93.0%
<i>25 Months–6 Years</i>	90.1%	89.6%	-0.6%	P=.540	84.0%
<i>7–11 Years</i>	91.1%	92.0%	1.0%	P=.123	83.0%
<i>12–19 Years</i>	88.4%	88.5%	0.1%	P=.743	82.0%
Chlamydia Screening in Women					
<i>Total</i>	8.3%	9.7%	17.3%	P=.352	63.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	52.1%	51.2%	-1.8%	P=.504	66.0%

¹ Significance levels (*p* values) noted in the table were calculated by AHCCCS and HSAG and demonstrate whether the differences in performance between CYE 2015 and CYE 2016 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.

The performance measure rate for *Adolescent Well-Care Visits* demonstrated statistically significant improvement, while the *Annual Dental Visits—2–20 Years* performance measure rate demonstrated statistically significant decline from CYE 2015 to CYE 2016. DES/DDD exceeded the CYE 2016 MPS for six of 11 performance measure rates (*Adolescent Well-Care Visits*; *Adults' Access to Preventive/Ambulatory Health Services*; and *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years*).

Conclusions

For DES/DDD, five of 11 performance measure rates (*Annual Dental Visits—2–20 Years*; *Breast Cancer Screening*; *Cervical Cancer Screening*; *Chlamydia Screening in Women—Total*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) did not meet MPSs for CYE 2016. More specifically, rates for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; *Cervical Cancer Screening*; and *Chlamydia Screening in Women—Total* fell below the respective MPSs by 14.8 percentage points, 46.6 percentage points, and 53.3 percentage points, respectively—demonstrating opportunities for improvement.

Conversely, the performance measure rates for *Adults' Access to Preventive/Ambulatory Health Services* and *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years and 12–24 Months* exceeded the MPSs by 11 percentage points, 9 percentage points, and 7 percentage points, respectively—demonstrating strengths for DES/DDD.

Recommendations

The performance for five of 11 measure rates for DES/DDD fell below the established MPSs, demonstrating that the Contractors have opportunities for improvement. Therefore, HSAG recommends that the DES/DDD Contractors focus efforts on increasing well-child and dental visits as well as screenings in women. Results of these focused efforts should be used to identify strategies that can be translated and applied to drive improvement for other performance measures. In addition, HSAG recommends that more appropriate MPSs be assigned to the performance measures, given that this special population may not benefit from exceeding the MPSs currently assigned.

Performance Improvement Projects (PIPs)

In CYE 2015 (October 1, 2014, through September 30, 2015), AHCCCS implemented a new PIP, *E-Prescribing*, for all lines of business. The baseline measurement period covered CYE 2014 (data from October 1, 2013, through September 30, 2014), to be followed by two remeasurement periods: Remeasurement 1 (October 1, 2015, through September 30, 2016), and Remeasurement 2 (October 1, 2016, through September 30, 2017). This annual report will include recalculated CYE 2014 baseline measurement data, CYE 2016 Remeasurement 1 period data, relative percentage changes from recalculated baseline data, statistical significance data, qualitative analysis, and interventions.

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.¹⁻² 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

¹⁻² 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.

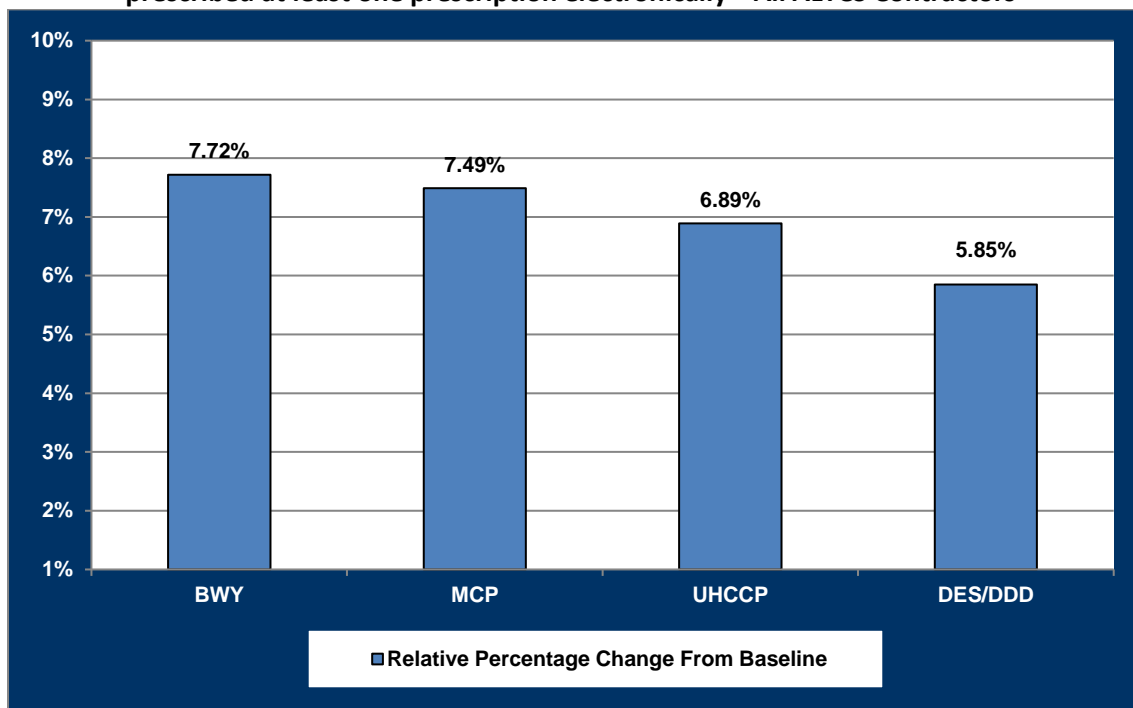
to medication management as well as potential reactions that members may encounter, especially for those taking multiple medications.

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.

Findings

This was the Remeasurement 1 reporting period for the *E-Prescribing* PIP. The Contractors implemented many solid interventions to improve the rate for both indicators.

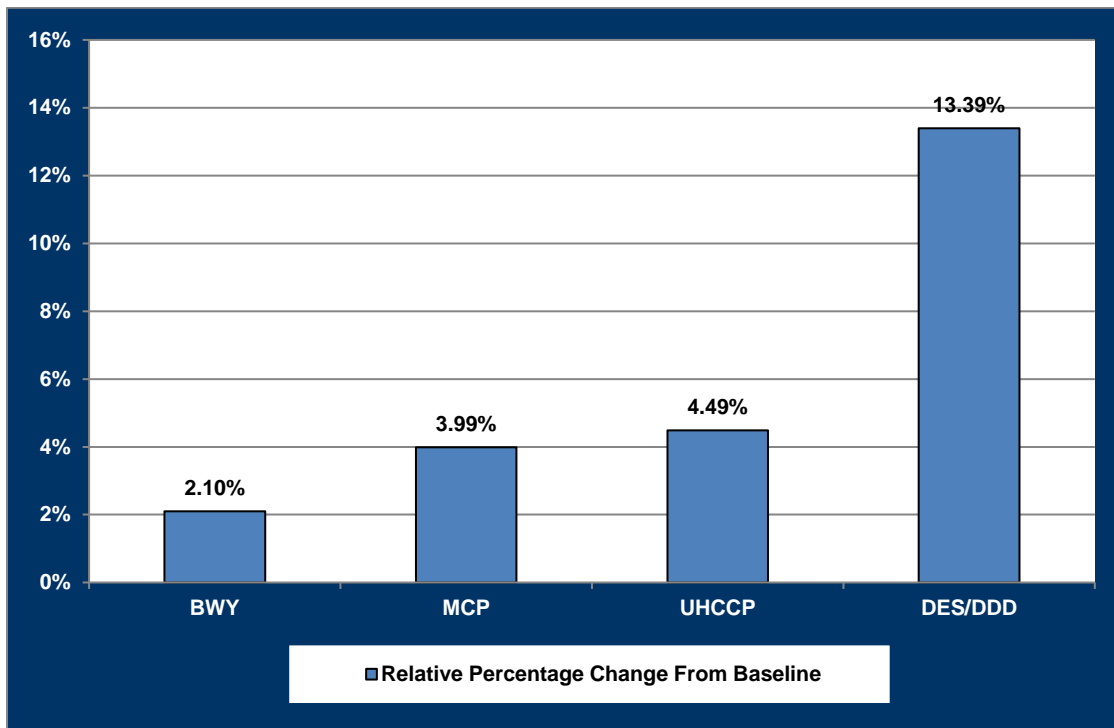
Figure 1-1—Performance Improvement Projects—E-Prescribing—Indicator 1: The percentage of providers who prescribed at least one prescription electronically—All ALTCS Contractors*



*Percentage totals have been rounded.

Figure 1-1 shows that the Contractor with the greatest improvement was BWY, with a relative percentage change from baseline of 7.72 percent. However, the Contractor with the most opportunity for improvement was also BWY as its Remeasurement 1 rate is still below all other Contractors’ Remeasurement 1 and baseline rates. All Contractors tasked with the PIP exceeded respective baseline rates by statistically significant amounts at the first remeasurement. This finding indicates that these Contractors need only sustain their gains for an additional remeasurement cycle.

Figure 1-2—Performance Improvement Projects—E-Prescribing—Indicator 2: The percentage of prescriptions sent electronically—All ALTCS Contractors*



*Percentage totals have been rounded.

Figure 1-2 shows that the Contractor with the greatest improvement was DES/DDD, with a relative percentage change from baseline of 13.39 percent. The Contractor with the most opportunity for improvement was BWY, with a relative percentage change from baseline of 2.10 percent. All Contractors tasked with the PIP exceeded respective baseline rates by statistically significant amounts at the first remeasurement. This finding indicates that these Contractors need only sustain their gains for an additional remeasurement cycle.

Conclusions

All ALTCS Contractors implemented strong interventions and performed well in CYE 2016 for the *E-Prescribing* PIP. Although the improvement must be sustained for an additional measurement cycle, the amount of improvement shown at the first remeasurement period suggests the likelihood of excellent outcomes in the next evaluation cycle.

Recommendations

The ALTCS Contractors should continue current interventions and sustain or further increase the demonstrated improvement through the next remeasurement period. DES/DDD demonstrated the smallest relative percentage change from baseline for Indicator 1; however, DES/DDD’s baseline and Remeasurement 1 rates were higher than were all other Contractors’ rates for the same measurement periods for both indicators. BWY attained the greatest relative percentage change from baseline for

Indicator 1 compared to other contractors; however, BWY rates were still the lowest for both indicators. The Contractors are 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 continue to increase by statistically significant amounts during the second remeasurement period. HSAG recommends that AHCCCS continue the collaboration among Contractors in the e-prescribing workgroup formed with other Arizona Contractors, Arizona Alliance of Health Plans (AzAHP) and Health Current (collectively referred to as “workgroup”) to improve these indicators.

Overall Findings and Conclusions

AHCCCS has completed a strategic plan for SFY 2017–2022 that includes goals related to long-term strategies that bend the cost curve while improving member outcomes, the pursuit of continuous quality improvement, and the reduction of fragmentation through an integrated healthcare system. The results of the three mandatory activities relative to Contractor performance support these goals. AHCCCS has a comprehensive system to monitor and improve the timeliness of, access to, and quality of care that Contractors provide to Medicaid members. All ALTCS Contractors are working toward improving the delivery of services and quality of care provided to members. Two of the four Contractors completed CAPs for the CYE 2016 comprehensive OR (two Contractors had CAPs that remained open at the time of reporting). Overall, the ALTCS Contractors’ performance measure rates demonstrated positive performance, excepting rates for *Follow-Up After Hospitalization for Mental Illness*, which fell well below the MPS. For DES/DDD, the performance measure rates related to access (including *Adults’ Access to Preventive/Ambulatory Health Services* and *Children and Adolescents’ Access to Primary Care Practitioners*) demonstrated positive performance, with these rates performing above the MPSs. However, the performance measure rates related to women’s screening measures fell below the MPSs, demonstrating opportunities for improvement. AHCCCS has selected for all lines of business a new PIP, *E-Prescribing*, which, to increase patient safety, measures the number of providers who write electronic prescriptions and the number of prescriptions submitted electronically. The ALTCS Contractors have employed significant interventions to improve the results of this PIP.

Organizational Assessment and Structure Standards

AHCCCS conducted a comprehensive OR for each ALTCS and DES/DDD Contractor during CYE 2017. AHCCCS organized the OR into 12 standard areas, including CM, CC, CIS, DS, GA, GS, MCH, MM, MI, QM, RI, and TPL.

For the GA as well as the Adult, EPSDT, and MCH standards, no corrective actions were required. For the GS standard three of four Contractors (BWY, MCP-LTC, and UHCCP-LTC) were not required to complete any CAPs. Likewise, three of four Contractors (MCP-LTC, UHCCP-LTC, and DES/DDD) were not required to complete any CAPs for the MI standard.

Although all Contractors made progress in meeting the standards, opportunities for improvement do exist. Based on the number of required CAPs, the four standard areas with greatest opportunity for

improvement were CM, CIS, MM, and QM. Performance for the CIS standard resulted in the highest number of CAPs assigned.

Performance Measures

Overall, performance for the ALTCS and DES/DDD Contractors varied across all three areas of **quality**, **access**, and **timeliness**. Across all three areas, the performance measure rates for the ALTCS Contractors for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* fell below the MPS, indicating opportunities for improvement. Conversely, the ALTCS Contractors demonstrated positive performance in the **access** area, with the *Adults' Access to Preventive/Ambulatory Health Services* measure demonstrating statistically significant improvement from CYE 2015 to CYE 2016 and exceeding the CYE 2016 MPS.

Compared to the CYE 2016 MPSs, DES/DDD's performance in the **quality** area indicated opportunities for improvement as only one measure rate, *Adolescent Well-Care Visits*, demonstrated statistically significant improvement from CYE 2015 to CYE 2016 and exceeded the MPS, while four other rates (*Breast Cancer Screening*; *Cervical Cancer Screening*; *Chlamydia Screening in Women—Total*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) fell below the MPSs. DES/DDD demonstrated mostly positive performance in the **access** area, with the *Adults' Access to Preventive/Ambulatory Health Services* measure and all four *Children and Adolescents' Access to Primary Care Practitioners* measure indicators exceeding the CYE 2016 MPS. However, the *Annual Dental Visits—2–20 Years* measure rate demonstrated a statistically significant decline and fell below the MPS, indicating an opportunity for DES/DDD to improve in the **access** area. **Timeliness** was not appropriate to evaluate for the reported performance measure rates; therefore, this area was not discussed.

Additionally, the utilization measure rates for the ALTCS and DES/DDD should be monitored for informational purposes.

Performance Improvement Projects

In CYE 2015, AHCCCS implemented for all lines of business a new PIP, *E-Prescribing*, which measures the number of providers who send prescriptions electronically (Indicator 1) and the number of prescriptions sent electronically (Indicator 2). This PIP seeks to improve preventable errors in communicating a medication between a prescriber and a pharmacy, thereby increasing patient safety.

HSAG recommends that ALTCS and DES/DDD Contractors consider the following:

- Continue to monitor and evaluate the effectiveness of interventions for this PIP.
- Identify and rank providers with greatest volume of prescriptions and lowest e-prescribing rates.
- Incorporate e-prescribing education and presentations into provider forums and provider engagement meetings.
- Perform outreach to prescribers with low e-prescribing rates.

Conclusions

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

This section of the report includes a brief history of the Arizona Health Care Cost Containment System (AHCCCS) Medicaid managed care programs and a description of AHCCCS' Strategic Plan for State Fiscal Years 2017–2022 (Strategic Plan). The description of the Strategic Plan includes the 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 \$11.4 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, then expanded the program in January 1989 to include the elderly and physically disabled (EPD) populations. In October 1990, AHCCCS began coverage of comprehensive behavioral health services for seriously emotionally disabled (SED) children younger than 18 years of age who required residential care. Through further expansion, AHCCCS added comprehensive behavioral health coverage for all Medicaid-eligible individuals. The Children's Health Insurance Program (CHIP) was incorporated in Arizona in 1998 and is known as KidsCare. In 2009, due to a persistently severe budget shortfall, a freeze was placed on enrollment in KidsCare. In 2016, Governor Ducey signed Senate Bill 1457 into law, ending the enrollment freeze on the KidsCare program. Children who qualify for this program receive care through AHCCCS Contractors.

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

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

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

AHCCCS' Strategic Plan

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

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

²⁻¹ AHCCCS Strategic Plan State Fiscal Years 2017-2022 Available at: https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan_17-22.pdf. Accessed on: January 17, 2018.

The plan offers four overarching goals:

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

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

2. AHCCCS must pursue continuous quality improvement.

- Achieve statistically significant improvements on Contractor Performance Improvement Projects (PIPs). For example, AHCCCS Contractors are expected to conduct PIPs in clinical care and non-clinical areas that are anticipated to have a favorable impact on health outcome and member satisfaction.
- Achieve and maintain improvement on quality performance measures.
- Leverage American Indian care management program to improve health outcomes.
- Increase transparency in health plan performance to inform members when selecting a health plan. 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 integrated care organizations that serves all AHCCCS members. The following are integration models AHCCCS is currently implementing:
 - CRS—Previously 17,000 children with complex medical needs were served by three different payers. These included an acute plan, RBHA and CRS plan. These members are now served by a single Integrated Contractor.
 - During 2014 and 2015, almost 40,000 individuals with Serious Mental Illness were transitioned to a single organization that was responsible for all services.



- Currently, 80,000 dual eligible members receive integrated general mental health and substance abuse services.
- In 2016, the requirements for Tribal Regional Behavioral Health Authority (TRBHA) contractors were streamlined to enhance and create integration and care coordination opportunities for members served by the TRBHAs.
- In 2016, AHCCCS had approximately 48% of the dual eligible member population aligned, which is the highest percentage ever.
- Establish policies and programs to support integrated providers. For example, the structure of AHCCCS is transforming towards integrated care delivery systems with better alignment of incentives that seeks to efficiently improve health outcomes.
- Leverage health information technology (HIT) investments to create more data flow in the 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 the workforce environment, promoting activities that support employee engagement and retention; and address potential gaps in the organization's knowledge base due to retirements and other staff departures.
- Strengthen system-wide security and compliance with privacy regulations related to all information and data by evaluating, analyzing and addressing potential security risks.
- Improve and maintain information technology (IT) infrastructure, including server based applications, ensuring business continuity.
- Continue work and effort around implementation of the Arizona management system.

AHCCCS Quality Strategy

The U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS) Medicaid managed care regulations at 42 CFR §438.200 and 438.340 implement Section 1932(c)(1) of the Medicaid managed care act, which defines certain Medicaid state agency responsibilities. The regulations require Medicaid state agencies operating Medicaid managed care programs to develop and

implement a written quality strategy for assessing and improving the quality of healthcare services offered to their members. The written strategy must describe the standards that a state and its contracted MCOs and PIHPs must meet. The Medicaid state agency quality strategy must include all of the following:

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

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

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

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

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

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

Operational Performance Standards

At least every three years, AHCCCS reviews Contractor performance in complying with standards in a number of performance areas to ensure Contractor compliance with Medicaid managed care act requirements and AHCCCS contract standards. AHCCCS conducts ORs and reviews Contractor deliverables to meet the requirements of the Medicaid managed care regulations (42 CFR 438.364). AHCCCS also conducts the reviews to determine the extent to which each Contractor complied with other federal and State regulations as well as AHCCCS contract requirements and policies. As part of the ORs, AHCCCS staff review Contractor progress in implementing recommendations made during prior ORs and determine each Contractor's compliance with its own policies and procedures. (AHCCCS did not perform any ORs for CYE 2017.)

Performance Measure Requirements and Targets

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

AHCCCS has been a leader in developing, implementing, and holding Contractors accountable to performance measurements. AHCCCS' consistent approach for performance expectations has resulted

in performance measures with rates closer to the NCQA HEDIS national Medicaid mean. AHCCCS made the decision to transition to measures found in the CMS Core Measure Sets that provide a better opportunity to shift the systems toward indicators of health outcomes, access to care, and member satisfaction.

Performance Improvement Project Requirements and Targets

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

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

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

3. Description of EQR Activities

Mandatory Activities

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

- Validate Contractors’ PIP—validation performed by AHCCCS.
- Validate Contractor performance measures—validation performed by AHCCCS.
- 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. (No operational reviews were performed by AHCCCS for this contract year.)

AHCCCS contracted with HSAG to aggregate and analyze the data AHCCCS obtained from conducting the three mandatory activities for its ALTCS and DES/DDD Contractors and to prepare this CMS-required CYE 2017 external quality review annual report of findings and recommendations.

Optional Activities

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

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

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

AHCCCS Quality Initiatives

AHCCCS continued to demonstrate innovative, 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, 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 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 Regional Behavioral Health Authorities (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 an SMI had to coordinate with several healthcare systems to obtain services. As such, the physical health services were provided through the acute health plan; the behavioral health services through the RBHA; and the Medicare system, if the member was also eligible for Medicaid and Medicare; and Medicare Part D for medications.

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

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

Starting on October 1, 2018, AHCCCS proposes, to offer fully integrated contracts to manage behavioral health and physical health services to children (including children with Children's Rehabilitative Services [CRS] eligible 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.

Integration efforts are ongoing at AHCCCS, as demonstrated by newly awarded ALTCS contracts. Contracts were awarded to three MCOs throughout Arizona to administer Arizona's integrated long-term care system. Contracts were awarded based on the bidder's proposed approaches for care and treatment of ALTCS individuals using a fully integrated care perspective at both the systemic and direct care levels (e.g., use of health homes, electronic health records, coordinated case management, collaboration between behavioral and physical health). An additional expectation is centered on their ability to demonstrate a more thorough understanding and use of Arizona's longstanding model of behavioral health service delivery, in conjunction with traditional ALTCS physical healthcare activities.

Although Arizona's ALTCS model has historically provided integrated care that included behavioral health treatment, emphasis was added to promote greater use of Arizona's behavioral health model, particularly regarding individuals who have been determined to have a serious mental illness (SMI). The ALTCS contracts were implemented on October 1, 2017.

AHCCCS CARE: Choice, Accountability, Responsibility, Engagement

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

- **Health Savings Account:** Adults over 100 percent of the federal poverty level (FPL) are required to pay a monthly premium at 2 percent of household income or \$25, whichever is lesser.
- **Giving Citizens Tools to Manage Their Own Health:** Member premium contributions go into their AHCCCS CARE accounts, which work like flexible health savings accounts. These funds can be withdrawn by members and used for non-covered services, including dental, vision, chiropractic care, recognized weight loss programs, nutrition counseling, gym membership, and sunscreen.
- **Enforcing Member Contribution Requirements:** Members will be disenrolled for failure to pay their monthly premium requirements.
- **Engaging the Business and Philanthropic Community:** Employers and charitable organizations may contribute funds into the AHCCCS CARE Account to support a healthy workforce and to support members achieving health goals.
- **Promoting Healthy Behaviors:** The AHCCCS CARE program includes incentives to promote healthy behaviors. Members may defer their premium payments for six months if they meet healthy targets that include: meeting preventive health targets like getting a wellness exam, flu shot, mammogram, or cholesterol screening; or managing chronic illnesses like diabetes, asthma, or tobacco cessation. Meeting these healthy targets allows members to roll unused funds over into the next year and unlock funds available in the AHCCCS CARE account to be used for non-covered services.
- **Supporting the Medical Home Through Strategic Coinsurance:** The AHCCCS CARE program uses a strategic coinsurance strategy that only assesses payment requirements retrospectively so that members are not denied services and providers are not burdened with uncompensated care and administrative hassle. Strategic coinsurance only applies to: opioid use, use of brand-name drugs when a generic is available, non-emergency use of the emergency department (ED), and seeing a specialist without a primary care provider's referral.
- **Connecting to Employment Opportunities:** Through an innovative partnership with the Arizona Department of Economic Security, all AHCCCS CARE members will be automatically enrolled in job-seeking programs.

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

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

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

Executive Order 2016-06—Prescription of Opioids

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

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

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

AHCCCS Opioid Initiative: The overarching goal of this initiative is to reduce the prevalence of opioid use disorders and opioid-related overdose deaths. The initiative's approach includes developing and supporting State, regional, and local collaborations and service enhancements to develop and implement best practices to comprehensively address the full continuum of care related to opioid misuse, abuse, and dependency. Strategies include:

- Increasing access to naloxone through community-based education and distribution as well as a co-prescribing campaign for individuals receiving opioid prescriptions exceeding morphine-equivalent daily doses and combinations of opioids and benzodiazepines.
- Increasing access to and participation and retention in medication-assisted treatment (MAT).
- Reducing the number of opioid-naïve members unnecessarily started on opioid treatment.

- Promoting best practices and improving care process models for chronic pain and high-risk members.

The Opioid State Targeted Response grant will enhance community-based prevention activities and treatment activities—to include offering 24/7 access to care points in “hotspot” areas throughout the state, increasing the availability of peer supports, providing additional care coordination efforts among high-risk and priority populations, and adding recovery supports.

During 2017, the following efforts supporting this initiative were made:

- The RBHAs contracted with opioid treatment programs (OTPs), which had transitioned from traditional service hours to expanded service hours (24/7 access): one in Maricopa County and one in Pima County. Between October 2, 2017, and December 7, 2017, Community Medical Services treated 316 unique individuals during expanded hours.
- As of October 1, 2017, RBHA contracts were amended and funded to provide access to peer support services for individuals with opioid use disorders for the purposes of navigating members to MAT as well as increasing participation and retention in treatment and recovery supports.
- AHCCCS implemented a seven-day limit on first-time fill of short-acting opioids.
- AHCCCS implemented a prior authorization requirement on all long-acting opioids.
- AHCCCS removed the prior authorization that had been required for medications used to treat opioid use disorder.

Targeted Investments Program

On January 18, 2017, the Centers for Medicare and Medicaid Services (CMS) approved Arizona’s request to implement the Targeted Investments (TI) Program to support the State’s ongoing efforts to integrate the health care delivery system for AHCCCS members. The TI Program is AHCCCS’ strategy to provide financial incentives to eligible AHCCCS providers to develop systems for integrated care. The TI Program will make almost \$300 million available over five years to Arizona providers who assist AHCCCS in promoting the integration of physical and behavioral health care, increasing efficiencies in care delivery and improving health outcomes.

Pursuant to 42 CFR 438.6 (c), the TI Program will fund time-limited, outcomes-based projects aimed at building the necessary infrastructure to create and sustain integrated, high-performing health care delivery systems that improve care coordination and drive better health and financial outcomes. The TI projects will support children and adults with behavioral health needs (including children with or at risk for Autism Spectrum Disorder and children engaged in the child welfare system) as well as individuals transitioning from incarceration who are AHCCCS-eligible. The TI 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.
- **Recommendations to Office of the Arizona Governor Policy Advisor for Health and Human Services on Autism Spectrum Disorder (ASD):** In February 2016, the ASD Advisory Committee (appointed by the Office of the Arizona Governor in spring 2015) publicized a report of recommendations to strengthen 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. During 2017, two centers of excellence opened in Maricopa County. AHCCCS Complete Care, the new contract for AHCCCS and the Contractors, is addressing the recommendation to integrate care for acute members. In addition, AHCCCS is developing a behavioral intervention policy that addresses this issue.
- **Summary of Activities Designed to Enhance the Credentialing/Recredentialing Process:** AHCCCS previously worked collaboratively with the Arizona Association of Health Plans (AzAHP), representing the AHCCCS Contractors, 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; with the CA, providers need only apply for credentialing or recredentialing for approved status to be accepted by all AHCCCS Contractors. During CYE 2016, the credentialing process for primary source verification was implemented. AHCCCS will continue its efforts to enhance the credentialing and recredentialing process.
- **Summary of Activities Designed to Enhance the Medical Record Review (MRR) Process:** AHCCCS has initiated a statewide workgroup designed to develop a consistent behavioral health chart review tool. The tool will be designed to:
 - Meet CFR and State statutory requirements.
 - Operate according to AHCCCS contractual guidelines.
 - Provide consistency across the state regarding clinical behavioral health practice.
 - Allow for consistency of results in chart analysis and review.
 - Allow for data comparison across geographic services areas related to consistent measurement of required chart elements.
- **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 and Child Health (MCH) 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.

- **Clinical Integration:** The Medical Management (MM) unit, which regularly partners with the Quality Management (QM) and MCH/EPSTD units, added a behavioral health coordinator to support efforts for the entire clinical team. The addition of a behavioral health coordinator enhances the ability for clinical considerations, service delivery, and program and contract development—to encompass a holistic approach in all aspects of care. AHCCCS continues to hire additional staff with behavioral health expertise from within its workforce.

Within the QM, QI, and MCH/EPSTD units, other activities designed to enhance integration have involved utilization of performance and quality measurement activities that provide a greater focus on specific aspects of integrated care. Highlights include:

- Required tracking of performance on frequency of diabetic screening for individuals with schizophrenia or bipolar disorder.
 - Tracking performance on prenatal and postnatal timeliness of care, with supplemental training provided to contracted health plan staff relative to physical and behavioral health aspects of perinatal mood disorders.
 - Implementation of regular community-based meetings open to AHCCCS membership—with focus on enhancing member and stakeholder involvement and investment in performance as well as on enhancing quality improvement activities for physical and behavioral healthcare.
- **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.
 - **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. 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 meet regularly to work on goals and objectives. The task force reviewed and developed publications and toolkits for members and providers. For providers, publications included the *Guidelines for Identifying Substance-Exposed Newborns*, while members' publications included information that related to the exposure/use of all drugs (prescription, opioids, alcohol, etc.) and neonatal abstinence syndrome (NAS). Mercy Care Plan (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.

- Interventions for Members with Alzheimer’s disease or Memory Issues: AHCCCS initiated discussions with the ADHS Bureau of Tobacco and Chronic Disease related to intervention strategies for members diagnosed with Alzheimer’s disease or memory issues and those at risk of Alzheimer’s disease. AHCCCS will implement requirements for its Contractors to use education and outreach material provided by ADHS to inform its members about evidence-based prevention and treatment options for individuals diagnosed or at risk for the conditions. In addition, AHCCCS will share information about upcoming ADHS-sponsored educational and continuing medical education events for providers.
- Involvement of Stakeholders and Community Subject Matter Experts: Throughout 2017, 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.
- ADHS Immunization Program and Vaccine for Children (VFC) program: Ongoing collaboration with the ADHS help 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 (ASIS), an immunization registry that can capture immunization data on individuals within the state. Staff provide monthly data sharing regarding AHCCCS members receiving immunizations and ongoing collaboration regarding Stage 1 and Stage 2 meaningful use (MU) public health requirements.
- Arizona Early Intervention Program: The Arizona Early Intervention Program (AzEIP), Arizona’s IDEA Part C program, is administered by the Division of Developmental Disabilities. 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. As an ongoing effort to promote care coordination and system clarification, the MCH/EPST manager undertook extensive efforts to create detailed flow charts that outline the

process from multiple points of entry and across many different MCO types and member conditions. These flow charts have been promoted at several stakeholder groups, with collaborative feedback. Once the charts undergo a final review, these tools will be made available on the AHCCCS website.

- The Arizona Partnership for Immunization (TAPI): Quality management staff attend ongoing 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 provides vaccination handouts. TAPI has a teen vaccination campaign (Tdap, meningococcal, and human papillomavirus [HPV] vaccines) that involves provider education as well as parent and teen outreach. Protect Me with 3, a parent-focused campaign, reminds parents that their children still need them to protect them and help with healthy decisions. Take Control, a teen campaign, 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 440 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 electronically shares hospital data with several other out-of-state HIEs through a project called the Patient-Centered Data Home (PCDH). The PCDH project provides the technical and legal agreements to support cross-state data sharing for the purpose of care coordination. Launched in early 2017, Southern Colorado, Arizona, Utah and now Santa Cruz and San Diego HIEs are capable of sharing hospital admission, discharge, or transfer information with a Medicaid member's home HIE if they seek care outside of their Arizona or "home" HIE.
- ADHS Bureau of Tobacco and Chronic Disease: In collaboration with ADHS, AHCCCS monitors 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 has developed 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. EMS teams are using 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 are 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 physician.

- **Payment Reform Initiative (PRI):** AHCCCS has implemented for the acute care population a PRI designed to encourage Contractor involvement in quality improvement, particularly with those initiatives conducive to improved health outcomes and cost savings and those related to child and adolescent health. This PRI process will be performed annually on a contract year basis. Starting with FFY 2015, AHCCCS also implemented a payment reform initiative for the ALTCS elderly and physically disabled (EPD) population. The EPD population quality measures target ED utilization, readmissions, diabetes management, and flu shots.
- **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 64,000 members enrolled in the same plan for Medicare and Medicaid. AHCCCS conducted a study to determine the impact on plan alignment related to 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 numerous VBP initiatives for both providers and Contractors. Implementation of initiatives is now contractually mandated, with requirements increasing each year. Additionally, AHCCCS leverages VBP strategies with the Contractors on certain performance measures, strengthening the focus on initiatives that AHCCCS deems most meaningful to the populations served.
- **Early Reach-In:** Contractors are required to participate in criminal justice system "reach-in" care coordination efforts through collaboration with criminal justice partners (e.g., jails; sheriff's office; Correctional Health Services; and Arizona Department of Corrections, including community supervision and probation courts). AHCCCS is engaged in a data exchange process that allows AHCCCS to suspend member eligibility upon incarceration rather than terminating coverage. Upon the member's release, the member's suspension of AHCCCS eligibility is lifted, allowing for immediate care coordination activities. Using the 834 data file 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 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, appointments, 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.

- **Quality Caregiver Initiative (QCI):** The objective of the QCI is to improve relationship-based, trauma-informed service supports for foster, kinship, and adoptive parents by identifying a matrix of evidence-based intervention programs that are developmentally appropriate and span the continuum of service intensity needs—from basic trauma trainings, to brief interventions, to intensive in-home services. The overarching goal is to provide to the family unit the right services at the right time so as to decrease disruptions, increase permanency, and, ultimately, improve the social and emotional outcomes of children in the child welfare system. The collaborative consists of several State agencies as well as behavioral health providers and experts in infant-toddler mental health, child development, family systems, and trauma-informed care. The group is reviewing the matrix of options and identifying training needs, provider capacity, and ways to integrate with developmental screening and referral processes from pediatrics and other acute care settings.

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

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

- **Agency with Choice:** AHCCCS has developed and implemented a member-directed option, Agency with Choice. This option is available to ALTCS members who prefer to reside in their own homes. The member and provider agency enter a formal partnership agreement that allows the provider agency to act as the legal employer of a direct care worker (DCW), with the member serving as the day-to-day managing employer. During CYE 2012, to progress with the implementation of the Agency with Choice member-directed option, AHCCCS worked in collaboration with a Development and Implementation Council comprised of ALTCS members, providers, community stakeholders, and Contractors—the primary function being to provide input on programmatic changes that AHCCCS needed to make in order to implement the Agency with Choice member-directed option. In CYE 2013, the primary focus was on supporting Contractors to educate members/individual representatives (IRs) about the available service model options, including member-directed options. In CYE 2014, AHCCCS prioritized the development of tools for the purpose of assessing members' support needs for directing their care under this option. AHCCCS planned to work in collaboration with Contractors to implement the use of these specific tools in CYE 2015. Since then, AHCCCS has been focusing on the development of home- and community-based services (HCBS), as well as person-centered planning.
- **Direct Care Workforce Development:** Significant activities continue regarding the growing challenges related to ensuring the establishment of an adequate direct care (caregiver) workforce. The foundation for current activities began in March of 2004 when former Governor Napolitano formed the Citizens' Workgroup on the Long-Term Care Workforce. The purpose of the Workgroup was to study the issue of the direct care workforce and provide recommendations regarding potential strategies to improve the workforce. As a direct result, the Direct Care Workforce Committee was formed and established training and competency standards for all in-home caregivers providing homemaker, personal care, and/or attendant care services.

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

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

AHCCCS has since continued its efforts on this ongoing project. During CYE 2017, AHCCCS has focused on maintaining the enhanced database.

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

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

is or can become compliant by the end of the transition period. AHCCCS identified the following settings for the heightened scrutiny process:

- Farmstead Community: Working ranches in rural areas on large parcels of land. One licensed farmstead community in Arizona exists, serving eight members.
- Memory/Dementia Care Units/Communities: Settings that provide supervisory and personal care services to persons incapable of recognizing danger, summoning assistance, expressing need, or making basic care decisions. Seventy-nine such memory/dementia care units/communities exist in Arizona, serving approximately 1,000 members. A statistically significant number of settings statewide were randomly selected to participate in the assessment process.

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

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

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

The assessments occurred in the months of October through December 2016.

Additionally, AHCCCS worked in partnership with a multi-stakeholder and multi-disciplinary workgroup to create the process and tools that will be used to collect information and submit evidence to CMS to make a determination. AHCCCS released the draft report for public comment in February 2017, prior to submitting the report in March 2017. CMS has since provided feedback on the proposed process and tools. AHCCCS' ongoing efforts will be in alignment with CMS' feedback.

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

5. Contractor Best and Emerging Practices

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

Bridgeway Health Solutions (BWY)

- EPSDT Dental Services for ALTCS Members: Bridgeway focused on improving the percentage of eligible EPSDT members who received at least one dental appointment during the contract year. Outreach efforts included:
 - Case managers notified the member or guardian when dental care was due.
 - Case managers assisted the member or guardian with setting up dental appointments.
 - Appointment dates were tracked to ensure timely notification of appointments for members/guardians; tracking sheets also allowed for identification of completed appointments.
 - Follow-up was completed with members/guardians and providers to ensure that appointments were completed.

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

- Delegation Oversight: MCP-LTC regularly monitors the results of corrective actions that identify deficiencies. MCP-LTC developed the Delegation Management Oversight Committee (DMOC) responsible for monitoring oversight of delegated entities. The committee and program implement a thoughtful approach prior to engaging in potential delegation and follow a thorough pre-delegation process that includes reviewing past performance to check for capacity and capability of the delegation of services, obtaining proper prior approvals, certifying contractual requirements, and confirming oversight capabilities prior to implementation. DMOC assigns to each delegate a relationship manager (who in most cases is also the subject matter expert for the services delegated) responsible for all monitoring and coordination of oversight, and who, if needed, follows a prescribed process for escalation and corrective action. The relationship manager acts as a liaison between the delegate and the plan and is responsible for regular communication, especially related to monitoring and oversight outcomes.
- ◆ Neonatal Abstinence Syndrome (NAS) Care Management Program: The NAS care management program was implemented in response to the rapidly growing rate of pregnant women with opioid use disorder (OUD). The NAS care management program consists of professional registered nurses who provide member-specific telephonic interventions and face-to-face visits when deemed necessary. Face-to-face visits may be implemented to promote care collaboration and to promote member engagement. Pregnant women with OUD early in their pregnancy are identified and engaged in member-specific integrated care through care team collaboration with the obstetrics and

behavioral health (BH) providers. This approach aligns members with access to medication-assisted therapy programs, BH intervention, education, and community resources. Infants diagnosed with NAS are also identified so as to facilitate care coordination among the parent or guardian, interdisciplinary team of providers, and community resources.

- ◆ **Exclusive Prescriber Program:** MCP-LTC uses the Exclusive Prescriber program to assist identified members to better utilize available benefits to obtain the best overall health outcomes. MCP-LTC regularly monitors pharmacy and utilization data to identify potential abuse, misuse, or fraud related to drugs with abuse potential. The dual focus of the program is to support members with biopsychosocial needs and to assist members to improve their pharmacy and benefit utilization appropriate to their healthcare needs. Identified members are enrolled in care management, wherein care coordination occurs quarterly minimally with the member and the prescription provider. The member is provided with education on available services and service referrals and is assisted related to any presenting barriers.
- ◆ **Naloxone Pilot:** MCP-LTC has recently initiated a pilot to improve access to naloxone for identified members enrolled in the High Need High Cost program and in behavioral healthcare management. The identified members are offered naloxone kits by their care managers during face-to-face interactions in the community. If the member chooses to accept the kit, the care manager will provide the member and applicable friends and/or family on how and when to administer the naloxone in the event of an opioid-related overdose.

UnitedHealthcare Community Plan-LTC (UHCCP-LTC)

- **Assisted Living Facility Enhanced Contracting Process:** To enhance quality review, criteria that indicate when enhanced quality review should be conducted were developed by a team composed of representatives from provider services, case management, and quality management. Quality management staff created a review tool to standardize the process for any facilities referred by provider services for this in-depth review. The review tool includes review of quality of care (QOC) referral trends, evaluation of substantiated concerns and corrective action plans, review of the required annual regulatory audits, review of any State sanctions, review of the manager's license and any disciplinary action as necessary, and detailed review of the ADHS survey results and any civil penalties. The contract and recontract process for assisted living facilities homes and centers review insurance requirements, the ADHS license and most recent survey, the federal Office of Inspector General (OIG) exclusion list, the sex offender registry, the sample CMS1500, and other documents.

Division of Developmental Disabilities (DDD)

- **Constipation Risk Reduction:** DDD's member population includes individuals with a cognitive disability and/or autism, cerebral palsy, or epilepsy; these conditions in and of themselves predispose members to an increased risk of constipation. Cognitive and intellectual disabilities impair independent nutrition, activity, and hydration maintenance. Neuromuscular impairments associated with cerebral palsy and seizure activity of an organic origin are intrinsic barriers to effective bowel evacuation. All conditions within the eligibility criteria for DDD's population also require

pharmacologic management with medications known for their propensity to increase risk of constipation. The interventions—including nurse-directed prevention plans, education, and case management activities across DDD departments and contracted health plans—will positively impact the following population care process areas:

- Nurse-directed case management (prevention plans)
- Care transition oversight
- Coordination of care (both internally and with contracted health plans and other external entities)
- **Prevention of Pneumonia (PN) Readmissions within 30 Days:** DDD’s goal is to improve member experience, improve quality of service, and decrease use of resources. At the inception of the program, data indicated that pneumonia admissions accounted for 65 percent to 70 percent of DDD’s readmissions occurring within thirty days. As the primary source of readmissions indicated poor outcomes post discharge, the pneumonia readmission prevention (care coordination enhancement) performance improvement project was implemented. Interventions such as the discharge planning protocol, transitional care case management, nursing education and resource provision, and provision of general health information targeting prevention and management of pneumonia are used regularly with vendors and caregivers, with prominent utilization during cold and flu seasons.

6. Organizational Assessment and Structure Performance

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

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

CYE 2016 commenced a new review cycle of ORs for which AHCCCS conducted a comprehensive OR for the ALTCS Contractors, including monitoring the progress of Contractors implementing CAPs for the recommendations from the 2016 OR; therefore, AHCCCS did not conduct an OR for the ALTCS Contractors in this reporting period. However, the following sections will describe the process that AHCCCS uses to determine whether or not its Contractors meet compliance with federal and AHCCCS' contract requirements.

Conducting the Review

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

Objectives for Conducting the Review

AHCCCS' objectives for conducting ORs are to:

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

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

Methodology for Conducting the Review

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

AHCCCS' methodology for conducting the OR included the following:

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

AHCCCS conducts activities following the review that include 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 is individually listed with the applicable performance designation based on AHCCCS' review findings and assessment of the degree to which the Contractor complied with the standards.

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

Standards

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

⁶⁻¹ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQRO)*, Version 2.0, September 2012. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-1.pdf>. Accessed on: March 28, 2018.

- Case Management (CM), 18 elements
- Corporate Compliance (CC), five elements
- Claims and Information Systems (CIS), 12 elements
- Delivery Systems (DS), nine elements
- General Administration (GA), three elements
- Grievance Systems (GS), 17 elements
- Adult, EPSDT, and Maternal Child Health (MCH), 14 elements
- Medical Management (MM), 20 elements
- Member Information (MI), nine elements
- Quality Management (QM), 28 elements
- Reinsurance (RI), four elements
- Third-Party Liability (TPL), seven elements

Scoring Methodology

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

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

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

Corrective Action Statements

As part of the AHCCCS methodology, each Contractor receives a report containing review findings. The Contractor has 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, then revises the report if necessary. AHCCCS issues the final report to the Contractor, describing the findings, scores, and required CAPs.

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

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

Contractor-Specific Results

For CYE 2016, AHCCCS conducted an OR for 12 standards for each Contractor. Contractor-specific results are presented in the CYE 2016 Annual Report. Contractor-specific CAP results are presented following.

Bridgeway Health Solutions (BWY)

The results of the CYE 2016 OR demonstrated opportunities for improvement as BWY was less than fully compliant in five of the 12 standards reviewed. In the report generated from BWY's CYE 2016 OR, AHCCCS included recommendations for BWY that required the submission of 12 CAPs.

BWY submitted CAPs for the CM, CC, CIS, MI, and QM standards, with proposed activities to correct the deficiencies; however, on July 29, 2016, AHCCCS did not accept all proposed CAPs. On September 2, 2016, AHCCCS accepted and/or closed all CAPs that BWY had resubmitted and informed BWY that AHCCCS must see demonstrated progress in the proposed steps until AHCCCS agrees that BWY has addressed the findings for the nine CAPs that remained open. With few exceptions, AHCCCS expected that all CAP steps be completed within six months.

The six-month CAP update submission was received by AHCCCS; and on April 19, 2017, AHCCCS closed the CAPs that had remained open. To close the CAPs that had remained open for the CC, CIS, and QM standards, BWY provided an attestation showing completion of the employee compliance program training, a revised dental remittance that included correct language regarding provider disputes, and a revised pharmacy remittance that reflected all required elements. In addition, BWY provided results from the interest payment audits and evidence of accurate interest applied on vision claims; evidence of an accurate quick-pay discount applied on a claim form that the provider identified as well as results of a completed load audit demonstrating that the pay-class field was reviewed; a summary of what is entailed for the new audit process for contract loading, a sample of completed audit findings, and an example of its quarterly joint operating committee (JOC) meeting minutes addressing oversight of the contract load process for dental claims; the training material(s) and sign-in sheets for training on performance monitoring; proof that the revised policy and procedure for performing provisional credentialing had been implemented; and training material(s) and sign-in sheets for trainings about the credentialing process as well as trainings about maintenance of individual credentialing and recredentialing files.

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

The results of the CYE 2016 OR demonstrated opportunities for improvement as MCP-LTC was less than fully compliant in seven of the 12 standards reviewed. In the report generated from MCP-LTC's CYE 2016 OR, AHCCCS included recommendations for MCP-LTC that required the submission of 10 CAPs.

MCP-LTC submitted CAPs for the CM, CC, CIS, DS, GS, MM, and QM standards with the proposed activities to correct the deficiencies; however, on September 12, 2016, AHCCCS did not accept all proposed CAPs. On October 25, 2016, AHCCCS accepted all CAPs that MCP-LTC had resubmitted and informed MCP-LTC that AHCCCS must see demonstrated progress in the proposed steps until AHCCCS agrees that MCP-LTC has addressed the findings for the five remaining CAPs. With few exceptions, AHCCCS expected that all CAP steps be completed within six months.

The first six-month CAP update submission was received by AHCCCS; and on July 18, 2017, AHCCCS closed three CAPs. To close the two CAPs that remain open, for CC and CIS standards, MCP-LTC is required to reassess the CAPs and provide a six-month CAP update resubmission. In the update resubmission, MCP-LTC is required to provide evidence that the process for reporting fraud, waste, and abuse using the online form on the AHCCCS website is included in relevant documents as well as in revised language in the remittance letter. (The six-month CAP update resubmission that MCP-LTC was required to provide was not available at the time of this report and is therefore not included.)

UnitedHealthcare Community Plan-LTC (UHCCP-LTC)

Results of the CYE 2016 OR demonstrated opportunities for improvement as UHCCP-LTC was less than fully compliant in six of the 12 standards reviewed. In the report generated from UHCCP-LTC's CYE 2016 OR, AHCCCS included recommendations for UHCCP-LTC that required the submission of 14 CAPs.

UHCCP-LTC submitted CAPs for the CM, CC, CIS, DS, MM, and QM standards on May 18, 2016, with proposed activities to correct the deficiencies; however, AHCCCS did not accept all proposed CAPs. On July 21, 2016, AHCCCS accepted all CAPs that UHCCP-LTC resubmitted and informed UHCCP-LTC that progress must be demonstrated in the proposed steps until AHCCCS agrees that UHCCP-LTC has addressed the findings for the two CAPs that remained open. With few exceptions, AHCCCS expected that all CAP steps be completed within six months.

The six-month CAP update submission was received by AHCCCS on January 30, 2017; and on March 22, 2017, AHCCCS closed the CAPs that remained open. To close the two CAPs for the CIS and DS standards, UHCCP-LTC completed the following: submitted examples of a claim with an original paid amount and a subsequent (higher) amount paid including interest, and evidence of paid date and amount paid; and provided the revised provider manual.

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

The results of the CYE 2016 OR demonstrated opportunities for improvement as DES/DDD was less than fully compliant in eight of the 12 standards reviewed. In the report generated from DES/DDD's CYE 2016 OR, AHCCCS included recommendations for DES/DDD that required the submission of 27 CAPs.

DES/DDD submitted CAPs for the CM, CC, CIS, DS, MM, QM, RI, and TPL standards with the proposed activities to correct the deficiencies; however, on October 21, 2016, AHCCCS accepted only some proposed CAPs. On December 2, 2016, AHCCCS accepted and/or closed all CAPs that DES/DDD had resubmitted and informed DES/DDD that AHCCCS must see demonstrated progress in the proposed steps until AHCCCS agrees that DES/DDD has addressed the findings for the CAPs that remained open. With few exceptions, AHCCCS expected that all CAP steps be completed within six months.

The first six-month CAP update submission was received by AHCCCS; and on November 2, 2017, AHCCCS did not accept and close all CAPs. To close the five CAPs that remained open for the CIS and DS standards, DES/DDD was required to reassess the CAPs and provide a six-month CAP update resubmission. In the update resubmission, DES/DDD was required to provide the following: sufficient documentation showing interest paid on a hospital claim, non-hospital claim, and ALTCS claim; examples of new claims received and processed with a quick-pay discount for its fee-for-service population; a policy on contract loading that addresses all AHCCCS requirements and includes the changes in contracted rates as well as methods used to generate a sample of claims from providers and to ensure that all providers are reviewed every five years; DES/DDD's CBT and desk aid for member appeals that addresses the claim dispute and appeal procedures separately; and the revised provider manual that contains all requirements listed in the ACOM 416, including evidence of communication to all affected parties. (The six-month CAP update resubmission that DES/DDD was required to provide was not available at the time of this report and is therefore not included.)

Opportunities for Improvement and Recommendations

Since a comprehensive OR had been completed in CYE 2016 for the ALTCS Contractors, AHCCCS only needed to review the CAPs in CYE 2017. AHCCCS did not accept from any ALTCS Contractors the first CAP submission from the CYE 2016 ORs. Based on this, HSAG makes to ALTCS Contractors the following general recommendations regarding ORs:

- Contractors should conduct internal reviews of operational systems to identify barriers that affect compliance with AHCCCS standards, State rules, and federal regulations. Specifically, Contractors should cross-reference existing policies, procedures, and information distributed to providers, subcontractors, and members with AHCCCS requirements and ensure, at a minimum, alignment with both the intent and content of AHCCCS standards, State rules, and federal regulations.

- Contractors should regularly monitor and ensure that updates are made to contracts with providers and that policy manual updates from AHCCCS are also included timely in Contractors' policies, procedures, and manuals (if impacted by the updates). Contractors should ensure that communications to all areas directly and indirectly impacted by these updates (including Contractor staff, providers, subcontractors, and members) are provided and documented. In addition, Contractors should assess current monitoring processes and activities to identify strengths and opportunities for improvement within operational processes. When deficiencies are noted, the Contractors should develop mechanisms to address such areas and enhance existing procedures. In addition, Contractors should implement periodic assessments of those elements reviewed by AHCCCS for which Contractors are found deficient.
- Contractors should apply lessons learned from improving performance for one category of standards to other categories. For example, Contractors should look at CAPs completed from previous ORs to determine best practices specific to their organizations to identify and correct policies, procedures, and practices so as to address deficient standards and monitor subsequent compliance. Further, Contractors should use opportunities to address and discuss issues identified during ORs. For example, include in OR interview discussions topics such as metrics and associated example methodologies currently reported in the medical homes report cards and discuss if and how the metrics align with the State's goals for effectively managing medical home services to members.

Based on AHCCCS' review of the ALTCS Contractors' performance in the comprehensive OR in CYE 2016 and the subsequent CAP submissions, HSAG recommends the following:

- AHCCCS should consider distributing technical assistance documents to all Contractors and holding in-person meetings with Contractors who scored lowest in the ALTCS OR standards, including guidance on how to complete a CAP.
- AHCCCS should consider using the quarterly meetings with Contractors as forums in which to share lessons learned from both the State and Contractor perspectives. AHCCCS should present identified best practices on the predominant issues for ALTCS Contractors' issues and facilitate a group discussion on Contractors' policies and procedures. In addition, AHCCCS should consider conducting a root cause analysis with the Contractors to determine why Contractors continue to have difficulty complying with specific standards.

7. Performance Measure Performance

In accordance with 42 CFR §438.240(b), AHCCCS requires Contractors to have a QAPI program that includes measuring and submitting 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 2017 annual report.

Conducting the Review

AHCCCS calculates and reports rates for a variety of Contractor-specific and statewide aggregate performance measures to address different quality initiatives. AHCCCS calculated and approved the rates for inclusion in this report for the following performance measures for the ALTCS–EPD population for CYE 2016:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Ambulatory Care (per 1,000 Member Months)—Emergency Department (ED) Visits—Total*
- *Annual Monitoring for Patients on Persistent Medications—Total*
- *Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (per 100,000 Member Months)*
- *Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up and 30-Day Follow-Up*
- *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*

For ALTCS–DES/DDD, AHCCCS calculated and approved the rates for inclusion for the following performance measures for CYE 2016:

- *Adolescent Well-Care Visits*

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*
- *Annual Dental Visits—2–20 Years*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years*
- *Chlamydia Screening in Women—Total*
- *COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)*
- *Developmental Screening in the First Three Years of Life—Total*
- *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*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Using AHCCCS' results and statistical analysis of the Contractors' performance measure rates, HSAG organized, aggregated, and analyzed the CYE 2016 results. From the analysis, HSAG was able to draw conclusions about Contractor-specific and statewide aggregate performance related to the quality of, access to, and timeliness of care and services that the Contractors provided to AHCCCS members for CYE 2016.

Objectives for Conducting the Review

As part of its objectives to measure, report, compare, and continually improve Contractor performance, AHCCCS conducted the following activities:

- Provided key information about AHCCCS-selected performance measures to each Contractor
- Collected Contractor data for use in calculating the performance measure rates

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

- Determine Contractor performance on each of the AHCCCS-selected performance measures.
- Compare Contractor performance to AHCCCS' minimum performance standard (MPS) for each measure, if available.

- Draw conclusions about the quality of, access to, and timeliness of care and services furnished by individual Contractors and statewide by all Contractors.
- Aggregate and assess the AHCCCS-required Contractor CAPs to provide an overall evaluation of performance for each Contractor and statewide.

Methodology for Conducting the Review

For the CYE 2016 review period (i.e., measurement year ending September 30, 2016), AHCCCS conducted the following activities:

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

CAPs, key components of the AHCCCS Quality Strategy, are used as foundational elements to improve performance measure rates that fall below contractual MPSs. At the time of the production of this report, AHCCCS had not yet formally required CAPs of Contractors based on CYE 2016 performance measure data. As a result, no CAP data are included in this section of the report for this year.

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

Performance measures used HEDIS or a HEDIS-like methodology for rate calculation. The HEDIS administrative methodology used for data collection in the current measurement did not differ from the methodology used for the previous measurement period. NCQA updates its methodology annually to add new codes to better identify the eligible population and/or services being measured or to delete codes retired from standardized coding sets used by providers.

AHCCCS analyzed Contractors' results for each performance measure to determine if performance measure rates met or exceeded the corresponding AHCCCS MPSs. Relative rate changes and statistical analyses are presented to show the magnitude and direction of any change in rates from the previous measurement period and whether that change was statistically significant.

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

The following sections describe HSAG's findings, conclusions, and recommendations for each Contractor as well as statewide comparative results for all Contractors for CYE 2016.

ALTCS Contractor-Specific Results

AHCCCS provided data to HSAG on the CYE 2016 performance measure rates for three ALTCS Contractors. The three CYE 2016 ALTCS Contractors were BWY, MCP-LTC, and UHCCP-LTC. The CYE 2016 performance measures reported for the ALTCS Contractors are listed in the “Conducting the Review” section preceding. No discussion of CAPs is included in the report this year for CYE 2016 data.

Bridgeway Health Solutions (BWY)

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

Findings

Table 7-1 presents the performance measure rates for BWY. The table displays CYE 2015 performance; CYE 2016 performance; the relative percentage change between the CYE 2015 and CYE 2016 rates; the statistical significance of the relative percentage change; and the AHCCCS MPS, when applicable.

Table 7-1—Performance Measurement Review for BWY

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (p value) ¹	Minimum Performance Standard
Adults’ Access to Preventive/Ambulatory Health Services					
Adults’ Access to Preventive/Ambulatory Health Services	90.3%	93.1%	3.1%	P<.001	75.0%
Ambulatory Care (per 1,000 Member Months)²					
ED Visits—Total	69	69	—	—	—
Annual Monitoring for Patients on Persistent Medications					
Total	—	93.9%	—	—	—
COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)²					
COPD or Asthma in Older Adults Admission Rate	138.9	85.9	—	—	—
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)²					
Diabetes Short-Term Complications Admission Rate	25.5	26.5	—	—	—

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (p value) ¹	Minimum Performance Standard
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up	—	25.0%	—	—	50.0%
30-Day Follow-Up	—	37.5%	—	—	70.0%
Heart Failure Admission Rate (per 100,000 Member Months)²					
Heart Failure Admission Rate	121.6	107.4	—	—	—
Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)					
Total Inpatient	—	205.5	—	—	—
Maternity	—	0.2	—	—	—
Surgery	—	106.1	—	—	—
Medicine	—	99.4	—	—	—
Plan All-Cause Readmissions²					
Total	11.6%	11.1%	-4.1%	P=.739	—

¹ Significance levels (p values) noted in the table were calculated by AHCCCS and HSAG and demonstrate whether the differences in performance between CYE 2015 and CYE 2016 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.

² A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance. — Indicates the Contractors were not required to report the measure, a comparison of performance between CYE 2015 and CYE 2016 was not possible, or an MPS has not yet been established by AHCCCS.

CAPs

No discussion of CAPs is included in this section for CYE 2016 data.

Strengths

For the *Adults’ Access to Preventive/Ambulatory Health Services* measure, BWY exceeded the MPS by 18.1 percentage points and showed statistically significant improvement from CYE 2015 to CYE 2016.

Opportunities for Improvement

Two of the three performance measure rates (*Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*) fell below the MPS by 25 percentage points and 32.5 percentage points, respectively. This suggests that BWY has an opportunity to improve in follow-up after hospitalization.

Summary

BWY’s performance measure rate for the *Adults’ Access to Preventive/Ambulatory Health Services* exceeds the established MPS by more than 18 percentage points, while the performance measure rates for both *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* fell below the MPSs by more than 20 percentage points.

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

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

Findings

Table 7-2 presents the performance measure rates for MCP-LTC. The table displays CYE 2015 performance; CYE 2016 performance; the relative percentage change between the CYE 2015 and CYE 2016 rates; the statistical significance of the relative percentage change; and the AHCCCS MPS, when applicable.

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

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (p value) ¹	Minimum Performance Standard
Adults' Access to Preventive/Ambulatory Health Services					
Adults' Access to Preventive/Ambulatory Health Services	94.7%	94.6%	-0.1%	P=.787	75.0%
Ambulatory Care (per 1,000 Member Months)²					
ED Visits—Total	75	77	—	—	—
Annual Monitoring for Patients on Persistent Medications					
Total	—	96.1%	—	—	—
COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)²					
COPD or Asthma in Older Adults Admission Rate	113.3	96.1	—	—	—
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)²					
Diabetes Short-Term Complications Admission Rate	7.9	18.8	—	—	—
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up	—	27.7%	—	—	50.0%
30-Day Follow-Up	—	56.9%	—	—	70.0%
Heart Failure Admission Rate (per 100,000 Member Months)²					
Heart Failure Admission Rate	151.9	157.1	—	—	—
Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)					
Total Inpatient	—	275.4	—	—	—
Maternity	—	0.2	—	—	—
Surgery	—	148.7	—	—	—
Medicine	—	126.6	—	—	—

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (p value) ¹	Minimum Performance Standard
Plan All-Cause Readmissions²					
Total	16.3%	13.3%	-18.3%	P=.002	—

¹ Significance levels (p values) noted in the table were calculated by AHCCCS and HSAG and demonstrate whether the differences in performance between CYE 2015 and CYE 2016 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.

² A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance. — Indicates the Contractors were not required to report the measure, a comparison of performance between CYE 2015 and CYE 2016 was not possible, or an MPS has not yet been established by AHCCCS.

CAPs

No discussion of CAPs is included in this section for CYE 2016 data.

Strengths

MCP-LTC exceeded the MPS for the *Adults’ Access to Preventive/Ambulatory Health Services* measure by 19.6 percentage points. Additionally, the performance measure rate for *Plan All-Cause Readmissions* demonstrated statistically significant improvement from CYE 2015 to CYE 2016, as a lower rate indicates better performance for this measure.

Opportunities for Improvement

Two of the three performance measure rates (*Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*) fell below the MPS by 22.3 percentage points and 13.1 percentage points, respectively. This suggests that MCP-LTC has an opportunity to improve in follow-up after hospitalization.

Summary

MCP-LTC’s performance measure rate for the *Adults’ Access to Preventive/Ambulatory Health Services* measure exceeds the established MPS by more than 19 percentage points, while the performance measure rates for both *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* fell below the MPSs by more than 10 percentage points.

UnitedHealthcare Community Plan (UHCCP-LTC)

UHCCP-LTC has contracted with AHCCCS since 1989.

Findings

Table 7-3 presents the performance measure rates for UHCCP-LTC. The table displays CYE 2015 performance; CYE 2016 performance; the relative percentage change between the CYE 2015 and CYE 2016 rates; the statistical significance of the relative percentage change; and the AHCCCS MPS, when applicable.

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

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (<i>p</i> value) ¹	Minimum Performance Standard
Adults' Access to Preventive/Ambulatory Health Services					
<i>Adults' Access to Preventive/Ambulatory Health Services</i>	85.0%	87.3%	2.7%	P<.001	75.0%
Ambulatory Care (per 1,000 Member Months)²					
<i>ED Visits—Total</i>	59	66	—	—	—
Annual Monitoring for Patients on Persistent Medications					
<i>Total</i>	—	89.0%	—	—	—
COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)²					
<i>COPD or Asthma in Older Adults Admission Rate</i>	78.6	81.2	—	—	—
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)²					
<i>Diabetes Short-Term Complications Admission Rate</i>	7.8	16.5	—	—	—
Follow-Up After Hospitalization for Mental Illness					
<i>7-Day Follow-Up</i>	—	31.4%	—	—	50.0%
<i>30-Day Follow-Up</i>	—	48.6%	—	—	70.0%
Heart Failure Admission Rate (per 100,000 Member Months)²					
<i>Heart Failure Admission Rate</i>	87.2	110.5	—	—	—
Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)					
<i>Total Inpatient</i>	—	129.1	—	—	—
<i>Maternity</i>	—	0.6	—	—	—
<i>Surgery</i>	—	65.6	—	—	—
<i>Medicine</i>	—	63.3	—	—	—

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (p value) ¹	Minimum Performance Standard
Plan All-Cause Readmissions²					
<i>Total</i>	7.3%	8.1%	11.2%	P=.512	—

¹ Significance levels (p values) noted in the table were calculated by AHCCCS and HSAG and demonstrate whether the differences in performance between CYE 2015 and CYE 2016 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.

² A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance. — Indicates the Contractors were not required to report the measure, a comparison of performance between CYE 2015 and CYE 2016 was not possible, or an MPS has not yet been established by AHCCCS.

CAPs

No discussion of CAPs is included in this section for CYE 2016 data.

Strengths

UHCCP-LTC exceeded the MPS by 12.3 percentage points and showed statistically significant improvement from CYE 2015 to CYE 2016 for the *Adults’ Access to Preventive/Ambulatory Health Services* measure.

Opportunities for Improvement

Two of the three performance measure rates (*Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*) fell below the MPS by 18.6 percentage points and 21.4 percentage points, respectively. This suggests that UHCCP-LTC has an opportunity to improve in follow-up after hospitalization.

Summary

UHCCP-LTC’s performance measure rate for the *Adults’ Access to Preventive/Ambulatory Health Services* exceed the established MPS by more than 10 percentage points, while the performance measure rates for both *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* fell below the MPSs by more than 15 percentage points.

Comparative Results for ALTCS Contractors—CYE 2016

Findings

Table 7-4 presents the aggregate performance measure rates for all ALTCS Contractors. The table displays CYE 2015 performance; CYE 2016 performance; the relative percentage change between the CYE 2015 and CYE 2016 rates; the statistical significance of the relative percentage change; and the AHCCCS MPS, when applicable.

Table 7-4—Performance Measurement Review for ALTCS Contractors

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (p value) ¹	Minimum Performance Standard
Adults' Access to Preventive/Ambulatory Health Services					
Adults' Access to Preventive/Ambulatory Health Services	90.5%	91.5%	1.0%	P=.001	75.0%
Ambulatory Care (per 1,000 Member Months)²					
ED Visits—Total	68	71	—	—	—
Annual Monitoring for Patients on Persistent Medications					
Total	—	93.6%	—	—	—
COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)²					
COPD or Asthma in Older Adults Admission Rate	106.2	88.3	—	—	—
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)²					
Diabetes Short-Term Complications Admission Rate	11.6	19.5	—	—	—
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up	—	28.2%	—	—	50.0%
30-Day Follow-Up	—	50.8%	—	—	70.0%
Heart Failure Admission Rate (per 100,000 Member Months)²					
Heart Failure Admission Rate	122.4	129.3	—	—	—
Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)					
Total Inpatient	—	205.8	—	—	—
Maternity	—	0.0	—	—	—
Surgery	—	108.6	—	—	—
Medicine	—	97.1	—	—	—

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (p value) ¹	Minimum Performance Standard
Plan All-Cause Readmissions²					
Total	13.7%	11.7%	-14.9%	P=.003	—

¹ Significance levels (p values) noted in the table were calculated by AHCCCS and HSAG and demonstrate whether the differences in performance between CYE 2015 and CYE 2016 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.

² A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance. — Indicates the Contractors were not required to report the measure, a comparison of performance between CYE 2015 and CYE 2016 was not possible, or an MPS has not yet been established by AHCCCS.

CAPs

No discussion of CAPs is included in this section for CYE 2016 data.

Strengths

The ALTCS Contractors’ performance measure rate had a statistically significant improvement and exceeded the MPS for the *Adults’ Access to Preventive/Ambulatory Health Services* measure by 16.5 percentage points. Additionally, the performance measure rate for *Plan All-Cause Readmissions* demonstrated statistically significant improvement from CYE 2015 to CYE 2016, as a lower rate indicates better performance for this measure.

Opportunities for Improvement and Recommendations

Two of the three performance measure rates (*Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*) with MPSs fell below those MPSs by 21.8 percentage points and 19.2 percentage points, respectively. This suggest an opportunity for improvement in follow-up care after hospitalization.

In addition, HSAG recommends that more appropriate MPSs be assigned to the performance measures, given that this special population may not benefit from exceeding the MPSs currently assigned.

Summary

The ALTCS Contractors’ aggregate performance measure rate exceeded the MPS for the *Adults’ Access to Preventive/Ambulatory Health Services* measure by more than 16 percentage points, while *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* both fell below the MPSs.

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

ALTCS–DES/DDD Results

ALTCS–DES/DDD has contracted with AHCCCS since 1989.

Findings

Table 7-5 presents the performance measure rates for ALTCS–DES/DDD. The table displays CYE 2015 performance; CYE 2016 performance; the relative percentage change between the CYE 2015 and CYE 2016 rate; the statistical significance of the relative percentage change; and the AHCCCS MPS, when applicable.

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

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (p value) ¹	Minimum Performance Standard
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	39.8%	43.5%	9.3%	P<.001	41.0%
Adults' Access to Preventive/Ambulatory Health Services					
Adults' Access to Preventive/Ambulatory Health Services	85.2%	86.0%	0.9%	P=.068	75.0%
Ambulatory Care (per 1,000 Member Months)²					
ED Visits—Total	44	43	—	—	—
Annual Dental Visits					
2–20 Years	55.7%	51.9%	-6.9%	P<.001	60.0%
Breast Cancer Screening					
Breast Cancer Screening	45.1%	46.2%	2.5%	P=.644	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	18.0%	17.4%	-3.1%	P=.493	64.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	98.3%	100.0%	1.7%	P=.100	93.0%
25 Months–6 Years	90.1%	89.6%	-0.6%	P=.540	84.0%
7–11 Years	91.1%	92.0%	1.0%	P=.123	83.0%
12–19 Years	88.4%	88.5%	0.1%	P=.743	82.0%

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (p value) ¹	Minimum Performance Standard
Chlamydia Screening in Women					
Total	8.3%	9.7%	17.3%	P=.352	63.0%
COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)²					
COPD or Asthma in Older Adults Admission Rate	12.0	9.8	—	—	—
Developmental Screening in the First Three Years of Life					
Total	16.5%	24.9%	50.6%	P=.005	—
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)²					
Diabetes Short-Term Complications Admission Rate	3.2	4.2	—	—	—
Heart Failure Admission Rate (per 100,000 Member Months)²					
Heart Failure Admission Rate	3.8	4.8	—	—	—
Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)					
Total Inpatient	—	48.2	—	—	—
Maternity	—	0.1	—	—	—
Surgery	—	25.3	—	—	—
Medicine	—	22.8	—	—	—
Plan All-Cause Readmissions²					
Total	9.2%	7.3%	-20.2%	P=.130	—
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	52.1%	51.2%	-1.8%	P=.504	66.0%

¹ Significance levels (p values) noted in the table were calculated by AHCCCS and HSAG and demonstrate whether the differences in performance between CYE 2015 and CYE 2016 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.

² A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance. — Indicates the Contractors were not required to report the measure, a comparison of performance between CYE 2015 and CYE 2016 was not possible, or an MPS has not yet been established by AHCCCS.

CAPs

No discussion of CAPs is included in this section for CYE 2016 data.

Strengths

ALTCS–DES/DDD exceeded the MPS for six of 11 performance measure rates (*Adolescent Well-Care Visits; Adults' Access to Preventive/Ambulatory Health Services; and Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years*). Of note, the performance measure rates for *Adolescent Well-Care* and *Developmental Screening in the First Three Years of Life* showed statistically significant increases from CYE 2015 to CYE 2016.

Opportunities for Improvement

Five of the 11 performance measure rates (*Annual Dental Visits—2–20 Years; Breast Cancer Screening; Cervical Cancer Screening; Chlamydia Screening in Women—Total; and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) fell below the MPSs. More specifically, the rates for *Cervical Cancer Screening; Chlamydia Screening in Women—Total; and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* fell below the MPSs by 46.6 percentage points, 53.3 percentage points, and 14.8 percentage points, respectively, demonstrating opportunities for improvement. Further, the performance measure rates for *Annual Dental Visits—2–20 Years* showed a statistically significant decline from CYE 2015 to CYE 2016. This suggests that ALTCS–DES/DDD has opportunities to improve in women's screenings and well-child visits.

Summary

Six of 11 performance measure rates (*Adolescent Well-Care Visits; Adults' Access to Preventive/Ambulatory Health Services; and Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years*) exceeded the MPSs, while five performance measure rates fell below the MPS (*Annual Dental Visits—2–20 Years; Breast Cancer Screening; Cervical Cancer Screening; Chlamydia Screening in Women—Total; and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*).

8. Performance Improvement Project Performance

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

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

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

Conducting the Review

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

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

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

In CYE 2015 (October 1, 2014, through September 30, 2015), AHCCCS implemented a new PIP, *E-Prescribing*, for all lines of business. The baseline measurement period covered CYE 2014 (data from October 1, 2013, through September 30, 2014), to be followed by two remeasurement periods: October 1, 2015, through September 30, 2016; and October 1, 2016, through September 30, 2017. This annual report will include CYE 2014 recalculated baseline measurement data, CYE 2016 Remeasurement 1 data, relative percentage changes from baseline data, statistical significance data, qualitative analyses, and interventions.

AHCCCS implemented the *E-Prescribing* PIP because research suggested that an opportunity existed to improve preventable errors in using the standard, handwritten paper method to communicate a medication between a prescriber and a pharmacy. Research indicated that clinicians make seven times fewer errors (decreasing from 42.5 per 100 prescriptions to 6.6 per 100 prescriptions after one year)

when using an electronic system rather than writing prescriptions by hand.⁸⁻¹ AHCCCS found that sending a clear and legible prescription electronically can reduce mistakes related to medication types, dosages, and member information. In addition, AHCCCS noted that electronic prescribing can assist pharmacies in identifying potential problems related to medication management and potential reactions members may encounter, especially for those taking multiple medications.

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

Objectives for Conducting the Review

In its objectives for evaluating Contractor PIPs, AHCCCS:

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

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

- Determine Contractor performance on the AHCCCS-selected PIP.

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

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

Methodology for Conducting the Review

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

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

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

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

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

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

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

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

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

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

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

⁸⁻² Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf> Accessed on September 21, 2017.

For the CYE 2017 annual report, the following sections have been updated to include Contractor-specific activities, qualitative analyses, and interventions during CYE 2016 (October 1, 2015, through September 30, 2016) as submitted to AHCCCS.

The following sections describe HSAG's findings, conclusions, and recommendations for ALTCS Contractors and DES/DDD.

Contractor-Specific Results

AHCCCS provided HSAG with its CYE 2016 Contractor PIP qualitative analyses and interventions for three ALTCS Contractors and DES/DDD. The three ALTCS Contractors for which data were provided were BWY, MCP-LTC, and UHCCP-LTC. The PIP conducted during CYE 2016 for the ALTCS Contractors and DES/DDD was *E-Prescribing*, which, to improve patient safety, focused on increasing both the number of providers ordering prescriptions electronically and the percentage of prescriptions submitted electronically rather than via paper or other method.

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

This section includes Contractors' PIP Remeasurement 1 results as calculated by AHCCCS by the Contractors, along with specific activities and interventions during the remeasurement period 1 from October 1, 2015, through September 30, 2016. HSAG has minimally edited the analyses and interventions for grammar and punctuation. Upon review of the previously reported *E-Prescribing* PIP provider prescribing rates, HSAG noted that the aggregate rates indicated for the 2015–2016 annual report did not account for duplication of providers. Provider rates were originally calculated at the health plan level that resulted and reported in one of two age bands (ages 0 through 64 and 65 and over). When calculating the aggregate rate per line of business, the numerators and denominators were noted to be added together and then divided by the number of health plans included for that line of business. In addition, the calculations did not include a combined rate of prescribing providers for all prescribers per health plan (versus the 0 through 64 and 65 and over age bands indicated previously).

To ensure accuracy and consistency among the CYE 2014 and CYE 2016 rates, AHCCCS conducted a retrospective review of claims and encounters for CYE 2014 (October 1, 2013, through September 30, 2014) and applied the same calculations for both years, thus providing a rate that accounted for the noted duplication in this area. This included analysis of provider prescribing and e-prescribing at the health plan level as well as unduplicated provider prescribing and e-prescribing rates at the line-of-business and AHCCCS aggregate levels.

Bridgeway Health Solutions (BWY)

Findings

Table 8-1 presents the baseline and Remeasurement 1 results for the E-Prescribing PIP for BWY members, including those members from 0 through 64 years of age and those members 65 years of age and over. The table also presents the relative percentage changes from baseline and the statistical significance of changes in rates.

Table 8-1—BWY E-Prescribing PIP*

PIP Measure	Baseline Period Oct. 1, 2013, through Sept. 30, 2014	Remeasurement 1 Oct. 1, 2015, through Sept. 30, 2016	Remeasurement 2 Oct. 1, 2016, through Sept. 30, 2017	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	37.70%	45.42%	NA	7.72%	P<.001
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	21.29%	23.39%	NA	2.10%	P<.001

*Percentages represent a combination of members 0 through 64 years of age and 65 years of age and over.

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-1 shows that, during the baseline period, 37.70 percent of BWY’s providers prescribed at least one prescription electronically and that 21.29 percent of prescriptions were sent by an AHCCCS-contracted provider electronically. For Remeasurement 1, 45.42 percent of BWY’s providers prescribed at least one prescription electronically and 23.29 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. BWY’s Remeasurement 1 rate for Indicator 1 demonstrated a relative percentage change from baseline of 7.72 percent and for Indicator 2 demonstrated a relative percentage change from baseline of 2.10 percent. BWY demonstrated statistically significant improvements for both quality indicators for this PIP but a substantively large improvement for Indicator 1 only.

BWY submitted the following qualitative analysis:

- Since electronic prescribing began, the long-term care sector has lagged in terms of adoption and use of this technology. When electronic prescribing was added to the meaningful-use incentive created by CMS, the long-term care sector was excluded from this mandate and any subsequent grants to adopt the new technology. Additionally, the addition, for members requiring long-term care, to live outside of skilled nursing facilities exacerbated the fragmentation that already existed related to services in the sector.
- The largest barrier that providers face in the adoption of electronic prescribing technology in the long-term care sector is being mobile and relying on the facility or parent company to provide them with electronic prescribing tools. Although some facilities are large national providers, most are independently owned by small business providers that cannot afford the upgrade in medical record systems that would allow electronic prescribing. Only in the last year has Point Click Care, the largest provider of electronic medical records for long-term care facilities in Arizona, added the functionality of electronic prescribing to their system. At this time the cost for installation of the system is approximately \$50,000, which is cost prohibitive for most facility owners. An option of obtaining a stand-alone electronic prescribing system does exist. While this reduces the costs associated with e-prescribing, the system would not be integrated into the medical record; therefore, the provider would necessarily record two sets of data entry. This option doubles the work for the provider and adds the burden of checking another system every time a refill or new prescription is needed.
- As part of BWY's efforts to understand and overcome barriers to electronic prescribing in long-term care, the plan has held multiple education events with its largest providers and with the Arizona Health Care Association. BWY has discussed the current workflow process for physicians with Independent Pharmacy Cooperative (IPC) and with nurse practitioners through Optum and Pop Health to see if using an electronic prescribing system would be feasible. Finally, BWY purchased its own stand-alone electronic prescribing system through MD Toolbox and gave access to 15 nurse practitioners who see BWY members in the community. This initiative has resulted in a 5 percent increase in electronic prescribing for BWY members within three months of initiation.
- BWY stated that many challenges in the adoption of electronic prescribing in long-term care remain. Each facility type, from assisted living to skilled nursing facility, has different rules for prescribing and medical recordkeeping of prescriptions. This use of multiple systems makes it difficult for a provider who operates in multiple venues to use electronic prescribing. Some slow gains are being made nationally, which will ultimately improve electronic prescribing in this sector. In 2016 several providers of long-term care medical record systems added electronic prescribing to their systems. As this market grows, the price should come down, making the adoption of e-prescribing more available for all facilities and providers. In talks with national provider groups such as IPC, Optum, Ensign, and Lifecare BWY learned that all are in process of creating individual electronic prescribing systems to integrate with their internal medical records. BWY will continue to look for short-term solutions and to educate providers until more cost-effective options are available.

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

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

Strengths

BWY analyzed the data from the surveys conducted and developed interventions to address the barrier to e-prescribing, including the purchase of a stand-alone electronic prescribing module for contracted prescribers. BWY conducted an analysis of the top 20 prescribers and enrolled them in the stand-alone system. BWY coordinated with Health Net regarding education materials and initiatives for electronic prescribing PIP. In addition, BWY and Health Net co-branded education flyers with both Contractor logos and information.

Opportunities for Improvement and Recommendations

HSAG recommends that BWY continue to monitor outcomes associated with the reported interventions. BWY needs to sustain the improvement for an additional measurement cycle and has an opportunity for improvement for both indicators. In addition, HSAG recommends that AHCCCS continue the collaboration among Contractors in the workgroup to improve performance for these indicators.

Summary

BWY's *E-Prescribing* PIP Remeasurement 1 rates were 45.42 percent for Indicator 1 and 23.39 percent for Indicator 2. Both indicator rates increased by statistically significant amounts. BWY is encouraged to monitor the progress of the PIP interventions employed to increase providers prescribing electronically and prescriptions sent electronically, then adjust interventions as needed to ensure that the rates continue to increase by statistically significant amounts during the second remeasurement period.

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

Findings

Table 8-2 presents the baseline and Remeasurement 1 results for the *E-Prescribing* PIP for MCP-LTC’s members, including those members from 0 through 64 years of age and those members 65 years of age and over. The table also presents the relative percentage change from baseline and the statistical significance of the change in rates.

Table 8-2—MCP-LTC *E-Prescribing* PIP*

PIP Measure	Baseline Period Oct. 1, 2013, through Sept. 30, 2014	Remeasurement 1 Oct. 1, 2015, through Sept. 30, 2016	Remeasurement 2 Oct. 1, 2016, through Sept. 30, 2017	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	47.62%	55.11%	NA	7.49%	P<.001
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	23.99%	27.98%	NA	3.99%	P<.001

*Percentages represent a combination of members 0 through 64 years of age and 65 years of age and over.

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-2 shows that, during the baseline period, 47.62 percent of MCP-LTC’s providers prescribed at least one prescription electronically and 23.09 percent of prescriptions were sent by an AHCCCS-contracted provider electronically. For Remeasurement 1, 55.11 percent of MCP-LTC’s providers prescribed at least one prescription electronically and 27.98 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. MCP-LTC’s Remeasurement 1 rate for Indicator 1 had a relative percentage change from baseline of 7.49 percent and for Indicator 2 had a relative percentage change from baseline of 3.99 percent. MCP-LTC demonstrated a statistically significant improvement in performance for this PIP.

MCP-LTC submitted the following qualitative analysis:

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

- Almost all providers surveyed by MCP-LTC have an EHR.
- Barriers identified by MCP-LTC:
 - Prescriptions written in a hospital setting rather than in a clinic, did not allow for providers to use e-prescribing software.
 - Lack of understanding exists about the ability to use e-prescribing for all prescriptions, including controlled substances.
 - Belief exists that prescriptions are submitted electronically when, in reality, the prescription is submitted into an EHR, then converted to a fax or paper script.
 - Additional cost is assessed to the practice to add to the practice’s EHR system the ability to e-prescribe.
 - EHR system limitations exist—multiple providers reported that their EHR systems did not allow e-prescribing of narcotics.
 - Providers reported that pharmacies rejected any controlled substances e-prescribed, indicating it was “illegal” to e-prescribe as an original signature is required on the script.
 - A practice was told that to be able to e-prescribe they would need to add a fingerprinting security system to their current EHR, which could be costly and time-consuming for the practice.
 - Usually, a two-day delay exists for pharmacies to process and dispense prescriptions for members if those prescriptions are submitted electronically, which may cause an issue if the medication is needed urgently or emergently.
 - Providers that have e-prescribed controlled medications reported the process to be difficult, including the requirement of having a different password and a key tag to facilitate a revolving identification.
- Additional costs exist to add the ability to e-prescribe controlled substances to MCP-LTC’s EHR.
- Barriers identified by other Contractors:
 - EHR system glitches sometimes caused electronic prescription transmission errors.
 - Provider preference for writing prescriptions and physicians’ preference to hand prescriptions to members exist.
 - System limitations exist related to e-prescribing.
 - Difficulty was expressed related to pharmacies accepting prescriptions electronically, specifically in rural areas.
 - Related to e-prescribing controlled substances, one physician provided the following feedback:
 - It is more complicated to e-prescribe controlled substances since the regulatory changes took effect in October 2014.
 - Availability of Class 2 controlled substances in the area, especially oxytocin and oxycodone, is limited.
 - Once an e-prescription was sent, it would have to be cancelled before another could be sent. This could be extremely time-consuming and is not something that could be done timely.

- When a patient used a pharmacy other than their usual, the new pharmacy insisted that all of that member's medications (not just the narcotics) be filled at that pharmacy; so, the same requirement would likely apply for non-narcotic medications.

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

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

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

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

- Developed, along with other members of the Arizona Association of Health Plans, a fact sheet for providers on the topic of EPCS.
- Conducted on-site visits and distribution of the EPCS fact sheet; the visits were conducted by an MCP-LTC medical director and provider relations staff.
- Targeted review/outreach to larger practices to show variances across providers.
- Incentivized e-prescribing with patient-centered medical homes (PCMHs) and Arizona Care Network (ACN). Improvements in e-prescribing will be one of MCP-LTC's performance measures for 2015, with targets and rewards varying by practice based on baseline and actual practice performance.
- Developed member educational materials to communicate the benefits of e-prescribing via the MCP-LTC website and/or Facebook posts.
- Developed and posted a provider toolkit to educate providers on the benefits and value of e-prescribing.
- Worked with CVS to send a fax blast to pharmacies reminding them of the importance of accurately reporting controlled substances prescription monitoring program (CSPMP) data.

Strengths

MCP-LTC analyzed the data from the surveys conducted and developed interventions to address the education barrier to e-prescribing. MCP-LTC has educated prescribers on the advantages of e-prescribing by developing e-prescribing educational materials, conducting on-site visits to distribute the educational materials, and offering rewards for performance improvement related to the PIP.

Opportunities for Improvement and Recommendations

HSAG recommends that MCP-LTC continue to monitor outcomes associated with the reported interventions. MCP-LTC needs to sustain the improvement for an additional measurement cycle and has an opportunity for improvement for both indicators. In addition, HSAG recommends that AHCCCS continue the collaboration among Contractors in the workgroup to improve performance for these indicators.

Summary

MCP-LTC's *E-Prescribing* PIP Remeasurement 1 rates were 55.11 percent for Indicator 1 and 27.98 percent for Indicator 2. Both indicator rates increased by statistically and substantively significant amounts. MCP-LTC is encouraged to monitor the progress of the PIP interventions employed to increase providers prescribing electronically and prescriptions sent electronically, then adjust interventions as needed to ensure that the rates continue to increase by statistically significant amounts during the second remeasurement period.

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

Table 8-3 presents the baseline and Remeasurement 1 results for the *E-Prescribing* PIP for UHCCP-LTC’s members, including those members from 0 through 64 years of age and those members 65 years of age and over. The table also presents the relative percentage changes from baseline and the statistical significance of changes in rates.

Table 8-3—UHCCP-LTC *E-Prescribing* PIP*

PIP Measure	Baseline Period Oct. 1, 2013, through Sept. 30, 2014	Remeasurement 1 Oct. 1, 2015, through Sept. 30, 2016	Remeasurement 2 Oct. 1, 2016, through Sept. 30, 2017	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	48.19%	55.08%	NA	6.89%	P<.001
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	27.42%	31.91%	NA	4.49%	P<.001

*Percentages represent a combination of members 0 through 64 years of age and 65 years of age and over.

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-3 shows that, during the baseline period, 48.19 percent of UHCCP-LTC’s providers prescribed at least one prescription electronically and 27.42 percent of prescriptions were sent by an AHCCCS-contracted provider electronically. For the Remeasurement 1 period, 55.08 percent of UHCCP-LTC’ providers prescribed at least one prescription electronically and 31.91 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For the Remeasurement 1 period, UHCCP-LTC demonstrated for Indicator 1 a relative percentage change from baseline of 6.89 percent and demonstrated for Indicator 2 a relative percentage change from baseline of 4.49 percent. UHCCP- LTC demonstrated statistically significant and substantively large improvements in performance for this PIP.

UHCCP-LTC submitted the following qualitative analysis:

- An e-prescribing workgroup was formed with other Arizona Contractors. The workgroup first discussed barriers to adoption of e-prescribing. The group surveyed providers on their perceived

barriers to e-prescribing. As several providers stated that their systems would not support EPCS, a survey of EMR vendors was initiated. From these activities were identified the need for further education on e-prescribing (including EPCS), the need to evaluate the ability for current EMR systems to support ECPS, and the identification and ranking of providers e-prescribing.

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

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

Strengths

UHCCP-LTC analyzed the data from the surveys conducted and developed interventions to address the education barrier to e-prescribing. UHCCP-LTC has produced a report that ranks providers as to volume of electronic prescriptions, reached out to prescribers with low e-prescribing rates, and incorporated the *E-Prescribing* PIP into provider forums.

Opportunities for Improvement and Recommendations

HSAG recommends that UHCCP-LTC continue to monitor outcomes associated with the reported interventions. UHCCP-LTC needs to sustain the improvement for an additional measurement cycle and has an opportunity for improvement for both indicators. In addition, HSAG recommends that AHCCCS continue the collaboration among Contractors in the workgroup to improve performance for these indicators.

Summary

UHCCP-LTC's *E-Prescribing* PIP Remeasurement 1 rates of 55.08 percent for Indicator 1 and 31.91 percent for Indicator 2 demonstrated improvement over the respective baseline rates. Both rates increased by statistically and substantively significant amounts. UHCCP-LTC is encouraged to monitor the progress of the PIP interventions employed to increase providers prescribing electronically and prescriptions sent electronically and to adjust interventions as needed to ensure that the rates increase by statistically significant amounts during the second remeasurement period.

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

Findings

Table 8-4 presents the baseline and Remeasurement 1 results for the *E-Prescribing* PIP for DES/DDD members, including those members from 0 through 64 years of age and those members 65 years of age and over. The table also presents the relative percentage changes from baseline and the statistical significance of changes in rates.

Table 8-4—DES/DDD E-Prescribing PIP*

PIP Measure	Baseline Period Oct. 1, 2013, through Sept. 30, 2014	Remeasurement 1 Oct. 1, 2015, through Sept. 30, 2016	Remeasurement 2 Oct. 1, 2016, through Sept. 30, 2017	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	56.97%	62.82%	NA	5.85%	P<.001
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	44.51%	57.89%	NA	13.39%	P<.001

*Percentages represent a combination of members 0 through 64 years of age and 65 years of age and over.

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-4 shows that, during the baseline period, 56.97 percent of DES/DDD providers prescribed at least one prescription electronically and 44.51 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For Remeasurement 1, 62.82 percent of DES/DDD providers prescribed at least one prescription electronically and 57.89 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For DES/DDD’s Remeasurement 1 period, Indicator 1 demonstrated a relative percentage change from baseline of 5.85 percent and Indicator 2 demonstrated a relative percentage change from baseline of 13.39 percent. DES/DDD demonstrated statistically significant and substantively large improvements in performance for this PIP.

DES/DDD submitted the following qualitative analysis.

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

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

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

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

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

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

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

- Educated members about e-prescribing in the member newsletter in Spanish and English. Some DES/DDD contracted health plans have begun member education.
- Provided education (regarding the benefits of e-prescribing) to residential and home-based services providers at the quarterly provider meetings around the State.
- Worked with contracted health plans to target high-volume providers for education surrounding e-prescribing. Incorporated e-prescribing education and information at provider forums and engagement meetings as well as in provider newsletters and other communications. All three contracted health plans committed to this education, and DES/DDD continues to monitor compliance.
- Incorporated e-prescribing into PCMH and quality improvement (QI) partnership agreements.

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

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

- Reported rankings of provider e-prescribing rates.
- Incorporated e-prescribing as a measure under Arizona Care Network targets for 2015 with rewards and incentives based on actual practice performance.
- Began quarterly data sharing for e-prescribing rates to practices.
- Developed member educational materials to communicate the benefits of e-prescribing via the website and/or Facebook posts.
- Developed and posted a provider toolkit to educate providers on the benefits and value of e-prescribing.
- Worked with CVS to send a fax blast to pharmacies reminding of the importance of accurately reporting CSPMP data.
- Sent fax blasts to providers reinforcing the legality of e-prescribing controlled substances, listing the benefits of e-prescribing, and outlining steps to get started on EPCS; the same blast fax was used multiple times to reinforce provider/staff education through consistent messaging.
- Developed an e-prescribe education and outreach program strategy through the workgroup to improve the adoption and use of e-prescribing among the AHCCCS Acute, Long Term Care, and Behavioral Health provider networks and to assist providers in advancing through the Meaningful Use stages.
- Mined data with the assistance of AHCCCS to determine changes (compared to data mining completed in 2015) and identified opportunities for further improvement (high-volume prescribers with low rates of e-prescribing, including EPCS).
- Developed physician education flyer for use by all AHCCCS health plans through the workgroup.

Strengths

DES/DDD has implemented positive interventions to increase the rates for e-prescribing. DES/DDD has worked with contracted health plans to provide education to members and providers via the website, Facebook, fax blasts, and education flyers. High-volume providers have been targeted for e-prescribing education, with messages reinforcing the legality of e-prescribing controlled substances, listing the benefits of e-prescribing, and outlining steps to get started on EPCS. DES/DDD has incorporated e-prescribing into PCMH and QI partnership agreements. The agency has reported e-prescribing rate rankings for providers and has begun to share with providers quarterly data about rates. Finally, the agency has incorporated e-prescribing as a measure under ACN targets for 2015, with rewards and incentives based on actual practice performance.

Opportunities for Improvement and Recommendations

HSAG recommends that DES/DDD continue to monitor the outcomes associated with the reported interventions. DES/DDD needs to sustain the improvement for an additional measurement cycle and has an opportunity for improvement for both indicators. HSAG recommends that DES/DDD continue to monitor the outcomes associated with the reported interventions with all contracted health plans. In addition, HSAG recommends that AHCCCS continue the collaboration among Contractors in the workgroup to improve performance for these indicators.

Summary

For DES/DDD’s *E-Prescribing* PIP Remeasurement 1, the Indicator 1 rate of 62.82 percent and the Indicator 2 rate of 57.89 percent demonstrated improvement over the respective baseline rates. Both rates increased by statistically and substantively significant amounts. DES/DDD is encouraged to monitor the progress of the PIP interventions employed to increase providers prescribing electronically and prescriptions sent electronically and to adjust interventions as needed to ensure that rates continue to increase by statistically significant amounts during the second remeasurement period.

Comparative Results for ALTCS and DES/DDD Contractors

Findings

Figure 8-1 presents comparison rates for the *E-Prescribing* PIP Indicator 1: The percentage of AHCCCS-contracted providers who prescribed at least one prescription electronically. The figure presents baseline and Remeasurement 1 rates for each ALTCS and DES/DDD Contractor tasked with completing this PIP.

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

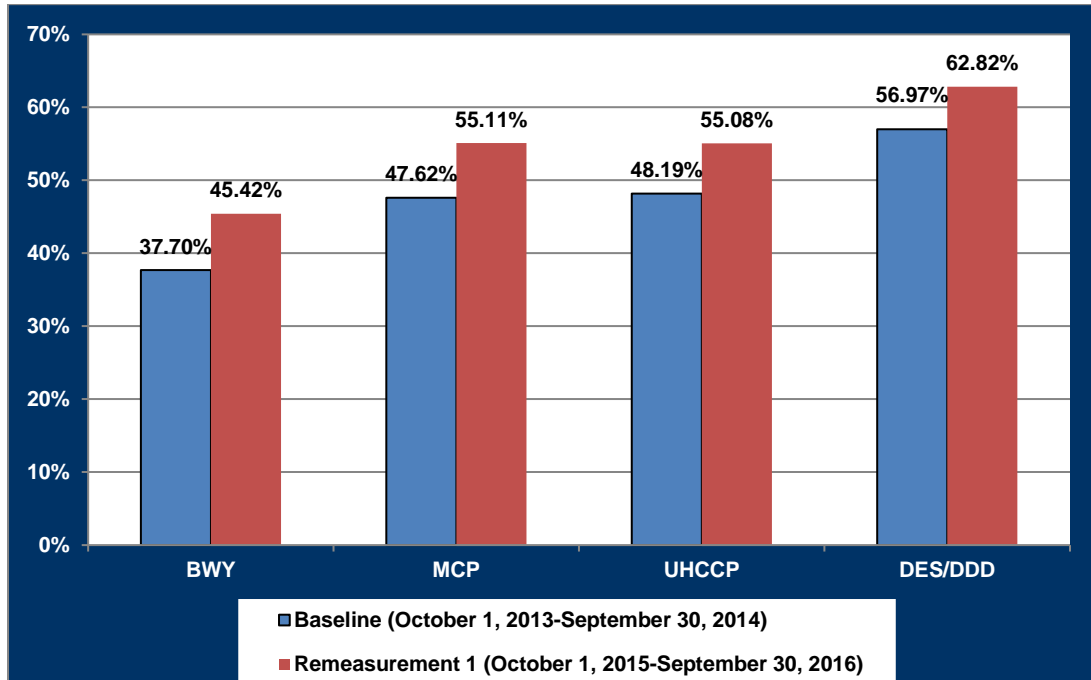


Figure 8-1 shows that each Contractor tasked with the PIP exceeded the respective baseline rate by a statistically significant amount at the first remeasurement. This finding indicates that these Contractors need only sustain the gains for a single additional remeasurement cycle.

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

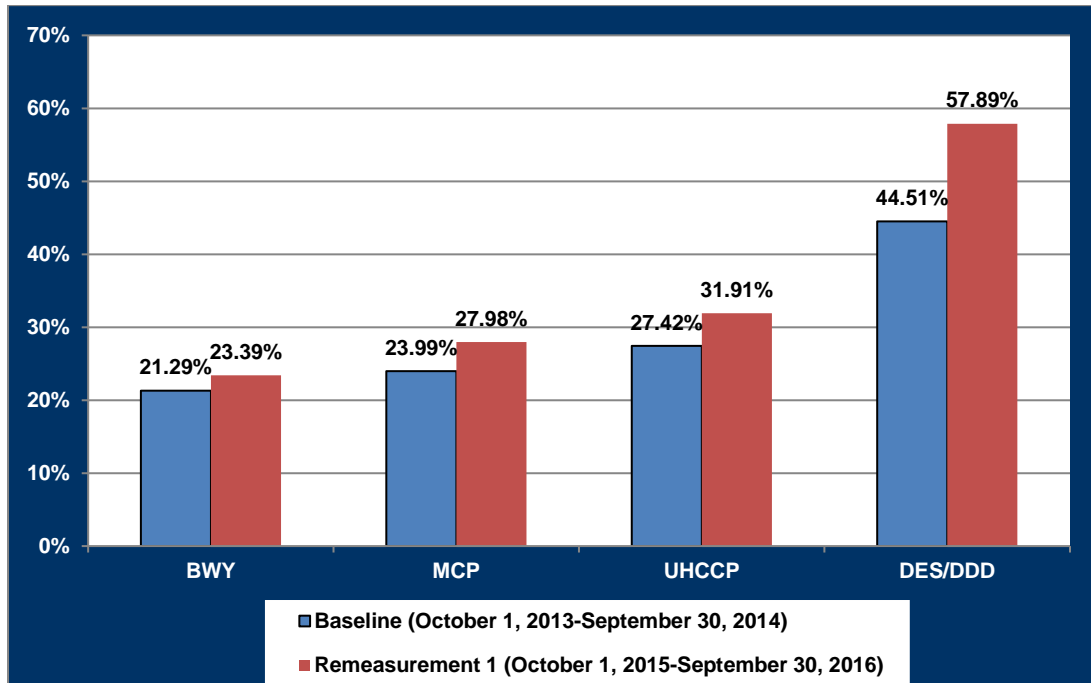


Figure 8-2 shows that each Contractor tasked with the PIP exceeded the respective baseline rate by a statistically significant amount at the first remeasurement. This finding indicates that these Contractors need only to sustain their gains for an additional remeasurement cycle.

Strengths

Figure 8-1 and Figure 8-2 demonstrate the strength of the ALTCS and DES/DDD Contractors’ *E-Prescribing* PIP. All Contractors participated in the completion of two surveys as part of the workgroup formed with other AHCCCS Contractors. The surveys asked providers to identify contributing factors to e-prescribing rates so as to highlight best practices or barriers and requested that Arizona EHR vendors determine system capabilities for e-prescribing controlled substances. In addition, all Contractors provided education to providers, with several Contractors including facilities staff and members in their education interventions. Several plans targeted high-volume prescribers and provided incentives to encourage e-prescribing. All Contractors improved their rates during their first remeasurement cycle for this PIP.

Opportunities for Improvement and Recommendations

Based on the submitted results for the *E-Prescribing* PIP and to support progress toward improved PIP outcomes in the future, HSAG offers the following recommendations related to the PIP rates:

- AHCCCS may want to consider offering and facilitating training opportunities to enhance the Contractors' capacity to implement robust interventions and QI processes and strategies for the *E-Prescribing* PIP. Increasing the Contractors' efficacy with QI tools such as root cause analyses, key driver diagrams, process mapping, failure modes and effects analysis (FMEA), and Plan-Do-Study-Act (PDSA) cycles should help to remove barriers to successfully achieving improvement in the PIP indicator rates.
- AHCCCS may want to use the quarterly meetings with Contractors as opportunities to identify and address, related to the PIP process, system-wide barriers which may be impacting ability to achieve meaningful improvement.
- AHCCCS should continue the collaboration among Contractors in the workgroup to improve the PIP study indicator rates.
- AHCCCS should consider including in the workgroup additional stakeholders who may help with improvement of the PIP study indicator rates.
- AHCCCS may want to explore any connection to the Governor's Executive Order 2616-06, Prescription of Opioids, to see if the activities of the task force might impact the PIP.
- The Contractors should continue to identify and prioritize barriers so as to develop robust interventions for the *E-Prescribing* PIP.
- The Contractors are encouraged to monitor the progress of the PIP interventions employed to increase providers prescribing electronically and prescriptions sent electronically, then adjust interventions as needed to ensure that the rates continue to increase by statistically significant amounts during the second remeasurement period.
- For system-wide barriers, AHCCCS may consider the following: facilitate a session to identify system-wide barriers impeding Contractors' abilities to impact Indicator 1 and Indicator 2; appoint a high-level AHCCCS manager as a champion for the workgroup; develop an action plan to address the system-wide barriers.

Summary

The ALTCS and DES/DDD Contractors performed well on the *E-Prescribing* PIP. Although the improvement must be sustained for an additional measurement cycle, the amount of improvement shown during the first remeasurement period suggests the likelihood of excellent outcomes in the next evaluation cycle.